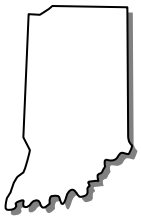

PROVIDER BULLETIN

BT200734 DECEMBER 27, 2007

To: **All Providers**

Subject: **Coverage Determinations for the New 2008 Healthcare Common Procedure Coding System Codes**

Overview

The purpose of this bulletin is to notify providers of the coverage determinations for the new 2008 Annual Healthcare Common Procedure Coding System (HCPCS) codes. The Indiana Health Coverage Programs (IHCP) has reviewed the new 2008 annual HCPCS codes to determine coverage and billing guidelines. This bulletin includes the following information:

- *Table 1:* A listing of the new alphanumeric and Current Procedural Codes Terminology (CPT®) codes for the 2008 annual HCPCS update sorted by procedure code. It also includes the description, prior authorization (PA) requirements, allowed modifiers, and program coverage determination for each code.
- *Table 2:* A listing of the new modifier codes for the 2008 annual HCPCS update sorted by modifier and including the description, type, and effective date.
- *Table 3:* A listing of the deleted and replacement codes for 2008.
- *Table 4:* A listing of the new codes currently under review for coverage by the IHCP. Claims will deny for Explanation of Benefit code 4021 – *Procedure code is not covered for the date of service for the program billed*, until program coverage is determined. Updates to coverage determinations will be published in future bulletins and banners.
- *Table 5:* A listing of new codes currently under review by the IHCP for pricing. Claims will deny for Explanation of Benefit code 4014 – *No Pricing on File* until a rate is established. Updates to rates will be published in future bulletins and banner pages.
- *Table 6:* A listing of the outpatient radiology codes billed on the UB-04 Claim Form. The rates for these codes will be published in a future bulletin.

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

New HCPCS Codes

The new 2008 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 for dates of service on or after January 1, 2008. Description changes have not been published in this bulletin. The 2008 HCPCS changed codes are available for download on the following Web site: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS.

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, 2008. Providers may bill these codes for dates of service on or after January 1, 2008. The standard global billing procedures and edits apply when using the new codes.

Notes: 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 a global service.

Codes marked with an asterisk (*) are currently non-reimbursable because a rebating manufacturer is not available at this time.

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
A6413	ADHESIVE BANDAGE, FIRST-AID TYPE, ANY SIZE, EACH	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A7027	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH	No for All Programs, No for Package C	NU	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH	No for All Programs, No for Package C	NU	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR	No for All Programs, No for Package C	NU	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A9155	ARTIFICIAL SALIVA, 30 ML	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
A9274	EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES	Yes for All Programs, Yes for Package C	NU, RR	Covered for All Programs, Covered for Package C	NA
A9276	SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NA
A9277	TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NA
A9278	RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NA
A9283	FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
C8921	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST FOR CONGENITAL CARDIAC ANOMALIES; COMPLETE	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
C8922	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST FOR CONGENITAL CARDIAC ANOMALIES; FOLLOW-UP OR LIMITED STUDY	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
C8923	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; COMPLETE	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
C8924	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D) WITH OR WITHOUT M-MODE RECORDING; FOLLOW-UP OR LIMITED STUDY	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
C8925	TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) WITH CONTRAST, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
C8926	TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) WITH CONTRAST FOR CONGENITAL CARDIAC ANOMALIES; INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
C8927	TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) WITH CONTRAST FOR MONITORING PURPOSES, INCLUDING PROBE PLACEMENT, REAL TIME 2-DIMENSIONAL IMAGE ACQUISITION AND INTERPRETATION LEADING TO ONGOING (CONTINUOUS) ASSESSMENT OF (DYNAMICALLY CHANGING) CARDIAC PUMPING	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
C8928	TRANSTHORACIC ECHOCARDIOGRAPHY WITH CONTRAST, REAL-TIME WITH IMAGE DOCUMENTATION (2D), WITH OR WITHOUT M-MODE RECORDING, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERP	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
C9238	INJECTION, LEVETIRACETAM, 10 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
C9239	INJECTION, TEMSIROLIMUS, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
C9352	MICROPOROUS COLLAGEN IMPLANTABLE TUBE (NEURAGEN NERVE GUIDE), PER CENTIMETER LENGTH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
C9353	MICROPOROUS COLLAGEN IMPLANTABLE SLIT TUBE (NEURAWRAP NERVE PROTECTOR), PER CENTIMETER LENGTH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
E0328	HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS	Yes for All Programs, Yes for Package C	NU, RR	Covered for All Programs, Covered for Package C	NA
E0329	HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS	Yes for All Programs, Yes for Package C	NU, RR	Covered for All Programs, Covered for Package C	NA
E0856	CERVICAL TRACTION DEVICE, CERVICAL COLLAR WITH INFLATABLE AIR BLADDER	Yes for All Programs, Yes for Package C	NU, RR	Covered for All Programs, Covered for Package C	NA
E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH	Yes for All Programs, Yes for Package C	NU, RR	Covered for All Programs, Covered for Package C	NA
E2228	MANUAL WHEELCHAIR ACCESSORY, WHEEL BRAKING SYSTEM AND LOCK, COMPLETE, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NA
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI-PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL,	No for All Programs, No for Package C	NU	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INCLUDING FIXED MOUNTING HARDWARE				
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM-BASED BATTERY, EACH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NA
G0396	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND BRIEF INTERVENTION 15 TO 30 MINUTES	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G0397	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND INTERVENTION, GREATER THAN 30 MINUTES	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8351	PATIENT NOT DOCUMENTED TO HAVE HAD ECG	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8354	PATIENT NOT DOCUMENTED TO HAVE RECEIVED OR TAKEN ASPIRIN 24 HOURS BEFORE EMERGENCY DEPARTMENT ARRIVAL OR DURING EMERGENCY DEPARTMENT STAY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8357	PATIENT NOT DOCUMENTED TO HAVE HAD ECG	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8360	PATIENT NOT DOCUMENTED TO HAVE VITAL SIGNS RECORDED AND REVIEWED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8362	PATIENT NOT DOCUMENTED TO HAVE OXYGEN SATURATION ASSESSED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8365	PATIENT NOT DOCUMENTED TO HAVE MENTAL STATUS ASSESSED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8367	PATIENT NOT DOCUMENTED TO HAVE APPROPRIATE EMPIRIC ANTIBIOTIC PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8370	ASTHMA PATIENTS WITH NUMERIC FREQUENCY OF SYMPTOMS OR PATIENT COMPLETION OF AN ASTHMA ASSESSMENT TOOL/SURVEY/QUESTIONNAIRE NOT DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8371	CHEMOTHERAPY DOCUMENTED AS NOT RECEIVED OR PRESCRIBED FOR STAGE III COLON CANCER PATIENTS	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8372	CHEMOTHERAPY DOCUMENTED AS RECEIVED OR PRESCRIBED FOR STAGE III COLON CANCER PATIENTS	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8373	CHEMOTHERAPY PLAN DOCUMENTED PRIOR TO CHEMOTHERAPY ADMINISTRATION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8374	CHEMOTHERAPY PLAN NOT DOCUMENTED PRIOR TO CHEMOTHERAPY ADMINISTRATION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8375	CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) PATIENT WITH NO DOCUMENTATION OF BASELINE FLOW CYTOMETRY PERFORMED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8376	CLINICIAN DOCUMENTATION THAT BREAST CANCER PATIENT WAS NOT ELIGIBLE FOR TAMOXIFEN OR AROMATASE INHIBITOR THERAPY MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8377	CLINICIAN DOCUMENTATION THAT COLON CANCER PATIENT IS NOT ELIGIBLE FOR CHEMOTHERAPY MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8378	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR RADIATION THERAPY MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8379	DOCUMENTATION OF RADIATION THERAPY RECOMMENDED WITHIN 12 MONTHS OF FIRST OFFICE VISIT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8380	FOR PATIENTS WITH ER OR PR POSITIVE, STAGE IC-III BREAST CANCER, CLINICIAN DID NOT DOCUMENT THAT THE PATIENT RECEIVED OR WAS PRESCRIBED TAMOXIFEN OR AROMATASE INHIBITOR	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8381	FOR PATIENTS WITH ER OR PR POSITIVE, STAGE IC-III BREAST CANCER, CLINICIAN DOCUMENTED OR PRESCRIBED THAT THE PATIENT IS RECEIVING TAMOXIFEN OR AROMATASE INHIBITOR	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8382	MULTIPLE MYELOMA PATIENTS WITH NO DOCUMENTATION OF PRESCRIBED OR RECEIVED INTRAVENOUS BISPHOSPHONATE THERAPY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8383	NO DOCUMENTATION OF RADIATION THERAPY RECOMMENDED WITHIN 12 MONTHS OF FIRST OFFICE VISIT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8384	BASELINE CYTOGENETIC TESTING NOT PERFORMED IN PATIENTS WITH MYELODYSPLASTIC SYNDROME (MDS) OR ACUTE LEUKEMIAS	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8385	DIABETIC PATIENTS WITH NO DOCUMENTATION OF HEMOGLOBIN A1C LEVEL (WITHIN THE LAST 12 MONTHS)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8386	DIABETIC PATIENTS WITH NO DOCUMENTATION OF LOW-DENSITY LIPOPROTEIN (WITHIN THE LAST 12 MONTHS)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8387	END-STAGE RENAL DISEASE PATIENT WITH A HEMATOCRIT OR HEMOGLOBIN NOT DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8388	END-STAGE RENAL DISEASE PATIENT WITH URR OR KT/V VALUE NOT DOCUMENTED, BUT OTHERWISE ELIGIBLE FOR MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8389	MYELODYSPLASTIC SYNDROME (MDS) PATIENTS WITH NO DOCUMENTATION OF IRON STORES PRIOR TO RECEIVING ERYTHROPOIETIN THERAPY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8390	DIABETIC PATIENTS WITH NO DOCUMENTATION OF BLOOD PRESSURE MEASUREMENT (WITHIN THE LAST 12 MONTHS)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8391	PATIENTS WITH PERSISTENT ASTHMA, NO DOCUMENTATION OF PREFERRED LONG TERM CONTROL MEDICATION OR ACCEPTABLE ALTERNATIVE TREATMENT PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8395	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS NORMAL OR MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8396	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8397	DILATED MACULAR OR FUNDUS EXAM PERFORMED, INCLUDING DOCUMENTATION OF THE PRESENCE OR ABSENCE OF MACULAR EDEMA AND LEVEL OF SEVERITY OF RETINOPATHY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8398	DILATED MACULAR OR FUNDUS EXAM NOT PERFORMED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8399	PATIENT WITH CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) RESULTS DOCUMENTED OR ORDERED OR PHARMACOLOGIC THERAPY (OTHER THAN MINERALS/VITAMINS) FOR OSTEOPOROSIS PRESCRIBED)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8400	PATIENT WITH CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) RESULTS NOT DOCUMENTED OR NOT ORDERED OR PHARMACOLOGIC THERAPY (OTHER THAN MINERALS/VITAMINS) FOR OSTEOPOROSIS NOT PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8401	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR SCREENING OR THERAPY FOR OSTEOPOROSIS FOR WOMEN MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8402	TOBACCO (SMOKE) USE CESSATION INTERVENTION, COUNSELING	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8403	TOBACCO (SMOKE) USE CESSATION INTERVENTION NOT COUNSELED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8404	LOWER EXTREMITY NEUROLOGICAL EXAM PERFORMED AND DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8405	LOWER EXTREMITY NEUROLOGICAL EXAM NOT PERFORMED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8406	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE	Not Applicable for All Programs, Not	NA	Non-Reimbursable for All Programs,	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	CANDIDATE FOR LOWER EXTREMITY NEUROLOGICAL EXAM MEASURE	Applicable for Package C		Non-Reimbursable for Package C	
G8407	ABI MEASURED AND DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8408	ABI MEASUREMENT WAS NOT OBTAINED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8409	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ABI MEASUREMENT MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8410	FOOTWEAR EVALUATION PERFORMED AND DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8415	FOOTWEAR EVALUATION WAS NOT PERFORMED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8416	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FOOTWEAR EVALUATION MEASURE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8417	BMI >= 30 WAS CALCULATED AND A FOLLOW-UP PLAN WAS DOCUMENTED IN THE MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8418	BMI < 22 WAS CALCULATED AND A FOLLOW-UP PLAN WAS DOCUMENTED IN THE MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8419	BMI >= 30 OR < 22 WAS CALCULATED, BUT NO FOLLOW-UP PLAN WAS DOCUMENTED IN THE MEDICAL RECORD	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8420	BMI < 30 AND >= 22 WAS CALCULATED AND DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8421	BMI NOT CALCULATED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8422	PATIENT NOT ELIGIBLE FOR BMI CALCULATION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8423	DOCUMENTED THAT PATIENT WAS SCREENED AND EITHER INFLUENZA VACCINATION STATUS IS CURRENT OR PATIENT WAS COUNSELED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8424	INFLUENZA VACCINE STATUS WAS NOT SCREENED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8425	INFLUENZA VACCINE STATUS SCREENED, PATIENT NOT CURRENT AND COUNSELING WAS NOT PROVIDED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8426	DOCUMENTED THAT PATIENT WAS NOT APPROPRIATE FOR SCREENING AND/OR COUNSELING ABOUT THE INFLUENZA VACCINE (E.G., ALLERGY TO EGGS)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8427	WRITTEN PROVIDER DOCUMENTATION WAS OBTAINED CONFIRMING THAT CURRENT MEDICATIONS WITH DOSAGES (INCLUDES PRESCRIPTION, OVER-THE-COUNTER, HERBALS, VITAMIN/MINERAL/DIETARY (NUTRITIONAL) SUPPLEMENTS) WERE VERIFIED WITH THE PATIENT OR AUTHORIZED REPRESENTA	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8428	CURRENT MEDICATIONS WITH DOSAGES (INCLUDES PRESCRIPTION, OVER-THE-COUNTER, HERBALS, VITAMIN/MINERAL/DIETARY (NUTRITIONAL) SUPPLEMENTS)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	WERE DOCUMENTED WITHOUT DOCUMENTED PATIENT VERIFICATION				
G8429	INCOMPLETE OR NO DOCUMENTATION THAT PATIENT'S CURRENT MEDICATIONS WITH DOSAGES (INCLUDES PRESCRIPTION, OVER-THE-COUNTER, HERBALS, VITAMIN/MINERAL/DIETARY (NUTRITIONAL) SUPPLEMENTS) WERE ASSESSED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8430	DOCUMENTATION THAT PATIENT IS NOT ELIGIBLE FOR MEDICATION ASSESSMENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8431	DOCUMENTATION OF CLINICAL DEPRESSION SCREENING USING A STANDARDIZED TOOL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8432	NO DOCUMENTATION OF CLINICAL DEPRESSION SCREENING USING A STANDARDIZED TOOL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8433	PATIENT NOT ELIGIBLE/NOT APPROPRIATE FOR CLINICAL DEPRESSION SCREENING	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8434	DOCUMENTATION OF COGNITIVE IMPAIRMENT SCREENING USING A STANDARDIZED TOOL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8435	NO DOCUMENTATION OF COGNITIVE IMPAIRMENT SCREENING USING A STANDARDIZED TOOL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8436	PATIENT NOT ELIGIBLE/NOT APPROPRIATE FOR COGNITIVE IMPAIRMENT SCREENING	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8437	DOCUMENTATION OF CLINICIAN AND PATIENT INVOLVEMENT WITH THE DEVELOPMENT OF A TREAMENT PLAN/PLAN OF CARE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INCLUDING SIGNATURE BY THE PRACTITIONER AND EITHER A CO-SIGNATURE BY THE PATIENT OR DOCUMENTED VERBAL AGREEMENT OBTAINED FROM THE PATIENT OR, WHEN				
G8438	NO DOCUMENTATION OF CLINICIAN AND PATIENT INVOLVEMENT WITH THE DEVELOPMENT OF A TREATMENT PLAN/PLAN OF CARE INCLUDING SIGNATURE BY THE PRACTITIONER AND EITHER A CO-SIGNATURE BY THE PATIENT OR DOCUMENTED VERBAL AGREEMENT OBTAINED FROM THE PATIENT OR,	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8439	DOCUMENTATION THAT PATIENT IS NOT ELIGIBLE FOR CO-DEVELOPING A TREATMENT PLAN/PLAN OF CARE INCLUDING SIGNATURE BY THE PRACTITIONER AND EITHER A CO-SIGNATURE BY THE PATIENT OR DOCUMENTED VERBAL AGREEMENT OBTAINED FROM THE PATIENT OR, WHEN NECESSARY, A	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8440	DOCUMENTATION OF PAIN ASSESSMENT (INCLUDING LOCATION, INTENSITY AND DESCRIPTION) PRIOR TO INITIATION OF TREATMENT OR DOCUMENTATION OF THE ABSENCE OF PAIN AS A RESULT OF ASSESSMENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8441	NO DOCUMENTATION OF PAIN ASSESSMENT (INCLUDING LOCATION, INTENSITY AND DESCRIPTION) PRIOR TO INITIATION OF TREATMENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8442	DOCUMENTATION THAT PATIENT IS NOT ELIGIBLE FOR PAIN ASSESSMENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8443	ALL PRESCRIPTIONS CREATED DURING THE ENCOUNTER WERE GENERATED USING A QUALIFIED E-PRESCRIBING SYSTEM	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8445	NO PRESCRIPTIONS WERE GENERATED DURING THE ENCOUNTER, PROVIDER DOES HAVE ACCESS TO A QUALIFIED E-PRESCRIBING SYSTEM	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8446	SOME OR ALL PRESCRIPTIONS GENERATED DURING THE ENCOUNTER WERE HANDWRITTEN OR PHONED IN DUE TO ONE OF THE FOLLOWING: REQUIRED BY STATE LAW, PATIENT REQUEST, OR QUALIFIED E-PRESCRIBING SYSTEM BEING TEMPORARILY INOPERABLE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8447	PATIENT ENCOUNTER WAS DOCUMENTED USING A CCHIT CERTIFIED EMR	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8448	PATIENT ENCOUNTER WAS DOCUMENTED USING A NON-CCHIT CERTIFIED EMR; TO QUALIFY, THE SYSTEM MUST BE CAPABLE OF ALL OF THE FOLLOWING: GENERATING A MEDICATION LIST, GENERATING A PROBLEM LIST, ENTERING LABORATORY TESTS AS DISCRETE SEARCHABLE DATA ELEMENTS	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8449	PATIENT ENCOUNTER WAS NOT DOCUMENTED USING AN EMR DUE TO SYSTEM REASONS SUCH AS, THE SYSTEM BEING INOPERABLE AT THE TIME OF THE VISIT; USE OF THIS CODE IMPLIES THAT AN EMR IS IN PLACE AND GENERALLY AVAILABLE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8450	BETA-BLOCKER THERAPY PRESCRIBED FOR PATIENTS WITH	Not Applicable for All Programs, Not	NA	Non-Reimbursable for All Programs,	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION AS MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Applicable for Package C		Non-Reimbursable for Package C	
G8451	CLINICIAN DOCUMENTED PATIENT WITH LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION AS MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION WAS NOT ELIGIBLE CANDIDATE FOR BETA-BLOCKER THERAPY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8452	BETA-BLOCKER THERAPY NOT PRESCRIBED FOR PATIENTS WITH LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION AS MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8453	TOBACCO USE CESSATION INTERVENTION, COUNSELING	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8454	TOBACCO USE CESSATION INTERVENTION NOT COUNSELED, REASON NOT SPECIFIED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8455	CURRENT TOBACCO SMOKER	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8456	CURRENT SMOKELESS TOBACCO USER	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8457	TOBACCO NON-USER	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8458	CLINICIAN DOCUMENTED THAT PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR GENOTYPE TESTING; PATIENT NOT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8459	CLINICIAN DOCUMENTED THAT PATIENT IS RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8460	CLINICIAN DOCUMENTED THAT PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR QUANTITATIVE RNA TESTING AT WEEK 12; PATIENT NOT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8461	PATIENT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8462	CLINICIAN DOCUMENTED THAT PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR COUNSELING REGARDING CONTRACEPTION PRIOR TO ANTIVIRAL TREATMENT; PATIENT NOT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8463	PATIENT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C DOCUMENTED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8464	CLINICIAN DOCUMENTED THAT PROSTATE CANCER PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR ADJUVANT HORMONAL THERAPY; LOW OR INTERMEDIATE RISK OF RECURRENCE OR RISK OF RECURRENCE NOT DETERMINED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8465	HIGH RISK OF RECURRENCE OF PROSTATE CANCER	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8466	CLINICIAN DOCUMENTED THAT PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR SUICIDE RISK ASSESSMENT; MAJOR DEPRESSIVE DISORDER, IN REMISSION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8467	DOCUMENTATION OF NEW DIAGNOSIS OF INITIAL OR RECURRENT EPISODE OF MAJOR DEPRESSIVE DISORDER	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8468	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY PRESCRIBED FOR PATIENTS WITH A LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC F	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8469	CLINICIAN DOCUMENTED THAT PATIENT WITH A LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION WAS NOT AN ELIGIBLE CANDIDATE FOR ANGIOTENSIN CONVERTING ENZYME (ACE) INHI	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8470	PATIENT WITH LEFT VENTRICULAR EJECTION FRACTION (LVEF) >=40% OR DOCUMENTATION AS NORMAL OR MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8471	LEFT VENTRICULAR EJECTION FRACTION (LVEF) WAS NOT	Not Applicable for All Programs, Not	NA	Non-Reimbursable for All Programs,	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PERFORMED OR DOCUMENTED	Applicable for Package C		Non-Reimbursable for Package C	
G8472	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY NOT PRESCRIBED FOR PATIENTS WITH A LEFT VENTRICULAR EJECTION FRACTION (LVEF) <40% OR DOCUMENTATION OF MODERATELY OR SEVERELY DEPRESSED LEFT VENTRICULAR SYSTOL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8473	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY PRESCRIBED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8474	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY NOT PRESCRIBED FOR REASONS DOCUMENTED BY THE CLINICIAN	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8475	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY NOT PRESCRIBED, REASON NOT SPECIFIED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8476	MOST RECENT BLOOD PRESSURE HAS A SYSTOLIC MEASUREMENT OF <130 MM/HG AND A DIASTOLIC MEASUREMENT OF <80 MM/HG	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8477	MOST RECENT BLOOD PRESSURE HAS A SYSTOLIC MEASUREMENT OF >=130 MM/HG AND/OR A DIASTOLIC MEASUREMENT OF >=80 MM/HG	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8478	BLOOD PRESSURE MEASUREMENT NOT PERFORMED OR DOCUMENTED, REASON NOT SPECIFIED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8479	CLINICIAN PRESCRIBED ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8480	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8481	CLINICIAN DID NOT PRESCRIBE ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY, REASON NOT SPECIFIED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8482	INFLUENZA IMMUNIZATION WAS ORDERED OR ADMINISTERED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8483	INFLUENZA IMMUNIZATION WAS NOT ORDERED OR ADMINISTERED FOR REASONS DOCUMENTED BY CLINICIAN	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G8484	INFLUENZA IMMUNIZATION WAS NOT ORDERED OR ADMINISTERED, REASON NOT SPECIFIED	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
G9140	FRONTIER EXTENDED STAY CLINIC DEMONSTRATION; FOR A PATIENT STAY IN A CLINIC APPROVED FOR THE CMS DEMONSTRATION PROJECT; THE FOLLOWING MEASURES SHOULD BE PRESENT: THE STAY MUST BE EQUAL TO OR GREATER THAN 4 HOURS; WEATHER OR OTHER CONDITIONS MUST PREV	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
J0220	AGLUCOSIDASE ALFA, 10MG	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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J0400	INJECTION, ARIPIPRAZOLE, INTRAMUSCULAR, 0.25MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J1300	INJECTION, ECULIZUMAB, 10MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID) 500MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J1568	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C*	Yes
J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J1571	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAMUSCULAR, 0.5 ML	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C*	Yes
J1572	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J1573	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAVENOUS, 0.5 ML	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C*	Yes
J1743	INJECTION, IDURSULFASE, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J2323	INJECTION, NATALIZUMAB, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J2724	INJECTION, PROTEIN C CONCENTRATE, INTRAVENOUS, HUMAN, 10 IU	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J2778	INJECTION, RANIBIZUMAB, 0.1 MG	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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J2791	INJECTION, RHO(D) IMMUNE GLOBULIN (HUMAN), (RHOPHYLAC), INTRAMUSCULAR OR INTRAVENOUS, 100 IU	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No
J7323	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No
J7347	DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (INTEGRA MATRIX), PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No
J7348	DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (TISSUEMEND), PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No
J7349	DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	No

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (PRIMATRIX), PER SQUARE CENTIMETER				
J7602	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J7603	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J7604	ACETYLCYSTEINE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J7605	ARFORMOTEROL, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 15 MICROGRAMS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J7632	CROMOLYN SODIUM, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
J7676	PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, COMPOUNDED PRODUCT, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
J9303	INJECTION, PANITUMUMAB, 10 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	Yes
L3925	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L3927	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G. STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L3931	WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
L7611	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L7612	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L7613	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L7614	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L7621	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
L7622	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
Q9965	LOW OSMOLAR CONTRAST MATERIAL, 100-199 MG/ML IODINE CONCENTRATION, PER ML	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
Q9966	LOW OSMOLAR CONTRAST MATERIAL, 200-299 MG/ML IODINE CONCENTRATION, PER ML	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
Q9967	LOW OSMOLAR CONTRAST MATERIAL, 300-399 MG/ML IODINE CONCENTRATION, PER ML	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
V2787	ASTIGMATISM CORRECTING FUNCTION OF INTRAOCULAR LENS	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0015F	MELANOMA FOLLOW UP COMPLETED (INCLUDES	Not Applicable for All Programs, Not	NA	Non-Reimbursable for All Programs,	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ASSESSMENT OF ALL OF THE FOLLOWING COMPONENTS) (ML)5: HISTORY OBTAINED REGARDING NEW OR CHANGING MOLES (1050F)5; COMPLETE PHYSICAL SKIN EXAM PERFORMED (2029F)5; PATIENT COUNSELED TO PERFORM A MONTHLY SELF SKIN E	Applicable for Package C		Non-Reimbursable for Package C	
0014F	COMPREHENSIVE PREOPERATIVE ASSESSMENT PERFORMED FOR CATARACT SURGERY WITH INTRAOCULAR LENS (IOL) PLACEMENT (INCLUDES ASSESSMENT OF ALL OF THE FOLLOWING COMPONENTS) (EC)5: DILATED FUNDUS EVALUATION PERFORMED WITHIN TWELVE MONTHS PRIOR TO CATARACT SURG	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0509F	URINARY INCONTINENCE PLAN OF CARE DOCUMENTED (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0513F	ELEVATED BLOOD PRESSURE PLAN OF CARE DOCUMENTED (CKD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0514F	PLAN OF CARE FOR ELEVATED HEMOGLOBIN LEVEL DOCUMENTED FOR PATIENT RECEIVING ERYTHROPOIESIS-STIMULATING AGENT THERAPY (ESA) (CKD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0516F	ANEMIA PLAN OF CARE DOCUMENTED (ESRD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0517F	GLAUCOMA PLAN OF CARE DOCUMENTED (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0518F	FALLS PLAN OF CARE DOCUMENTED (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0519F	PLANNED CHEMOTHERAPY REGIMEN, INCLUDING AT A MINIMUM: DRUG(S) PRESCRIBED, DOSE, AND DURATION, DOCUMENTED PRIOR TO INITIATION OF A NEW TREATMENT REGIMEN (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0520F	NORMAL TISSUE DOSE CONSTRAINTS ESTABLISHED WITHIN FIVE TREATMENT DAYS FROM THE INITIATION OF A COURSE OF 3D CONFORMAL RADIATION FOR A MINIMUM OF ONE TISSUE/ORGAN (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0521F	PLAN OF CARE TO ADDRESS PAIN DOCUMENTED (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1060F	DOCUMENTATION OF PERMANENT OR PERSISTENT OR PAROXYSMAL ATRIAL FIBRILLATION (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1061F	DOCUMENTATION OF ABSENCE OF PERMANENT AND PERSISTENT AND PAROXYSMAL ATRIAL FIBRILLATION (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1065F	ISCHEMIC STROKE SYMPTOM ONSET OF LESS THAN 3 HOURS PRIOR TO ARRIVAL (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1066F	ISCHEMIC STROKE SYMPTOM ONSET GREATER THAN OR EQUAL TO 3 HOURS PRIOR TO ARRIVAL (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1070F	ALARM SYMPTOMS (INVOLUNTARY WEIGHT LOSS, DYSPHAGIA, OR GASTROINTESTINAL BLEEDING) ASSESSED; NONE PRESENT (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
1071F	ALARM SYMPTOMS (INVOLUNTARY WEIGHT LOSS, DYSPHAGIA, OR GASTROINTESTINAL BLEEDING) ASSESSED; ONE OR MORE PRESENT (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1090F	PRESENCE OR ABSENCE OF URINARY INCONTINENCE ASSESSED (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1091F	URINARY INCONTINENCE CHARACTERIZED (EG FREQUENCY, VOLUME, TIMING, TYPE OF SYMPTOMS, HOW BOTHERSOME) (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1100F	PATIENT SCREENED FOR FUTURE FALL RISK; DOCUMENTATION OF TWO OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1101F	PATIENT SCREENED FOR FUTURE FALL RISK; DOCUMENTATION OF NO FALLS IN THE PAST YEAR OR ONLY ONE FALL WITHOUT INJURY IN THE PAST YEAR (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1110F	PATIENT DISCHARGED FROM AN INPATIENT FACILITY (EG HOSPITAL, SKILLED NURSING FACILITY, OR REHABILITATION FACILITY) WITHIN THE LAST 60 DAYS (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1111F	DISCHARGE MEDICATIONS RECONCILED WITH THE CURRENT MEDICATION LIST IN OUTPATIENT MEDICAL RECORD (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1116F	AURICULAR OR PERIAURICULAR PAIN ASSESSED (AOE)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1118F	GERD SYMPTOMS ASSESSED AFTER 12 MONTHS OF THERAPY (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
1119F	INITIAL EVALUATION FOR CONDITION (HEP C)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1121F	SUBSEQUENT EVALUATION FOR CONDITION (HEP C)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1123F	ADVANCE CARE PLANNING DISCUSSED AND DOCUMENTED; ADVANCE CARE PLAN OR SURROGATE DECISION MAKER DOCUMENTED IN THE MEDICAL RECORD (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1124F	ADVANCE CARE PLANNING DISCUSSED AND DOCUMENTED IN THE MEDICAL RECORD; PATIENT DID NOT WISH OR WAS NOT ABLE TO NAME A SURROGATE DECISION MAKER OR PROVIDE AN ADVANCE CARE PLAN (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1125F	PAIN SEVERITY QUANTIFIED; PAIN PRESENT (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1126F	PAIN SEVERITY QUANTIFIED; NO PAIN PRESENT (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1127F	NEW EPISODE FOR CONDITION (ML)5	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
1128F	SUBSEQUENT EPISODE FOR CONDITION (ML)5	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
2035F	TYMPANIC MEMBRANE MOBILITY ASSESSED WITH PNEUMATIC OTOSCOPY OR TYMPANOMETRY (OME)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3100F	CAROTID IMAGING STUDY REPORT (INCLUDES DIRECT OR INDIRECT REFERENCE TO MEASUREMENTS OF DISTAL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT) (STR)5				
3110F	PRESENCE OR ABSENCE OF HEMORRHAGE AND MASS LESION AND ACUTE INFARCTION DOCUMENTED IN FINAL CT OR MRI REPORT (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3111F	CT OR MRI OF THE BRAIN PERFORMED WITHIN 24 HOURS OF ARRIVAL TO THE HOSPITAL (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3112F	CT OR MRI OF THE BRAIN PERFORMED GREATER THAN 24 HOURS AFTER ARRIVAL TO THE HOSPITAL (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3120F	12-LEAD ECG PERFORMED (EM)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3130F	UPPER GASTROINTESTINAL ENDOSCOPY PERFORMED (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3132F	DOCUMENTATION OF REFERRAL FOR UPPER GASTROINTESTINAL ENDOSCOPY (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3140F	UPPER GASTROINTESTINAL ENDOSCOPY REPORT INDICATES SUSPICION OF BARRETT'S ESOPHAGUS (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3141F	UPPER GASTROINTESTINAL ENDOSCOPY REPORT INDICATES NO SUSPICION OF BARRETT'S ESOPHAGUS (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3142F	BARIUM SWALLOW TEST ORDERED (GERD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
3150F	FORCEPS ESOPHAGEAL BIOPSY PERFORMED (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3155F	CYTOGENETIC TESTING PERFORMED ON BONE MARROW AT TIME OF DIAGNOSIS OR PRIOR TO INITIATING TREATMENT (HEM)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3160F	DOCUMENTATION OF IRON STORES PRIOR TO INITIATING ERYTHROPOIETIN THERAPY (HEM)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3170F	FLOW CYTOMETRY STUDIES PERFORMED AT TIME OF DIAGNOSIS OR PRIOR TO INITIATING TREATMENT (HEM)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3200F	BARIUM SWALLOW TEST NOT ORDERED (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3210F	GROUP A STREP TEST PERFORMED (PHAR)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3215F	PATIENT HAS DOCUMENTED IMMUNITY TO HEPATITIS A (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3216F	PATIENT HAS DOCUMENTED IMMUNITY TO HEPATITIS B (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3218F	RNA TESTING FOR HEPATITIS C DOCUMENTED AS PERFORMED WITHIN SIX MONTHS PRIOR TO INITIATION OF ANTIVIRAL TREATMENT FOR HEPATITIS C (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3220F	HEPATITIS C QUANTITATIVE RNA TESTING DOCUMENTED AS PERFORMED AT 12 WEEKS FROM INITIATION OF ANTIVIRAL TREATMENT (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
3230F	DOCUMENTATION THAT HEARING TEST WAS PERFORMED WITHIN 6 MONTHS PRIOR TO TYMPANOSTOMY TUBE INSERTION (OME)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3260F	PT CATEGORY (PRIMARY TUMOR), PN CATEGORY (REGIONAL LYMPH NODES), AND HISTOLOGIC GRADE DOCUMENTED IN PATHOLOGY REPORT (PATH)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3265F	RIBONUCLEIC ACID (RNA) TESTING FOR HEPATITIS C VIREMIA ORDERED OR RESULTS DOCUMENTED (HEP C)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3266F	HEPATITIS C GENOTYPE TESTING DOCUMENTED AS PERFORMED PRIOR TO INITIATION OF ANTIVIRAL TREATMENT FOR HEPATITIS C (HEP C)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3268F	PROSTATE-SPECIFIC ANTIGEN (PSA), AND PRIMARY TUMOR (T) STAGE, AND GLEASON SCORE DOCUMENTED PRIOR TO INITIATION OF TREATMENT (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3269F	BONE SCAN PERFORMED PRIOR TO INITIATION OF TREATMENT OR AT ANY TIME SINCE DIAGNOSIS OF PROSTATE CANCER (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3270F	BONE SCAN NOT PERFORMED PRIOR TO INITIATION OF TREATMENT NOR AT ANY TIME SINCE DIAGNOSIS OF PROSTATE CANCER (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3271F	LOW RISK OF RECURRENCE, PROSTATE CANCER (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3272F	INTERMEDIATE RISK OF RECURRENCE, PROSTATE CANCER (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
3273F	HIGH RISK OF RECURRENCE, PROSTATE CANCER (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3274F	PROSTATE CANCER RISK OF RECURRENCE NOT DETERMINED OR NEITHER LOW, INTERMEDIATE NOR HIGH (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3278F	SERUM LEVELS OF CALCIUM, PHOSPHORUS, INTACT PARATHYROID HORMONE (PTH) AND LIPID PROFILE ORDERED (CKD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3279F	HEMOGLOBIN LEVEL GREATER THAN OR EQUAL TO 13 G/DL (CKD,ESRD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3280F	HEMOGLOBIN LEVEL 11 G/DL TO 12.9 G/DL (CKD, ESRD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3281F	HEMOGLOBIN LEVEL LESS THAN 11 G/DL (CKD,ESRD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3284F	INTRAOCULAR PRESSURE (IOP) REDUCED BY A VALUE OF GREATER THAN OR EQUAL TO 15% FROM THE PRE-INTERVENTION LEVEL (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3285F	INTRAOCULAR PRESSURE (IOP) REDUCED BY A VALUE LESS THAN 15% FROM THE PRE-INTERVENTION LEVEL (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3288F	FALLS RISK ASSESSMENT DOCUMENTED (GER)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3290F	PATIENT IS D (RH) NEGATIVE AND UNSENSITIZED (PRENATAL)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
3291F	PATIENT IS D (RH) POSITIVE OR SENSITIZED (PRENATAL)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3292F	HIV TESTING ORDERED OR DOCUMENTED AND REVIEWED DURING THE FIRST OR SECOND PRENATAL VISIT (PRENATAL)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3300F	AMERICAN JOINT COMMITTEE ON CANCER (AJCC) STAGE DOCUMENTED AND REVIEWED PRIOR TO THE INITIATION OF THERAPY (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3301F	CANCER STAGE DOCUMENTED IN MEDICAL RECORD AS METASTATIC AND REVIEWED PRIOR TO THE INITIATION OF THERAPY (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3302F	AJCC CANCER STAGE 0, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3303F	AJCC CANCER STAGE IA, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3304F	AJCC CANCER STAGE IB, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3305F	AJCC CANCER STAGE IC, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3306F	AJCC CANCER STAGE IIA, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3307F	AJCC CANCER STAGE IIB, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
3308F	AJCC CANCER STAGE IIC, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3309F	AJCC CANCER STAGE IIIA, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3310F	AJCC CANCER STAGE IIIB, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3311F	AJCC CANCER STAGE IIIC, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3312F	AJCC CANCER STAGE IVA, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3313F	AJCC CANCER STAGE IVB, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3314F	AJCC CANCER STAGE IVC, DOCUMENTED (ONC)1, (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3315F	ESTROGEN RECEPTOR (ER) OR PROGESTERONE RECEPTOR (PR) POSITIVE BREAST CANCER (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3316F	ESTROGEN RECEPTOR (ER) AND PROGESTERONE RECEPTOR (PR) NEGATIVE BREAST CANCER (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3317F	PATHOLOGY REPORT CONFIRMING MALIGNANCY DOCUMENTED IN THE MEDICAL RECORD AND REVIEWED PRIOR TO THE INITIATION OF CHEMOTHERAPY (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
3318F	PATHOLOGY REPORT CONFIRMING MALIGNANCY DOCUMENTED IN THE MEDICAL RECORD AND REVIEWED PRIOR TO THE INITIATION OF RADIATION THERAPY (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3319F	ONE OF THE FOLLOWING DIAGNOSTIC IMAGING STUDIES ORDERED: (CHEST X-RAY, CT, ULTRASOUND, MRI, PET, OR NUCLEAR MEDICINE SCANS) (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3320F	NONE OF THE FOLLOWING DIAGNOSTIC IMAGING STUDIES ORDERED: (CHEST X-RAY, CT, ULTRASOUND, MRI, PET, OR NUCLEAR MEDICINE SCANS) (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3325F	PREOPERATIVE ASSESSMENT OF FUNCTIONAL OR MEDICAL INDICATION(S) FOR SURGERY PRIOR TO THE CATARACT SURGERY WITH INTRAOCULAR LENS PLACEMENT (MUST BE PERFORMED WITHIN TWELVE MONTHS PRIOR TO CATARACT SURGERY) (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4041F	DOCUMENTATION OF ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4042F	DOCUMENTATION THAT PROPHYLACTIC ANTIBIOTICS WERE NEITHER GIVEN WITHIN 4 HOURS PRIOR TO SURGICAL INCISION NOR GIVEN INTRAOPERATIVELY (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4043F	DOCUMENTATION THAT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME, CARDIAC PROCEDURES (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4044F	DOCUMENTATION THAT AN ORDER WAS GIVEN FOR VENOUS	Not Applicable for All Programs, Not	NA	Non-Reimbursable for All Programs,	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME (PERI 2)5	Applicable for Package C		Non-Reimbursable for Package C	
4046F	DOCUMENTATION THAT PROPHYLACTIC ANTIBIOTICS WERE GIVEN WITHIN 4 HOURS PRIOR TO SURGICAL INCISION OR GIVEN INTRAOPERATIVELY (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4047F	DOCUMENTATION OF ORDER FOR PROPHYLACTIC ANTIBIOTICS TO BE GIVEN WITHIN ONE HOUR (IF FLUOROQUINOLONE OR VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED) (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4048F	DOCUMENTATION THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN WITHIN ONE HOUR (IF FLUOROQUINOLONE OR VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED) (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4049F	DOCUMENTATION THAT ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME, NON-CARDIAC PROCEDURE (PERI 2)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4070F	DEEP VEIN THROMBOSIS (DVT) PROPHYLAXIS RECEIVED BY END OF HOSPITAL DAY 2 (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4073F	ORAL ANTIPLATELET THERAPY PRESCRIBED AT DISCHARGE (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4075F	ANTICOAGULANT THERAPY PRESCRIBED AT DISCHARGE (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4077F	DOCUMENTATION THAT TISSUE PLASMINOGEN ACTIVATOR (T-PA) ADMINISTRATION WAS CONSIDERED (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4079F	DOCUMENTATION THAT REHABILITATION SERVICES WERE CONSIDERED (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4084F	ASPIRIN RECEIVED WITHIN 24 HOURS BEFORE EMERGENCY DEPARTMENT ARRIVAL OR DURING EMERGENCY DEPARTMENT STAY (EM)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4090F	PATIENT RECEIVING ERYTHROPOIETIN THERAPY (HEM)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4095F	PATIENT NOT RECEIVING ERYTHROPOIETIN THERAPY (HEM)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4100F	BISPHOSPHONATE THERAPY, INTRAVENOUS, ORDERED OR RECEIVED (HEM)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4110F	INTERNAL MAMMARY ARTERY GRAFT PERFORMED FOR PRIMARY, ISOLATED CORONARY ARTERY BYPASS GRAFT PROCEDURE (CABG)6	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4115F	BETA BLOCKER ADMINISTERED WITHIN 24 HOURS PRIOR TO SURGICAL INCISION (CABG)6	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4120F	ANTIBIOTIC PRESCRIBED OR DISPENSED (URI, PHAR)2, (A-BRONCH)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4124F	ANTIBIOTIC NEITHER PRESCRIBED NOR DISPENSED (URI, PHAR)2, (A-BRONCH)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4130F	TOPICAL PREPARATIONS (INCLUDING OTC) PRESCRIBED FOR ACUTE OTITIS EXTERNA (AOE)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4131F	SYSTEMIC ANTIMICROBIAL THERAPY PRESCRIBED (AOE)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4132F	SYSTEMIC ANTIMICROBIAL THERAPY NOT PRESCRIBED (AOE)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4133F	ANTIHISTAMINES OR DECONGESTANTS PRESCRIBED OR RECOMMENDED (OME)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4134F	ANTIHISTAMINES OR DECONGESTANTS NEITHER PRESCRIBED NOR RECOMMENDED (OME)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4135F	SYSTEMIC CORTICOSTEROIDS PRESCRIBED (OME)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4136F	SYSTEMIC CORTICOSTEROIDS NOT PRESCRIBED (OME)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4150F	PATIENT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4151F	PATIENT NOT RECEIVING ANTIVIRAL TREATMENT FOR HEPATITIS C (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4152F	DOCUMENTATION THAT COMBINATION PEGINTERFERON AND RIBAVIRIN THERAPY CONSIDERED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4153F	COMBINATION PEGINTERFERON AND RIBAVIRIN THERAPY PRESCRIBED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4154F	HEPATITIS A VACCINE SERIES RECOMMENDED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4155F	HEPATITIS A VACCINE SERIES PREVIOUSLY RECEIVED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4156F	HEPATITIS B VACCINE SERIES RECOMMENDED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4157F	HEPATITIS B VACCINE SERIES PREVIOUSLY RECEIVED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4158F	PATIENT EDUCATION REGARDING RISK OF ALCOHOL CONSUMPTION PERFORMED (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4159F	COUNSELING REGARDING CONTRACEPTION RECEIVED PRIOR TO INITIATION OF ANTIVIRAL TREATMENT (HEP-C)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4163F	PATIENT COUNSELING AT A MINIMUM ON ALL OF THE FOLLOWING TREATMENT OPTIONS FOR CLINCIALLY LOCALIZED PROSTATE CANCER: ACTIVE SURVEILLANCE, AND INTERSTITIAL PROSTATE BRACHYTHERAPY, AND EXTERNAL BEAM RADIOTHERAPY, AND RADICAL PROSTATECTOMY, PROVIDED PRIO	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4164F	ADJUVANT (IE, IN COMBINATION WITH EXTERNAL BEAM RADIOTHERAPY TO THE PROSTATE FOR PROSTATE CANCER) HORMONAL THERAPY (GONADOTROPIN-RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST) PRESCRIBED/ADMINISTERED (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4165F	THREE-DIMENSIONAL CONFORMAL RADIOTHERAPY (3D-CRT) OR INTENSITY MODULATED RADIATION THERAPY (IMRT) RECEIVED (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4167F	HEAD OF BED ELEVATION (30-45 DEGREES) ON FIRST VENTILATOR DAY ORDERED (CRIT)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4168F	PATIENT RECEIVING CARE IN THE INTENSIVE CARE UNIT (ICU) AND RECEIVING MECHANICAL VENTILATION, 24 HOURS OR LESS (CRIT)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4169F	PATIENT EITHER NOT RECEIVING CARE IN THE INTENSIVE CARE UNIT (ICU) OR NOT RECEIVING MECHANICAL VENTILATION OR RECEIVING MECHANICAL VENTILATION GREATER THAN 24 HOURS (CRIT)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4171F	PATIENT RECEIVING ERYTHROPOIESIS-STIMULATING AGENTS (ESA) THERAPY (CKD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4172F	PATIENT NOT RECEIVING ERYTHROPOIESIS-STIMULATING AGENTS (ESA) THERAPY (CKD)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4174F	COUNSELING ABOUT THE POTENTIAL IMPACT OF GLAUCOMA ON VISUAL FUNCTIONING AND QUALITY OF LIFE, AND IMPORTANCE OF	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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	TREATMENT ADHERENCE PROVIDED TO PATIENT AND/OR CAREGIVER(S) (EC)5				
4175F	BEST-CORRECTED VISUAL ACUITY OF 20/40 OR BETTER (DISTANCE OR NEAR) ACHIEVED WITHIN THE 90 DAYS FOLLOWING CATARACT SURGERY (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4176F	COUNSELING ABOUT VALUE OF PROTECTION FROM UV LIGHT AND LACK OF PROVEN EFFICACY OF NUTRITIONAL SUPPLEMENTS IN PREVENTION OR PROGRESSION OF CATARACT DEVELOPMENT PROVIDED TO PATIENT AND/OR CAREGIVER(S) (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4177F	COUNSELING ABOUT THE BENEFITS AND/OR RISKS OF THE AGE-RELATED EYE DISEASE STUDY (AREDS) FORMULATION FOR PREVENTING PROGRESSION OF AGE-RELATED MACULAR DEGENERATION (AMD) PROVIDED TO PATIENT AND/OR CAREGIVER(S) (EC)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4178F	ANTI-D IMMUNE GLOBULIN RECEIVED BETWEEN 26 AND 30 WEEKS GESTATION (PRENATAL)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4179F	TAMOXIFEN OR AROMATASE INHIBITOR (AI) PRESCRIBED (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4180F	ADJUVANT CHEMOTHERAPY PRESCRIBED OR PREVIOUSLY RECEIVED FOR STAGE IIIA THROUGH STAGE IIIC COLON CANCER (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4181F	CONFORMAL RADIATION THERAPY RECEIVED (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4182F	CONFORMAL RADIATION THERAPY NOT RECEIVED (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4185F	CONTINUOUS (12-MONTHS) THERAPY WITH PROTON PUMP INHIBITOR (PPI) OR HISTAMINE H2 RECEPTOR ANTAGONIST (H2RA) RECEIVED (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4186F	NO CONTINUOUS (12-MONTHS) THERAPY WITH EITHER PROTON PUMP INHIBITOR (PPI) OR HISTAMINE H2 RECEPTOR ANTAGONIST (H2RA) RECEIVED (GERD)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4187F	DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY PRESCRIBED OR DISPENSED (RA)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4188F	APPROPRIATE ANGIOTENSIN CONVERTING ENZYME (ACE)/ANGIOTENSIN RECEPTOR BLOCKERS (ARB) THERAPEUTIC MONITORING TEST ORDERED OR PERFORMED (AM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4189F	APPROPRIATE DIGOXIN THERAPEUTIC MONITORING TEST ORDERED OR PERFORMED (AM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4190F	APPROPRIATE DIURETIC THERAPEUTIC MONITORING TEST ORDERED OR PERFORMED (AM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4191F	APPROPRIATE ANTICONVULSANT THERAPEUTIC MONITORING TEST ORDERED OR PERFORMED (AM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4200F	EXTERNAL BEAM RADIOTHERAPY TO PROSTATE ONLY (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4201F	EXTERNAL BEAM RADIOTHERAPY FOR PROSTATE CANCER TO REGION(S) OTHER THAN PROSTATE ONLY (PRCA)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4210F	ANGIOTENSIN CONVERTING ENZYME (ACE) OR ANGIOTENSIN RECEPTOR BLOCKERS (ARB) MEDICATION THERAPY FOR 6 MONTHS OR MORE (MM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4220F	DIGOXIN MEDICATION THERAPY FOR 6 MONTHS OR MORE (MM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4221F	DIURETIC MEDICATION THERAPY FOR 6 MONTHS OR MORE (MM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4230F	ANTICONVULSANT MEDICATION THERAPY FOR 6 MONTHS OR MORE (MM)2	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
5020F	TREATMENT SUMMARY REPORT COMMUNICATED TO PHYSICIAN(S) MANAGING CONTINUING CARE WITHIN ONE MONTH OF COMPLETING TREATMENT (ONC)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
5050F	TREATMENT PLAN COMMUNICATED TO PROVIDER(S) MANAGING CONTINUING CARE WITHIN ONE MONTH OF DIAGNOSIS (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
6010F	DYSPHAGIA SCREENING CONDUCTED PRIOR TO ORDER FOR OR RECEIPT OF ANY FOODS, FLUIDS OR MEDICATION BY MOUTH (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
6015F	PATIENT RECEIVING OR ELIGIBLE TO RECEIVE FOODS, FLUIDS OR MEDICATION BY MOUTH (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

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6020F	NPO (NOTHING BY MOUTH) ORDERED (STR)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
6030F	ALL ELEMENTS OF MAXIMAL STERILE BARRIER TECHNIQUE INCLUDING: CAP AND MASK AND STERILE GOWN AND STERILE GLOVES AND A LARGE STERILE SHEET AND HAND HYGIENE AND 2% CHLORHEXIDINE FOR CUTANEOUS ANTISEPSIS, FOLLOWED (CRIT)1	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
7010F	PATIENT INFORMATION ENTERED INTO A RECALL SYSTEM WITH THE TARGET DATE FOR THE NEXT EXAM SPECIFIED (ML)5	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0178T	ELECTROCARDIOGRAM, 64 LEADS OR GREATER, WITH GRAPHIC PRESENTATION AND ANALYSIS; WITH INTERPRETATION AND REPORT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
0179T	ELECTROCARDIOGRAM, 64 LEADS OR GREATER, WITH GRAPHIC PRESENTATION AND ANALYSIS; TRACING AND GRAPHICS ONLY, WITHOUT INTERPRETATION AND REPORT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
0180T	ELECTROCARDIOGRAM, 64 LEADS OR GREATER, WITH GRAPHIC PRESENTATION AND ANALYSIS; INTERPRETATION AND REPORT ONLY	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
0181T	CORNEAL HYSTERESIS DETERMINATION, BY AIR IMPULSE STIMULATION, BILATERAL, WITH INTERPRETATION AND REPORT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
0182T	HIGH DOSE RATE ELECTRONIC BRACHYTHERAPY, PER FRACTION	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0184T	EXCISION OF RECTAL TUMOR, TRANSANAL ENDOSCOPIC MICROSURGICAL APPROACH (IE, TEMS)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0185T	MULTIVARIATE ANALYSIS OF PATIENT SPECIFIC FINDINGS WITH QUANTIFIABLE COMPUTER PROBABILITY ASSESSMENT, INCLUDING REPORT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0186T	SUPRACHOROIDAL DELIVERY OF PHARMACOLOGIC AGENT (DOES NOT INCLUDE SUPPLY OF MEDICATION)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
0187T	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
01935	ANESTHESIA FOR PERCUTANEOUS IMAGE GUIDED PROCEDURES ON THE SPINE AND SPINAL CORD; DIAGNOSTIC	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
01936	ANESTHESIA FOR PERCUTANEOUS IMAGE GUIDED PROCEDURES ON THE SPINE AND SPINAL CORD; THERAPEUTIC	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
20555	PLACEMENT OF NEEDLES OR CATHETERS INTO MUSCLE AND/OR SOFT TISSUE FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION (AT THE TIME OF OR SUBSEQUENT TO THE PROCEDURE)	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
20985	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES; IMAGE-LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS,	Covered for All Programs, Covered for Package C	NA
20986	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES; WITH IMAGE	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	GUIDANCE BASED ON INTRAOPERATIVELY OBTAINED IMAGES (EG, FLUOROSCOPY, ULTRASOUND) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)				
20987	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES; WITH IMAGE GUIDANCE BASED ON PREOPERATIVE IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ), THERAPEUTIC, REQUIRING AN ANESTHESIA SERVICE (IE, GENERAL OR MONITORED ANESTHESIA CARE)	No for All Programs, No for Package C	80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
22206	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, THREE COLUMNS, ONE VERTEBRAL SEGMENT (EG, PEDICLE/VERTEBRAL BODY SUBTRACTION); THORACIC	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
22207	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, THREE COLUMNS, ONE VERTEBRAL SEGMENT (EG, PEDICLE/VERTEBRAL BODY SUBTRACTION); LUMBAR	No for All Programs, No for Package C	54, 55, 62, , 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
22208	OSTEOTOMY OF SPINE, POSTERIOR OR POSTEROLATERAL APPROACH, THREE COLUMNS, ONE VERTEBRAL SEGMENT (EG, PEDICLE/VERTEBRAL BODY SUBTRACTION); EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS,	Covered for All Programs, Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
24357	TENOTOMY, ELBOW, LATERAL OR MEDIAL (EG, EPICONDYLITIS, TENNIS ELBOW, GOLFER'S ELBOW); PERCUTANEOUS	No for All Programs, No for Package C	50, 54, 55, 80, 81, 82	Covered for All Programs, Covered for Package C	NA
24358	TENOTOMY, ELBOW, LATERAL OR MEDIAL (EG, EPICONDYLITIS, TENNIS ELBOW, GOLFER'S ELBOW); DEBRIDEMENT, SOFT TISSUE AND/OR BONE, OPEN	No for All Programs, No for Package C	50, 54, 55, 80, 81, 82	Covered for All Programs, Covered for Package C	NA
24359	TENOTOMY, ELBOW, LATERAL OR MEDIAL (EG, EPICONDYLITIS, TENNIS ELBOW, GOLFER'S ELBOW); DEBRIDEMENT, SOFT TISSUE AND/OR BONE, OPEN WITH TENDON REPAIR OR REATTACHMENT	No for All Programs, No for Package C	50, 54, 55, 80, 81, 82,	Covered for All Programs, Covered for Package C	NA
27267	CLOSED TREATMENT OF FEMORAL FRACTURE, PROXIMAL END, HEAD; WITHOUT MANIPULATION	No for All Programs, No for Package C	50, 54, 55,	Covered for All Programs, Covered for Package C	NA
27268	CLOSED TREATMENT OF FEMORAL FRACTURE, PROXIMAL END, HEAD; WITH MANIPULATION	No for All Programs, No for Package C	50, 54, 55	Covered for All Programs, Covered for Package C	NA
27269	OPEN TREATMENT OF FEMORAL FRACTURE, PROXIMAL END, HEAD, INCLUDES INTERNAL FIXATION, WHEN PERFORMED	No for All Programs, No for Package C	50, 54, 55, 80, 81, 82, AS,,	Covered for All Programs, Covered for Package C	NA
27416	OSTEOCHONDRAL AUTOGRAFT(S), KNEE, OPEN (EG, MOSAICPLASTY) (INCLUDES HARVESTING OF AUTOGRAFT[S])	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
27726	REPAIR OF FIBULA NONUNION AND/OR MALUNION WITH INTERNAL FIXATION	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
27767	CLOSED TREATMENT OF POSTERIOR MALLEOLUS FRACTURE; WITHOUT MANIPULATION	No for All Programs, No for Package C	50, 54, 55	Covered for All Programs, Covered for Package C	NA
27768	CLOSED TREATMENT OF POSTERIOR MALLEOLUS FRACTURE; WITH MANIPULATION	No for All Programs, No for Package C	50, 54, 55	Covered for All Programs, Covered for Package C	NA
27769	OPEN TREATMENT OF POSTERIOR	No for All	50, 54, 55,	Covered for All	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	MALLEOLUS FRACTURE, INCLUDES INTERNAL FIXATION, WHEN PERFORMED	Programs, No for Package C	62, 80, 81, 82, AS	Programs, Covered for Package C	
28446	OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING GRAFT[S])	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
29828	ARTHROSCOPY, SHOULDER, SURGICAL; BICEPS TENODESIS	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
29904	ARTHROSCOPY, SUBTALAR JOINT, SURGICAL; WITH REMOVAL OF LOOSE BODY OR FOREIGN BODY	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
29905	ARTHROSCOPY, SUBTALAR JOINT, SURGICAL; WITH SYNOVECTOMY	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
29906	ARTHROSCOPY, SUBTALAR JOINT, SURGICAL; WITH DEBRIDEMENT	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
29907	ARTHROSCOPY, SUBTALAR JOINT, SURGICAL; WITH SUBTALAR ARTHRODESIS	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
32421	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
32422	THORACENTESIS WITH INSERTION OF TUBE, INCLUDES WATER SEAL (EG, FOR PNEUMOTHORAX), WHEN PERFORMED (SEPARATE PROCEDURE)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
32550	INSERTION OF INDWELLING TUNNELED PLEURAL CATHETER WITH CUFF	No for All Programs, No for Package C	80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
32551	TUBE THORACOSTOMY, INCLUDES WATER SEAL (EG, FOR ABSCESS, HEMOTHORAX, EMPYEMA), WHEN PERFORMED (SEPARATE PROCEDURE)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
32560	CHEMICAL PLEURODESIS (EG, FOR RECURRENT OR PERSISTENT PNEUMOTHORAX)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
33257	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, PERFORMED AT THE TIME OF OTHER CARDIAC PROCEDURE(S), LIMITED (EG, MODIFIED MAZE PROCEDURE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
33258	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, PERFORMED AT THE TIME OF OTHER CARDIAC PROCEDURE(S), EXTENSIVE (EG, MAZE PROCEDURE), WITHOUT CARDIOPULMONARY BYPASS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
33259	OPERATIVE TISSUE ABLATION AND RECONSTRUCTION OF ATRIA, PERFORMED AT THE TIME OF OTHER CARDIAC PROCEDURE(S), EXTENSIVE (EG, MAZE PROCEDURE), WITH CARDIOPULMONARY BYPASS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
33864	ASCENDING AORTA GRAFT, WITH CARDIOPULMONARY BYPASS WITH VALVE SUSPENSION, WITH CORONARY RECONSTRUCTION AND VALVE-SPARING AORTIC ANNULUS REMODELING (EG, DAVID PROCEDURE, YACOUB PROCEDURE)	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
35523	BYPASS GRAFT, WITH VEIN; BRACHIAL-ULNAR OR -RADIAL	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
36591	COLLECTION OF BLOOD SPECIMEN FROM A COMPLETELY IMPLANTABLE VENOUS ACCESS DEVICE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
36592	COLLECTION OF BLOOD SPECIMEN USING ESTABLISHED	No for All Programs, No for	NA	Covered for All Programs, Covered	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	CENTRAL OR PERIPHERAL CATHETER, VENOUS, NOT OTHERWISE SPECIFIED	Package C		for Package C	
36593	DECLOTTING BY THROMBOLYTIC AGENT OF IMPLANTED VASCULAR ACCESS DEVICE OR CATHETER	No for All Programs, No for Package C	50,54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
41019	PLACEMENT OF NEEDLES, CATHETERS, OR OTHER DEVICE(S) INTO THE HEAD AND/OR NECK REGION (PERCUTANEOUS, TRANSORAL, OR TRANSNASAL) FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION	No for All Programs, No for Package C	62	Covered for All Programs, Covered for Package C	NA
49203	EXCISION OR DESTRUCTION, OPEN, INTRA-ABDOMINAL TUMORS, CYSTS OR ENDOMETRIOMAS, 1 OR MORE PERITONEAL, MESENTERIC, OR RETROPERITONEAL PRIMARY OR SECONDARY TUMORS; LARGEST TUMOR 5 CM DIAMETER OR LESS	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
49204	EXCISION OR DESTRUCTION, OPEN, INTRA-ABDOMINAL TUMORS, CYSTS OR ENDOMETRIOMAS, 1 OR MORE PERITONEAL, MESENTERIC, OR RETROPERITONEAL PRIMARY OR SECONDARY TUMORS; LARGEST TUMOR 5.1-10.0 CM DIAMETER	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
49205	EXCISION OR DESTRUCTION, OPEN, INTRA-ABDOMINAL TUMORS, CYSTS OR ENDOMETRIOMAS, 1 OR MORE PERITONEAL, MESENTERIC, OR RETROPERITONEAL PRIMARY OR SECONDARY TUMORS; LARGEST TUMOR GREATER THAN 10.0 CM DIAMETER	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
49440	INSERTION OF GASTROSTOMY TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	DOCUMENTATION AND REPORT				
49441	INSERTION OF DUODENOSTOMY OR JEJUNOSTOMY TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
49442	INSERTION OF CECOSTOMY OR OTHER COLONIC TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
49446	CONVERSION OF GASTROSTOMY TUBE TO GASTRO-JEJUNOSTOMY TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
49450	REPLACEMENT OF GASTROSTOMY OR CECOSTOMY (OR OTHER COLONIC) TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
49451	REPLACEMENT OF DUODENOSTOMY OR JEJUNOSTOMY TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
49452	REPLACEMENT OF GASTRO-JEJUNOSTOMY TUBE, PERCUTANEOUS, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
49460	MECHANICAL REMOVAL OF OBSTRUCTIVE MATERIAL FROM GASTROSTOMY, DUODENOSTOMY, JEJUNOSTOMY, GASTRO-JEJUNOSTOMY, OR CECOSTOMY (OR OTHER COLONIC) TUBE, ANY METHOD, UNDER FLUOROSCOPIC GUIDANCE INCLUDING CONTRAST INJECTION(S), IF PERFORMED, IMAGE DOCUMENTATI	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
49465	CONTRAST INJECTION(S) FOR RADIOLOGICAL EVALUATION OF EXISTING GASTROSTOMY, DUODENOSTOMY, JEJUNOSTOMY, GASTRO-JEJUNOSTOMY, OR CECOSTOMY (OR OTHER COLONIC) TUBE, FROM A PERCUTANEOUS APPROACH INCLUDING IMAGE DOCUMENTATION AND REPORT	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
50385	REMOVAL (VIA SNARE/CAPTURE) AND REPLACEMENT OF INTERNALLY DWELLING URETERAL STENT VIA TRANSURETHRAL APPROACH, WITHOUT USE OF CYSTOSCOPY, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	50	Covered for All Programs, Covered for Package C	NA
50386	REMOVAL (VIA SNARE/CAPTURE) OF INTERNALLY DWELLING URETERAL STENT VIA TRANSURETHRAL APPROACH, WITHOUT USE OF CYSTOSCOPY, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	50	Covered for All Programs, Covered for Package C	NA
50593	ABLATION, RENAL TUMOR(S), UNILATERAL, PERCUTANEOUS, CRYOTHERAPY	No for All Programs, No for Package C	54, 55, , 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
51100	ASPIRATION OF BLADDER; BY NEEDLE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
51101	ASPIRATION OF BLADDER; BY TROCAR OR INTRACATHETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
51102	ASPIRATION OF BLADDER; WITH INSERTION OF SUPRAPUBIC CATHETER	No for All Programs, No for Package C	54, 55	Covered for All Programs, Covered for Package C	NA
52649	LASER ENUCLEATION OF THE PROSTATE WITH MORCELLATION, INCLUDING CONTROL OF POSTOPERATIVE BLEEDING, COMPLETE (VASECTOMY, MEATOTOMY, CYSTOURETHROSCOPY, URETHRAL CALIBRATION AND/OR DILATION, INTERNAL URETHROTOMY AND TRANSURETHRAL RESECTION OF PROSTATE AR	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
55920	PLACEMENT OF NEEDLES OR CATHETERS INTO PELVIC ORGANS AND/ OR GENITALIA (EXCEPT PROSTATE) FOR SUBSEQUENT INTERSTITIAL RADIOELEMENT APPLICATION	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
57285	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE, IF PERFORMED); VAGINAL APPROACH	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
57423	PARAVAGINAL DEFECT REPAIR (INCLUDING REPAIR OF CYSTOCELE, IF PERFORMED), LAPAROSCOPIC APPROACH	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
58570	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
58571	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
58572	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G;	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
58573	LAPAROSCOPY, SURGICAL, WITH	No for All	54, 55, 62,	Covered for All	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	Programs, No for Package C	80, 81, 82, AS	Programs, Covered for Package C	
60300	ASPIRATION AND/OR INJECTION, THYROID CYST	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
67041	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH REMOVAL OF PRERETINAL CELLULAR MEMBRANE (EG, MACULAR PUCKER)	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
67042	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH REMOVAL OF INTERNAL LIMITING MEMBRANE OF RETINA (EG, FOR REPAIR OF MACULAR HOLE, DIABETIC MACULAR EDEMA), INCLUDES, IF PERFORMED, INTRAOCULAR TAMPONADE (IE, AIR, GAS OR SILICONE OIL)	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
67043	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH REMOVAL OF SUBRETINAL MEMBRANE (EG, CHOROIDAL NEOVASCULARIZATION), INCLUDES, IF PERFORMED, INTRAOCULAR TAMPONADE (IE, AIR, GAS OR SILICONE OIL) AND LASER PHOTOCOAGULATION	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
67113	REPAIR OF COMPLEX RETINAL DETACHMENT (EG, PROLIFERATIVE VITREORETINOPATHY, STAGE C-1 OR GREATER, DIABETIC TRACTION RETINAL DETACHMENT, RETINOPATHY OF PREMATURITY, RETINAL TEAR OF GREATER THAN 90 DEGREES), WITH VITRECTOMY AND MEMBRANE PEELING, MAY INC	No for All Programs, No for Package C	50, 54, 55, 62, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NA
67229	TREATMENT OF EXTENSIVE OR PROGRESSIVE RETINOPATHY, ONE OR MORE SESSIONS;	No for All Programs, No for Package C	50, 54, 55,	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PRETERM INFANT (LESS THAN 37 WEEKS GESTATION AT BIRTH), PERFORMED FROM BIRTH UP TO 1 YEAR OF AGE (EG, RETINOPATHY OF PREMATURITY), PHOTOCOAGULATION OR CRYOTHERAPY				
68816	PROBING OF NASOLACRIMAL DUCT, WITH OR WITHOUT IRRIGATION; WITH TRANSLUMINAL BALLOON CATHETER DILATION	No for All Programs, No for Package C	50, 54, 55,	Covered for All Programs, Covered for Package C	NA
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL;	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES;	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
80047	BASIC METABOLIC PANEL (CALCIUM, IONIZED)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
82610	CYSTATIN C	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
83993	CALPROTECTIN, FECAL	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
84704	GONADOTROPIN, CHORIONIC (HCG); FREE BETA CHAIN	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
86356	MONONUCLEAR CELL ANTIGEN, QUANTITATIVE (EG, FLOW CYTOMETRY), NOT OTHERWISE SPECIFIED, EACH ANTIGEN	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
86486	SKIN TEST; UNLISTED ANTIGEN, EACH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
87500	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); VANCOMYCIN RESISTANCE (EG, ENTEROCOCCUS SPECIES VAN A, VAN B), AMPLIFIED PROBE TECHNIQUE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
87809	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; ADENOVIRUS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
88381	MICRODISSECTION (IE, SAMPLE PREPARATION OF MICROSCOPICALLY IDENTIFIED TARGET); MANUAL	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
89322	SEMEN ANALYSIS; VOLUME, COUNT, MOTILITY, AND DIFFERENTIAL USING STRICT MORPHOLOGIC CRITERIA (EG, KRUGER)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
89331	SPERM EVALUATION, FOR RETROGRADE EJACULATION, URINE (SPERM CONCENTRATION, MOTILITY, AND MORPHOLOGY, AS INDICATED)	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
90284	IMMUNE GLOBULIN (SCIG), HUMAN, FOR USE IN SUBCUTANEOUS INFUSIONS, 100 MG, EACH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
90661	INFLUENZA VIRUS VACCINE, DERIVED FROM CELL CULTURES, SUBUNIT, PRESERVATIVE AND ANTIBIOTIC FREE, FOR INTRAMUSCULAR USE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
90662	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, ENHANCED IMMUNOGENICITY VIA INCREASED ANTIGEN CONTENT, FOR INTRAMUSCULAR USE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
90663	INFLUENZA VIRUS VACCINE, PANDEMIC FORMULATION	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
93982	NONINVASIVE PHYSIOLOGIC STUDY OF IMPLANTED WIRELESS PRESSURE SENSOR IN ANEURYSMAL SAC FOLLOWING ENDOVASCULAR REPAIR, COMPLETE STUDY INCLUDING RECORDING, ANALYSIS OF PRESSURE AND WAVEFORM TRACINGS, INTERPRETATION AND REPORT	No for All Programs, No for Package C	TC, 26	Covered for All Programs, Covered for Package C	NA
95980	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (EG, RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT MEASUREMENTS) GAST	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
95981	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (EG, RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT MEASUREMENTS) GAST	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
95982	ELECTRONIC ANALYSIS OF IMPLANTED NEUROSTIMULATOR PULSE GENERATOR SYSTEM (EG, RATE, PULSE AMPLITUDE AND DURATION, CONFIGURATION OF	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	WAVE FORM, BATTERY STATUS, ELECTRODE SELECTABILITY, OUTPUT MODULATION, CYCLING, IMPEDANCE AND PATIENT MEASUREMENTS) GAST				
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING (EG, ROSS INFORMATION PROCESSING ASSESSMENT) PER HOUR OF A QUALIFIED HEALTH CARE PROFESSIONAL'S TIME, BOTH FACE-TO-FACE TIME ADMINISTERING TESTS TO THE PATIENT AND TIME INTERPRETING THESE TEST RESULTS AND PR	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
98966	TELEPHONE ASSESSMENT AND MANAGEMENT SERVICE PROVIDED BY A QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED ASSESSMENT AND MANAGEMENT SERVICE PROVIDED WITHIN THE PREVIOUS SEV	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
98967	TELEPHONE ASSESSMENT AND MANAGEMENT SERVICE PROVIDED BY A QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED ASSESSMENT AND MANAGEMENT SERVICE PROVIDED WITHIN THE PREVIOUS SEV	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
98968	TELEPHONE ASSESSMENT AND MANAGEMENT SERVICE PROVIDED BY A QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED ASSESSMENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	AND MANAGEMENT SERVICE PROVIDED WITHIN THE PREVIOUS SEV				
98969	ONLINE ASSESSMENT AND MANAGEMENT SERVICE PROVIDED BY A QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL TO AN ESTABLISHED PATIENT, GUARDIAN, OR HEALTH CARE PROVIDER NOT ORIGINATING FROM A RELATED ASSESSMENT AND MANAGEMENT SERVICE PROVIDED WITHIN THE P	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99174	OCULAR PHOTOSCREENING WITH INTERPRETATION AND REPORT, BILATERAL	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
99366	MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, FACE-TO-FACE WITH PATIENT AND/OR FAMILY, 30 MINUTES OR MORE, PARTICIPATION BY NONPHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99367	MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, PATIENT AND/OR FAMILY NOT PRESENT, 30 MINUTES OR MORE; PARTICIPATION BY PHYSICIAN	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99368	MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, PATIENT AND/OR FAMILY NOT PRESENT, 30 MINUTES OR MORE; PARTICIPATION BY NONPHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99406	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTERMEDIATE, GREATER THAN	Not Applicable for All Programs, Not Applicable for	NA	Non-Reimbursable for All Programs, Non-Reimbursable	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	3 MINUTES UP TO 10 MINUTES	Package C			
99407	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTENSIVE, GREATER THAN 10 MINUTES	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable	NA
99408	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED SCREENING (EG, AUDIT, DAST), AND BRIEF INTERVENTION (SBI) SERVICES; 15 TO 30 MINUTES	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable	NA
99409	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED SCREENING (EG, AUDIT, DAST), AND BRIEF INTERVENTION (SBI) SERVICES; GREATER THAN 30 MINUTES	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable	NA
99441	TELEPHONE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS NOR LEADING TO AN E/M SERVICE OR PROCEDURE WITHIN THE NE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99442	TELEPHONE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS NOR LEADING TO AN E/M SERVICE OR PROCEDURE WITHIN THE NE	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99443	TELEPHONE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, PARENT, OR GUARDIAN NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS NOR	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	LEADING TO AN E/M SERVICE OR PROCEDURE WITHIN THE NE				
99444	ONLINE EVALUATION AND MANAGEMENT SERVICE PROVIDED BY A PHYSICIAN TO AN ESTABLISHED PATIENT, GUARDIAN, OR HEALTH CARE PROVIDER NOT ORIGINATING FROM A RELATED E/M SERVICE PROVIDED WITHIN THE PREVIOUS 7 DAYS, USING THE INTERNET OR SIMILAR ELECTRONIC COM	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99477	INITIAL HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE NEONATE, 28 DAYS OF AGE OR LESS, WHO REQUIRES INTENSIVE OBSERVATION, FREQUENT INTERVENTIONS, AND OTHER INTENSIVE CARE SERVICES	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
99605	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; INITIAL 15 MINUTES, NEW PATIENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99606	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED; INITIAL 15 MINUTES, ESTABLISHED PATIENT	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
99607	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, WITH ASSESSMENT AND INTERVENTION IF PROVIDED;	Not Applicable for All Programs, Not Applicable for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2008 Annual HCPCS Codes, Effective January 1, 2008

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)				

Note: Codes marked with an asterisk (*) are currently non-reimbursable because a rebating manufacturer is not available at this time.

Table 2 – New Modifier Codes for the 2008 Annual HCPCS Update

Modifier Code	Description	Type	Effective Date
8P	Performance Modifier in OS	Informational	1/1/2008
EA	ESA, Anemia, Chemo Induced	Informational	1/1/2008
EB	ESA, Anemia, Radio Induced	Informational	1/1/2008
EC	ESA, Anemia, Non-Chem/Radio	Informational	1/1/2008
ED	HCT > than 39% or Hgb > than 13g> = 3 Cycle	Informational	1/1/2008
EE	HCT > than 39% or Hgb > than 13g< 3 Cycel	Informational	1/1/2008
FC	Part Credit, replaced device	Informational	1/1/2008
GD	Unit of Service > MUE Value	Informational	1/1/2008
KV	DMEPOS Item, Profession Serv	Informational	1/1/2008
KW	DMEPOS Comp Bid Prgm no 4	Informational	1/1/2008
KY	DMEPOS Comp Bid Prgm no 5	Informational	1/1/2008
Q0	Invest Clinical Research	Informational	1/1/2008
Q1	Routine Clinical Research	Informational	1/1/2008

Note: The replacement codes in Table 3 are effective for dates of service of January 1, 2008, or after.

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
0024T	NON-SURGICAL SEPTAL REDUCTION THERAPY (EG, ALCOHOL ABLATION), FOR HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY, WITH CORONARY ARTERIOGRAMS, WITH OR WITHOUT TEMPORARY PACEMAKER	93799

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
0054T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	20985-20987
0055T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON CT/MRI IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	20985-20987
0056T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, IMAGE-LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	20985-20987
0065T	OCULAR PHOTOSCREENING, WITH INTERPRETATION AND REPORT, BILATERAL	99174
0074T	ONLINE EVALUATION AND MANAGEMENT SERVICE, PER ENCOUNTER, PROVIDED BY A PHYSICIAN, USING THE INTERNET OR SIMILAR ELECTRONIC COMMUNICATIONS NETWORK, IN RESPONSE TO A PATIENT'S REQUEST, ESTABLISHED PATIENT	NA
0115T	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, INITIAL 15 MINUTES, WITH ASSESSMENT, AND INTERVENTION IF PROVIDED; INITIAL ENCOUNTER	NA
0116T	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, INITIAL 15 MINUTES, WITH ASSESSMENT, AND INTERVENTION IF PROVIDED; SUBSEQUENT ENCOUNTER	NA
0117T	MEDICATION THERAPY MANAGEMENT SERVICE(S) PROVIDED BY A PHARMACIST, INDIVIDUAL, FACE-TO-FACE WITH PATIENT, INITIAL 15 MINUTES, WITH ASSESSMENT, AND INTERVENTION IF PROVIDED; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY S	NA
0133T	UPPER GASTROINTESTINAL ENDOSCOPY, INCLUDING ESOPHAGUS, STOMACH, AND EITHER THE DUODENUM AND/OR JEJUNUM AS APPROPRIATE, WITH INJECTION OF IMPLANT MATERIAL INTO AND ALONG THE MUSCLE OF THE LOWER ESOPHAGEAL SPHINCTER (EG, FOR TREATMENT OF GASTROESOPHAGE	NA
0135T	ABLATION, RENAL TUMOR(S), UNILATERAL, PERCUTANEOUS, CRYOTHERAPY	50593
0153T	TRANSCATHETER PLACEMENT OF WIRELESS PHYSIOLOGIC SENSOR IN ANEURYSMAL SAC DURING ENDOVASCULAR REPAIR, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION AND INSTRUMENT CALIBRATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NA
0154T	NONINVASIVE PHYSIOLOGIC STUDY OF IMPLANTED WIRELESS PRESSURE SENSOR IN ANEURYSMAL SAC FOLLOWING ENDOVASCULAR REPAIR, COMPLETE STUDY INCLUDING RECORDING, ANALYSIS OF	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
	PRESSURE AND WAVEFORM TRACINGS, INTERPRETATION AND REPORT	
1080F	SURROGATE DECISION MAKER OR ADVANCE CARE PLAN DOCUMENTED IN THE MEDICAL RECORD (GER)5	NA
3047F	MOST RECENT HEMOGLOBIN A1C LEVEL <= 9.0% (DM)	NA
3076F	MOST RECENT SYSTOLIC BLOOD PRESSURE 140 MM HG (HTN) (DM)	NA
4007F	AGE-RELATED EYE DISEASE STUDY (AREDS) FORMULATION PRESCRIBED OR RECOMMENDED (EC)5	NA
01905	ANESTHESIA FOR MYELOGRAPHY, DISCOGRAPHY, VERTEBROPLASTY	01935 and 01936
24350	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS);	24357
24351	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH EXTENSOR ORIGIN DETACHMENT	24358
24352	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH ANNULAR LIGAMENT RESECTION	24359
24354	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH STRIPPING	24359
24356	FASCIOTOMY, LATERAL OR MEDIAL (EG, TENNIS ELBOW OR EPICONDYLITIS); WITH PARTIAL OSTECTOMY	24359
32000	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT	32421
32002	THORACENTESIS WITH INSERTION OF TUBE WITH OR WITHOUT WATER SEAL (EG, FOR PNEUMOTHORAX) (SEPARATE PROCEDURE)	32422
32005	CHEMICAL PLEURODESIS (EG, FOR RECURRENT OR PERSISTENT PNEUMOTHORAX)	32560
32019	INSERTION OF INDWELLING TUNNELED PLEURAL CATHETER WITH CUFF	32550
32020	TUBE THORACOSTOMY WITH OR WITHOUT WATER SEAL (EG, FOR ABSCESS, HEMOTHORAX, EMPYEMA) (SEPARATE PROCEDURE)	32551
36540	COLLECTION OF BLOOD SPECIMEN FROM A COMPLETELY IMPLANTABLE VENOUS ACCESS DEVICE	36591
36550	DECLOTTING BY THROMBOLYTIC AGENT OF IMPLANTED VASCULAR ACCESS DEVICE OR CATHETER	36593
43750	PERCUTANEOUS PLACEMENT OF GASTROSTOMY TUBE	43246
47719	ANASTOMOSIS, CHOLEDOCHAL CYST, WITHOUT EXCISION	Use most appropriate code
49200	EXCISION OR DESTRUCTION, OPEN, INTRA-ABDOMINAL OR RETROPERITONEAL TUMORS OR CYSTS OR ENDOMETRIOMAS;	49203
49201	EXCISION OR DESTRUCTION, OPEN, INTRA-ABDOMINAL OR RETROPERITONEAL TUMORS OR CYSTS OR ENDOMETRIOMAS; EXTENSIVE	49203, 49204, 49205
51000	ASPIRATION OF BLADDER BY NEEDLE	51100

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
51005	ASPIRATION OF BLADDER; BY TROCAR OR INTRACATHETER	51101
51010	ASPIRATION OF BLADDER; WITH INSERTION OF SUPRAPUBIC CATHETER	51102
52510	TRANSURETHRAL BALLOON DILATION OF THE PROSTATIC URETHRA	Use most appropriate code
60001	ASPIRATION AND/OR INJECTION, THYROID CYST	60300
67038	VITRECTOMY, MECHANICAL, PARS PLANA APPROACH; WITH EPIRETINAL MEMBRANE STRIPPING	67041, 67042, 67043
74350	PERCUTANEOUS PLACEMENT OF GASTROSTOMY TUBE, RADIOLOGICAL SUPERVISION AND INTERPRETATION	49440
75552	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY; WITHOUT CONTRAST MATERIAL	75557-75564
75553	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY; WITH CONTRAST MATERIAL	75557-75564
75554	CARDIAC MAGNETIC RESONANCE IMAGING FOR FUNCTION, WITH OR WITHOUT MORPHOLOGY; COMPLETE STUDY	75557-75564
75555	CARDIAC MAGNETIC RESONANCE IMAGING FOR FUNCTION, WITH OR WITHOUT MORPHOLOGY; LIMITED STUDY	75557-75564
75556	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW MAPPING	75557-75564
78615	CEREBRAL VASCULAR FLOW	78610
86586	UNLISTED ANTIGEN, EACH	86486
99361	MEDICAL CONFERENCE BY A PHYSICIAN WITH INTERDISCIPLINARY TEAM OF HEALTH PROFESSIONALS OR REPRESENTATIVES OF COMMUNITY AGENCIES TO COORDINATE ACTIVITIES OF PATIENT CARE (PATIENT NOT PRESENT); APPROXIMATELY 30 MINUTES	NA
99362	MEDICAL CONFERENCE BY A PHYSICIAN WITH INTERDISCIPLINARY TEAM OF HEALTH PROFESSIONALS OR REPRESENTATIVES OF COMMUNITY AGENCIES TO COORDINATE ACTIVITIES OF PATIENT CARE (PATIENT NOT PRESENT); APPROXIMATELY 60 MINUTES	NA
99371	TELEPHONE CALL BY A PHYSICIAN TO PATIENT OR FOR CONSULTATION OR MEDICAL MANAGEMENT OR FOR COORDINATING MEDICAL MANAGEMENT WITH OTHER HEALTH CARE PROFESSIONALS (EG, NURSES, THERAPISTS, SOCIAL WORKERS, NUTRITIONISTS, PHYSICIANS, PHARMACISTS); SIMPLE OR	NA
99372	TELEPHONE CALL BY A PHYSICIAN TO PATIENT OR FOR CONSULTATION OR MEDICAL MANAGEMENT OR FOR COORDINATING MEDICAL MANAGEMENT WITH OTHER HEALTH CARE PROFESSIONALS (EG, NURSES, THERAPISTS, SOCIAL WORKERS, NUTRITIONISTS, PHYSICIANS, PHARMACISTS); INTERMEDI	NA
99373	TELEPHONE CALL BY A PHYSICIAN TO PATIENT OR FOR CONSULTATION OR MEDICAL MANAGEMENT OR FOR COORDINATING MEDICAL MANAGEMENT WITH OTHER HEALTH CARE PROFESSIONALS (EG,	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
	NURSES, THERAPISTS, SOCIAL WORKERS, NUTRITIONISTS, PHYSICIANS, PHARMACISTS); COMPLEX O	
A9565	INDIUM IN-111 PENTETREOTIDE, DIAGNOSTIC, PER MILLICURIE	A9572
B4086	GASTROSTOMY / JEJUNOSTOMY TUBE, ANY MATERIAL, ANY TYPE, (STANDARD OR LOW PROFILE), EACH	B4087, B4088
C1718	BRACHYTHERAPY SOURCE, IODINE 125, PER SOURCE	C2638, C2639
C1720	BRACHYTHERAPY SOURCE, PALLADIUM 103, PER SOURCE	C2640, C2641
C1879	TISSUE MARKER (IMPLANTABLE)	A4648
C2633	BRACHYTHERAPY SOURCE, CESIUM-131, PER SOURCE	NA
C9232	INJECTION, IDURSULFASE, 1 MG	J1743
C9233	INJECTION, RANIBIZUMAB, 0.5 MG	J2778
C9234	INJECTION, ALGLUCOSIDASE ALFA, 10 MG	NA
C9235	INJECTION, PANITUMUMAB, 10 MG	J9303
C9236	INJECTION, ECULIZUMAB, 10 MG	J1300
C9350	MICROPOROUS COLLAGEN TUBE OF NON-HUMAN ORIGIN, PER CENTIMETER LENGTH	C9353
C9351	ACELLULAR DERMAL TISSUE MATRIX OF NON-HUMAN ORIGIN, PER SQUARE CENTIMETER (DO NOT REPORT C9351 IN CONJUNCTION WITH J7345)	J7347, J7348, J7349
E2618	WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), FOR USE WITH MANUAL WHEELCHAIR OR LIGHTWEIGHT POWER WHEELCHAIR, INCLUDES ANY TYPE MOUNTING HARDWARE	NA
G0265	CRYOPRESERVATION, FREEZING AND STORAGE OF CELLS FOR THERAPEUTIC USE, EACH CELL LINE	38207
G0266	THAWING AND EXPANSION OF FROZEN CELLS FOR THERAPEUTIC USE, EACH ALIQUOT	38208
G0267	BONE MARROW OR PERIPHERAL STEM CELL HARVEST, MODIFICATION OR TREATMENT TO ELIMINATE CELL TYPE(S) (E.G. T-CELLS, METASTATIC CARCINOMA)	38210-38215
G0298	INSERTION OF DUAL CHAMBER PACING CARDIOVERTER DEFIBRILLATOR PULSE GENERATOR	NA
G0299	INSERTION OR REPOSITIONING OF ELECTRODE LEAD FOR SINGLE CHAMBER PACING CARDIOVERTER DEFIBRILLATOR AND INSERTION OF PULSE GENERATOR	NA
G0375	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTERMEDIATE, GREATER THAN 3 MINUTES UP TO 10 MINUTES	NA
G0376	SMOKING AND TOBACCO USE CESSATION COUNSELING VISIT; INTENSIVE, GREATER THAN 10 MINUTES	NA
G8158	PATIENT DOCUMENTED TO HAVE RECEIVED CORONARY ARTERY BYPASS GRAFT WITH USE OF INTERNAL MAMMARY ARTERY	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
G8160	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CORONARY ARTERY BYPASS GRAFT WITH USE OF INTERNAL MAMMARY ARTERY MEASURE	NA
G8161	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT DOCUMENTED TO HAVE RECEIVED PRE-OPERATIVE BETA-BLOCKADE	NA
G8163	CLINICIAN DOCUMENTED THAT PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-OPERATIVE BETA-BLOCKADE MEASURE	NA
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)	NA
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)	NA
G8194	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PROPHYLACTIC ANTIBIOTIC	NA
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)	NA
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)	NA
G8198	PATIENT DOCUMENTED TO HAVE ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	NA
G8199	CLINICIAN DOCUMENTED TO HAVE GIVEN CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	NA
G8201	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	NA
G8202	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME	NA
G8203	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTICS WERE DISCONTINUED WITHIN 24 HOURS OF SURGICAL END TIME	NA
G8205	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PROPHYLACTIC ANTIBIOTIC DISCONTINUATION WITHIN 24 HOURS OF SURGICAL END TIME	NA
G8206	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN	NA
G8207	CLINICIAN DOCUMENTED AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
G8208	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTICS WERE DISCONTINUED WITHIN 48 HOURS OF SURGICAL END TIME	NA
G8210	CLINICIAN DOCUMENTED PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DISCONTINUATION OF PROPHYLACTIC ANTIBIOTIC DISCONTINUATION WITHIN 48 HOURS OF SURGICAL END TIME	NA
G8211	CLINICIAN DOCUMENTED THAT PROPHYLACTIC ANTIBIOTIC WAS GIVEN	NA
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	NA
G8213	CLINICIAN DOCUMENTED TO HAVE GIVEN VTE PROPHYLAXIS WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME	NA
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	NA
G8216	PATIENT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY TWO	NA
G8218	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2, INCLUDING PHYSICIAN DOCUMENTATION THAT PATIENT IS AMBULATORY	NA
G8222	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED ANTIPLATELET THERAPY AT DISCHARGE	NA
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	NA
G8225	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED AN ANTICOAGULANT AT DISCHARGE	NA
G8227	PATIENT NOT DOCUMENTED TO HAVE PERMANENT, PERSISTENT, OR PAROXYSMAL ATRIAL FIBRILLATION	NA
G8228	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTICOAGULANT THERAPY AT DISCHARGE	NA
G8229	PATIENT DOCUMENTED TO HAVE BEEN ADMINISTERED OR CONSIDERED FOR T-PA	NA
G8230	PATIENT NOT ELIGIBLE FOR T-PA ADMINISTRATION, ISCHEMIC STROKE SYMPTOM ONSET OF MORE THAN 3 HOURS	NA
G8232	PATIENT DOCUMENTED TO HAVE RECEIVED DYSPHAGIA SCREENING PRIOR TO TAKING ANY FOODS, FLUIDS OR MEDICATION BY MOUTH	NA
G8235	PATIENT NOT RECEIVING OR INELIGIBLE TO RECEIVE FOOD, FLUIDS OR MEDICATION BY MOUTH, OR DOCUMENTATION OF NPO (NOTHING BY MOUTH) ORDER	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
G8236	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DYSPHAGIA SCREENING PRIOR TO TAKING ANY FOODS, FLUIDS OR MEDICATION BY MOUTH	NA
G8237	PATIENT DOCUMENTED TO HAVE RECEIVED ORDER FOR REHABILITATION SERVICES OR DOCUMENTATION OF CONSIDERATION FOR REHABILITATION SERVICES	NA
G8239	INTERNAL CAROTID STENOSIS PATIENT BELOW 30%, REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT NOT NECESSARY	NA
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	NA
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	NA
G8245	CLINICIAN DOCUMENTED PRESENCE OR ABSENCE ALARM SYMPTOMS	NA
G8247	PATIENT WITH ALARM SYMPTOM(S) DOCUMENTED TO HAVE HAD UPPER ENDOSCOPY PERFORMED OR REFERRAL FOR UPPER ENDOSCOPY	NA
G8249	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR UPPER ENDOSCOPY	NA
G8250	PATIENT WITH SUSPICION OF BARRETT'S ESOPHAGUS IN ENDOSCOPY REPORT AND DOCUMENTED TO HAVE RECEIVED AN ESOPHAGEAL BIOPSY	NA
G8252	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ESOPHAGEAL BIOPSY	NA
G8253	PATIENT DOCUMENTED TO HAVE RECEIVED AN ORDER FOR A BARIUM SWALLOW TEST	NA
G8255	CLINICIAN DOCUMENTATION THAT PATIENT WAS AN ELIGIBLE CANDIDATE FOR BARIUM SWALLOW TEST	NA
G8256	CLINICIAN DOCUMENTED RECONCILIATION OF DISCHARGE MEDICATIONS WITH CURRENT MEDICATION LIST IN MEDICAL RECORD	NA
G8258	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DISCHARGE MEDICATIONS REVIEW	NA
G8259	PATIENT DOCUMENTED TO HAVE SURROGATE DECISION MAKER OR ADVANCE CARE PLAN IN MEDICAL RECORD	NA
G8261	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR SURROGATE DECISION MAKER OR ADVANCE CARE PLAN	NA
G8262	PATIENT DOCUMENTED TO HAVE BEEN ASSESSED FOR PRESENCE OR ABSENCE OF URINARY INCONTINENCE	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
G8264	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR AN ASSESSMENT OF THE PRESENCE OR ABSENCE OF URINARY INCONTINENCE	NA
G8265	PATIENT DOCUMENTED TO HAVE RECEIVED CHARACTERIZATION OF URINARY INCONTINENCE	NA
G8267	PATIENT DOCUMENTED TO HAVE RECEIVED A PLAN OF CARE FOR URINARY INCONTINENCE	NA
G8269	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME TO DEVELOP PLAN OF CARE FOR URINARY INCONTINENCE	NA
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)	NA
G8272	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR FALL RISK SCREENING	NA
G8273	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME TO SCREEN FOR FALL RISK	NA
G8275	PATIENT DOCUMENTED TO HAVE MEDICAL HISTORY TAKEN WHICH INCLUDED ASSESSMENT OF NEW OR CHANGING MOLES	NA
G8277	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MEDICAL HISTORY REVIEW WITH ASSESSMENT OF NEW OR CHANGING MOLES	NA
G8278	PATIENT DOCUMENTED TO HAVE RECEIVED COMPLETE PHYSICAL SKIN EXAM	NA
G8280	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COMPLETE PHYSICAL SKIN EXAM DURING THE REPORTING YEAR	NA
G8281	PATIENT DOCUMENTED TO HAVE RECEIVED COUNSELING TO PERFORM A SELF-EXAMINATION	NA
G8283	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR COUNSELING TO PERFORM SELF-EXAMINATION	NA
G8284	PATIENT DOCUMENTED TO HAVE RECEIVED A PRESCRIPTION FOR PHARMACOLOGIC THERAPY FOR OSTEOPOROSIS	NA
G8286	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PHARMACOLOGIC THERAPY	NA
G8287	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR THE PHARMACOLOGIC THERAPY MEASURE	NA
G8288	PATIENT DOCUMENTED TO HAVE RECEIVED CALCIUM AND VITAMIN D OR COUNSELING ON BOTH CALCIUM AND VITAMIN D USE, AND EXERCISE	NA
G8290	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CALCIUM AND VITAMIN D, AND EXERCISE DURING THE REPORTING YEAR	NA
G8291	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
	REQUIRED TIME FOR THE CALCIUM, VITAMIN D, AND EXERCISE MEASURE	
G8292	COPD PATIENT WITH SPIROMETRY RESULTS DOCUMENTED	NA
G8294	COPD PATIENT WAS NOT ELIGIBLE FOR SPIROMETRY RESULTS	NA
G8295	COPD PATIENT DOCUMENTED TO HAVE RECEIVED INHALED BRONCHODILATOR THERAPY	NA
G8297	COPD PATIENT WAS NOT ELIGIBLE FOR INHALED BRONCHODILATOR THERAPY	NA
G8300	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR OPTIC NERVE HEAD EVALUATION DURING THE REPORTING YEAR	NA
G8301	CLINICIAN HAS NOT PROVIDED CARE FOR THE PRIMARY OPEN-ANGLE GLAUCOMA PATIENT FOR THE REQUIRED TIME FOR OPTIC NERVE HEAD EVALUATION MEASURE	NA
G8309	PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED/RECOMMENDED ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT	NA
G8311	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT DURING THE REPORTING YEAR	NA
G8312	CLINICIAN HAS NOT PROVIDED CARE FOR THE AGE-RELATED MACULAR DEGENERATION PATIENT FOR THE REQUIRED TIME FOR ANTIOXIDANT SUPPLEMENT PRESCRIPTION/RECOMMENDED MEASURE	NA
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	NA
G8315	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MACULAR EXAMINATION DURING THE REPORTING YEAR	NA
G8316	CLINICIAN HAS NOT PROVIDED CARE FOR THE AGE-RELATED MACULAR DEGENERATION PATIENT FOR THE REQUIRED TIME FOR MACULAR EXAMINATION MEASUREMENT	NA
G8317	PATIENT DOCUMENTED TO HAVE VISUAL FUNCTIONAL STATUS ASSESSED	NA
G8319	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ASSESSMENT OF VISUAL FUNCTIONAL STATUS	NA
G8320	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR ASSESSMENT OF VISUAL FUNCTIONAL STATUS MEASUREMENT	NA
G8321	PATIENT DOCUMENTED TO HAVE HAD PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
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	NA
G8324	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR PRE-SURGICAL MEASUREMENT AND INTRAOCULAR LENS POWER CALCULATION MEASURE	NA
G8325	PATIENT DOCUMENTED TO HAVE RECEIVED FUNDUS EVALUATION WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY	NA
G8327	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PRE-SURGICAL FUNDUS EVALUATION	NA
G8328	CLINICIAN HAS NOT PROVIDED CARE FOR THE CATARACT PATIENT FOR THE REQUIRED TIME FOR FUNDUS EVALUATION MEASUREMENT	NA
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	NA
G8331	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DILATED MACULAR OR FUNDUS EXAM DURING THE REPORTING YEAR	NA
G8332	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC RETINOPATHY PATIENT FOR THE REQUIRED TIME FOR MACULAR EDEMA AND RETINOPATHY MEASUREMENT	NA
G8333	PATIENT DOCUMENTED TO HAVE HAD FINDINGS OF MACULAR OR FUNDUS EXAM COMMUNICATED TO THE PHYSICIAN MANAGING THE DIABETES CARE	NA
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	NA
G8336	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC RETINOPATHY PATIENT FOR THE REQUIRED TIME FOR PHYSICIAN COMMUNICATION MEASUREMENT	NA
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	NA
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	NA
G8340	PATIENT DOCUMENTED TO HAVE HAD CENTRAL DEXA PERFORMED AND RESULTS DOCUMENTED OR CENTRAL DEXA ORDERED OR PHARMACOLOGIC THERAPY PRESCRIBED	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
G8342	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CENTRAL DEXA MEASUREMENT OR PRESCRIBING PHARMACOLOGIC	NA
G8343	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGICAL THERAPY MEASURE	NA
G8344	PATIENT DOCUMENTED TO HAVE HAD CENTRAL DEXA ORDERED OR PERFORMED AND RESULTS DOCUMENTED OR PHARMACOLOGICAL THERAPY PRESCRIBED	NA
G8346	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGIC THERAPY	NA
G8347	CLINICIAN HAS NOT PROVIDED CARE FOR THE PATIENT FOR THE REQUIRED TIME FOR CENTRAL DEXA MEASUREMENT OR PHARMACOLOGICAL THERAPY MEASURE	NA
G8348	INTERNAL CAROTID STENOSIS PATIENT IN THE 30-99% RANGE DOCUMENTED TO HAVE REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT	NA
G8349	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DOCUMENTATION OF PRESENCE OR ABSENCE OF ALARM SYMPTOMS	NA
G8350	PATIENT DOCUMENTED TO HAVE HAD 12-LEAD ECG PERFORMED	NA
G8352	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ECG	NA
G8353	PATIENT DOCUMENTED TO HAVE RECEIVED OR TAKEN ASPIRIN 24 HOURS BEFORE EMERGENCY DEPARTMENT ARRIVAL OR DURING EMERGENCY DEPARTMENT STAY	NA
G8355	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE TO RECEIVE ASPIRIN	NA
G8356	PATIENT DOCUMENTED TO HAVE HAD ECG PERFORMED	NA
G8358	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ECG	NA
G8359	PATIENT DOCUMENTED TO HAVE HAD VITAL SIGNS RECORDED AND REVIEWED	NA
G8361	PATIENT DOCUMENTED TO HAVE OXYGEN SATURATION ASSESSED	NA
G8363	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR OXYGEN SATURATION ASSESSMENT	NA
G8364	PATIENT DOCUMENTED TO HAVE MENTAL STATUS ASSESSED	NA
G8366	PATIENT DOCUMENTED TO HAVE APPROPRIATE EMPIRIC ANTIBIOTIC PRESCRIBED	NA
G8368	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR APPROPRIATE EMPIRIC ANTIBIOTIC	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
J1567	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	J1568
J7319	HYALURONAN (SODIUM HYALURONATE) OR DERIVATIVE, INTRA-ARTICULAR INJECTION, PER INJECTION	J7321
J7345	DERMAL (SUBSTITUTE) TISSUE OF NON-HUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS, PER SQUARE CENTIMETER	J7347, J7348, J7349
J7611	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG	J7602, J7603
J7612	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG	J7602, J7603
J7613	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 1 MG	J7602, J7603
J7614	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG	J7602, J7603
K0553	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH	NA
K0554	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH	NA
K0555	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR	NA
L0960	TORSO SUPPORT, POST SURGICAL SUPPORT, PADS FOR POST SURGICAL SUPPORT	NA
L1855	KNEE ORTHOSIS, MOLDED PLASTIC, THIGH AND CALF SECTIONS, WITH DOUBLE UPRIGHT KNEE JOINTS, CUSTOM-FABRICATED	Use most appropriate code
L1858	KNEE ORTHOSIS, MOLDED PLASTIC, POLYCENTRIC KNEE JOINTS, PNEUMATIC KNEE PADS (CTI), CUSTOM-FABRICATED	Use most appropriate code
L1870	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF LACERS WITH KNEE JOINTS, CUSTOM-FABRICATED	Use most appropriate code
L1880	KNEE ORTHOSIS, DOUBLE UPRIGHT, NON-MOLDED THIGH AND CALF CUFFS/LACERS WITH KNEE JOINTS, CUSTOM-FABRICATED	Use most appropriate code
L3800	WRIST HAND FINGER ORTHOSIS, SHORT OPPONENS, NO ATTACHMENTS, CUSTOM-FABRICATED	L3931
L3805	WRIST HAND FINGER ORTHOSIS, LONG OPPONENS, NO ATTACHMENT, CUSTOM-FABRICATED	L3931
L3810	WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB ABDUCTION ('C') BAR	L3931
L3815	WHFO, ADDITION TO SHORT AND LONG OPPONENS, SECOND M.P. ABDUCTION ASSIST	L3931

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
L3820	WHFO, ADDITION TO SHORT AND LONG OPPONENS, I.P. EXTENSION ASSIST, WITH M.P. EXTENSION STOP	L3931
L3825	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. EXTENSION STOP	L3931
L3830	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. EXTENSION ASSIST	L3931
L3835	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. SPRING EXTENSION ASSIST	L3931
L3840	WHFO, ADDITION TO SHORT AND LONG OPPONENS, SPRING SWIVEL THUMB	L3931
L3845	WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB I.P. EXTENSION ASSIST, WITH M.P. STOP	L3931
L3850	WHO, ADDITION TO SHORT AND LONG OPPONENS, ACTION WRIST, WITH DORSIFLEXION ASSIST	L3931
L3855	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL	L3931
L3860	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL AND I.P.	L3931
L3907	WRIST HAND FINGER ORTHOSIS, WRIST GAUNTLET WITH THUMB SPICA, CUSTOM-FABRICATED	L3931
L3910	WRIST HAND FINGER ORTHOSIS, SWANSON DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3927
L3916	WRIST HAND FINGER ORTHOSIS, WRIST EXTENSION COCK-UP WITH OUTRIGGER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3918	HAND FINGER ORTHOSIS, KNUCKLE BENDER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3920	HAND FINGER ORTHOSIS, KNUCKLE BENDER WITH OUTRIGGER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3922	HAND FINGER ORTHOSIS, KNUCKLE BENDER, TWO SEGMENT TO FLEX JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3924	WRIST HAND FINGER ORTHOSIS, OPPENHEIMER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3926	WRIST HAND FINGER ORTHOSIS, THOMAS SUSPENSION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3928	HAND FINGER ORTHOSIS, FINGER EXTENSION, WITH CLOCK SPRING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3930	WRIST HAND FINGER ORTHOSIS, FINGER EXTENSION, WITH WRIST SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3932	FINGER ORTHOSIS, SAFETY PIN, SPRING WIRE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3925
L3934	FINGER ORTHOSIS, SAFETY PIN, MODIFIED, PREFABRICATED, INCLUDES	L3925

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
	FITTING AND ADJUSTMENT	
L3936	WRIST HAND FINGER ORTHOSIS, PALMER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3938	WRIST HAND FINGER ORTHOSIS, DORSAL WRIST, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3940	WRIST HAND FINGER ORTHOSIS, DORSAL WRIST, WITH OUTRIGGER ATTACHMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3942	HAND FINGER ORTHOSIS, REVERSE KNUCKLE BENDER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3944	HAND FINGER ORTHOSIS, REVERSE KNUCKLE BENDER, WITH OUTRIGGER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3946	HAND FINGER ORTHOSIS, COMPOSITE ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3948	FINGER ORTHOSIS, FINGER KNUCKLE BENDER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3925
L3950	WRIST HAND FINGER ORTHOSIS, COMBINATION OPPENHEIMER, WITH KNUCKLE BENDER AND TWO ATTACHMENTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3952	WRIST HAND FINGER ORTHOSIS, COMBINATION OPPENHEIMER, WITH REVERSE KNUCKLE AND TWO ATTACHMENTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3931
L3954	HAND FINGER ORTHOSIS, SPREADING HAND, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3929
L3985	UPPER EXTREMITY FRACTURE ORTHOSIS, FOREARM, HAND WITH WRIST HINGE, CUSTOM-FABRICATED	Use most appropriate code
L3986	UPPER EXTREMITY FRACTURE ORTHOSIS, COMBINATION OF HUMERAL, RADIUS/ULNAR, WRIST, (EXAMPLE--COLLES' FRACTURE), CUSTOM FABRICATED	Use most appropriate code
Q4079	INJECTION, NATALIZUMAB, 1 MG	J2323
Q4083	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE	J7321
Q4084	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	J7322
Q4085	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	J7323
Q4086	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	J7324
Q4087	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	J1568
Q4088	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	J1569

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
Q4089	INJECTION, RHO(D) IMMUNE GLOBULIN (HUMAN), (RHOPHYLAC), INTRAMUSCULAR OR INTRAVENOUS, 100 IU	J2791
Q4090	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAGAM B), INTRAMUSCULAR, 0.5 ML	J1571
Q4091	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	J1572
Q4092	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	J1561
Q4093	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)	J7602
Q4094	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)	J7603
Q4095	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG	J3488
Q9945	LOW OSMOLAR CONTRAST MATERIAL, UP TO 149 MG/ML IODINE CONCENTRATION, PER ML	Q9965
Q9946	LOW OSMOLAR CONTRAST MATERIAL, 150-199 MG/ML IODINE CONCENTRATION, PER ML	Q9965
Q9947	LOW OSMOLAR CONTRAST MATERIAL, 200-249 MG/ML IODINE CONCENTRATION, PER ML	Q9966
Q9948	LOW OSMOLAR CONTRAST MATERIAL, 250-299 MG/ML IODINE CONCENTRATION, PER ML	Q9966
Q9949	LOW OSMOLAR CONTRAST MATERIAL, 300-349 MG/ML IODINE CONCENTRATION, PER ML	Q9967
Q9950	LOW OSMOLAR CONTRAST MATERIAL, 350-399 MG/ML IODINE CONCENTRATION, PER ML	Q9967
Q9952	INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, PER ML	A9579
S0147	INJECTION, ALGLUCOSIDASE ALFA, 20 MG	NA
S0167	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG	J0364
S0180	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES	J7307
S0820	COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL	NA
S1025	INHALED NITRIC OXIDE FOR THE TREATMENT OF HYPOXIC RESPIRATORY FAILURE IN THE NEONATE; PER DIEM	NA
S2078	LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR WITHOUT REMOVAL OF TUBE(S), WITH OR WITHOUT REMOVAL OF OVARY(S)	NA

Table 3 – Deleted HCPCS Codes

Procedure Code	Description	Replacement Code for 2008
S2114	ARTHROSCOPY, SHOULDER, SURGICAL; TENODESIS OF BICEPS	29828
S2213	IMPLANTATION OF GASTRIC ELECTRICAL STIMULATION DEVICE	NA
S2250	UTERINE ARTERY EMBOLIZATION FOR UTERINE FIBROIDS	NA
S3618	BLOOD CHEMISTRY FOR FREE BETA HUMAN CHORIONIC GONADOTROPIN (HCG)	NA

Table 4 – New 2008 Annual HCPCS Codes Under Review for Coverage

Procedure Code	Description
0183T	LOW FREQUENCY, NON-CONTACT, NON-THERMAL ULTRASOUND, INCLUDING TOPICAL APPLICATION(S), WHEN PERFORMED, WOUND ASSESSMENT, AND
A4252	BLOOD KETONE TEST OR REAGENT STRIP, EACH
A4648	TISSUE MARKER IMPLANTABLE, ANY TYPE, EACH
A4650	IMPLANTABLE RADIATION DOSIMETER, EACH INJECTION
A9501	TECHNETIUM TC-99M TEBOROXIME, DIAGNOSTIC, PER STUDY DOSE
A9509	IODINE I-123 SODIUM IODIDE, DIAGNOSTIC, PER MILLICURIE
A9569	TECHNETIUM TC-99M EXAMETAZIME LABELED AUTOLOGOUS WHITE BLOOD CELLS, DIAGNOSTIC, PER STUDY DOSE
A9570	INDIUM IN-111 LABELED AUTOLOGOUS WHITE BLOOD CELLS, DIAGNOSTIC, PER STUDY DOSE
A9571	INDIUM IN-111 LABELED AUTOLOGOUS PLATELETS, DIAGNOSTIC, PER STUDY DOSE
A9572	INDIUM IN-111 PENTETREOTIDE, DIAGNOSTIC, PER STUDY DOSE, UP TO 6 MILLICURIES
A9576	INJECTION, GADOTERIDOL, (PROHANCE MULTIPACK), PER ML
A9577	INJECTION, GADOBENATE DIMEGLUMINE (MULTIHANCE), PER ML
A9578	INJECTION, GADOBENATE DIMEGLUMINE (MULTIHANCE MULTIPACK), PER ML
A9579	INJECTION, GADOLINIUM-BASED MAGNETIC RESONANCE CONTRAST AGENT, NOT OTHERWISE SPECIFIED (NOS), PER ML
J9226	HISTRELIN IMPLANT (SUPPRELIN LA), 50 MG
34806	TRANSCATHETER PLACEMENT OF WIRELESS PHYSIOLOGIC SENSOR IN ANEURYSMAL SAC DURING ENDOVASCULAR REPAIR, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION, INSTRUMENT CALIBRATION, AND COLLECTION OF PRESSURE DATA
75558	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH FLOW/VELOCITY QUANTIFICATION
75560	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH FLOW/VELOCITY QUANTIFICATION AND STRESS
75562	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER

Table 4 – New 2008 Annual HCPCS Codes Under Review for Coverage

Procedure Code	Description
	SEQUENCES; WITH FLOW/VELOCITY QUANTIFICATION
75564	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH FLOW/VELOCITY QUANTIFICATION AND STRESS
90769	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO ONE HOUR, INCLUDING PUMP SET-UP AND ESTABLISHMENT OF SUBCUTANEOUS INFUSION SITE(S)
90770	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
90771	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE OR DRUG); ADDITIONAL PUMP SET-UP WITH ESTABLISHMENT OF NEW SUBCUTANEOUS INFUSION SITE(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
90776	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH OF THE SAME SUBSTANCE/DRUG PROVIDED IN A FACILITY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Table 5 – New 2008 Annual HCPCS Codes Under Review for Pricing

Procedure Code	Description
0178T	ELECTROCARDIOGRAM, 64 LEADS OR GREATER, WITH GRAPHIC PRESENTATION AND ANALYSIS; WITH INTERPRETATION AND REPORT
0179T	ELECTROCARDIOGRAM, 64 LEADS OR GREATER, WITH GRAPHIC PRESENTATION AND ANALYSIS; TRACING AND GRAPHICS ONLY, WITHOUT INTERPRETATION AND REPORT
0180T	ELECTROCARDIOGRAM, 64 LEADS OR GREATER, WITH GRAPHIC PRESENTATION AND ANALYSIS; INTERPRETATION AND REPORT ONLY
0181T	CORNEAL HYSTERESIS DETERMINATION, BY AIR IMPULSE STIMULATION, BILATERAL, WITH INTERPRETATION AND REPORT
0182T	HIGH DOSE RATE ELECTRONIC BRACHYTHERAPY, PER FRACTION
0187T	EXCISION OF RECTAL TUMOR, TRANSANAL ENDOSCOPIC MICROSURGICAL APPROACH (IE, TEMS)
01935	ANESTHESIA FOR PERCUTANEOUS IMAGE GUIDED PROCEDURES ON THE SPINE AND SPINAL CORD; DIAGNOSTIC
01936	ANESTHESIA FOR PERCUTANEOUS IMAGE GUIDED PROCEDURES ON THE SPINE AND SPINAL CORD; THERAPEUTIC
20985	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES; IMAGE-LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Table 5 – New 2008 Annual HCPCS Codes Under Review for Pricing

Procedure Code	Description
20986	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES; WITH IMAGE GUIDANCE BASED ON INTRAOPERATIVELY OBTAINED IMAGES (EG, FLUOROSCOPY, ULTRASOUND) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
20987	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES; WITH IMAGE GUIDANCE BASED ON PREOPERATIVE IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
38207-38215	Note: CPT code range 38207-38215 replace HCPCS codes G0265-G0267. Pricing has not yet been established for existing 38207-38215.
80047	BASIC METABOLIC PANEL (CALCIUM, IONIZED)
82610	CYSTATIN C
83993	CALPROTECTIN, FECAL
84704	GONADOTROPIN, CHORIONIC (HCG); FREE BETA CHAIN
86356	MONONUCLEAR CELL ANTIGEN, QUANTITATIVE (EG, FLOW CYTOMETRY), NOT OTHERWISE SPECIFIED, EACH ANTIGEN
87500	SKIN TEST; UNLISTED ANTIGEN, EACH
87809	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); VANCOMYCIN RESISTANCE (EG, ENTEROCOCCUS SPECIES VAN A, VAN B), AMPLIFIED PROBE TECHNIQUE
90284	IMMUNE GLOBULIN (SCIG), HUMAN, FOR USE IN SUBCUTANEOUS INFUSIONS, 100 MG, EACH
99174	OCULAR PHOTOSCREENING WITH INTERPRETATION AND REPORT, BILATERAL
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA
A9274	EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES
A9276	SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY
J7347	DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (INTEGRA MATRIX), PER SQUARE CENTIMETER
J7348	DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (TISSUEMEND), PER SQUARE CENTIMETER
J7349	DERMAL (SUBSTITUTE) TISSUE OF NONHUMAN ORIGIN, WITH OR WITHOUT OTHER BIOENGINEERED OR PROCESSED ELEMENTS, WITHOUT METABOLICALLY ACTIVE ELEMENTS (PRIMATRIX), PER SQUARE CENTIMETER

Table 6 – Outpatient Radiology Rates for UB-04 Claims Only

Procedure Code	Description	Outpatient Rate for UB-04 Claims Only	Effective Date of Rate
75557	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL;	To Be Determined and Published at a Later Date	1/1/2008
75559	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH STRESS IMAGING	To Be Determined and Published at a Later Date	1/1/2008
75561	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES;	To Be Determined and Published at a Later Date	1/1/2008
75563	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH STRESS IMAGING	To Be Determined and Published at a Later Date	1/1/2008
0182T	HIGH DOSE RATE ELECTRONIC BRACHYTHERAPY, PER FRACTION	To Be Determined and Published at a Later Date	1/1/2008
0187T	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL	To Be Determined and Published at a Later Date	1/1/2008

Note: The outpatient rate for UB-O4 claims will be published in a forthcoming bulletin.

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