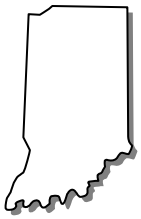

PROVIDER BULLETIN

BT201001 JANUARY 11, 2010

To: All Providers

Subject: Coverage Determinations for the New 2010 Healthcare Common Procedure Coding System Codes

Overview

The purpose of this bulletin is to notify providers of the coverage determinations for the new 2010 Annual Healthcare Common Procedure Coding System (HCPCS) codes. The Indiana Health Coverage Programs (IHCP) has reviewed the new 2010 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® [1]) codes for the 2010 annual HCPCS update by procedure code, description, allowed modifiers, and program coverage determination.
- Table 2: A listing of the new modifier codes for the 2010 annual HCPCS update by modifier, description, type, and effective date.
- Table 3: A listing of the codes that are deleted and the replacement codes for 2010.
- Table 4: A listing of the new code(s) that are currently under review by the IHCP for coverage. 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 that are 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.

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

New HCPCS Codes

The new 2010 Annual HCPCS codes in this bulletin are identified by code, description, and coverage. The IHCP is advising providers of these determinations so that the appropriate codes can be billed beginning for dates of service on or after January 1, 2010. Description changes have not been published in this bulletin. The 2010 HCPCS changed codes are available for download on the following website. http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS.

[1] ® *Current Procedural Terminology (CPT) is copyright 2004 American Medical Association. All tights teserved.*

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, 2010. Providers may bill these codes for dates of service on or after January 1, 2010. The standard global billing procedures and edits apply when using the new codes.

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

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0199T	PHYSIOLOGIC RECORDING OF TREMOR USING ACCELEROMETER(S) AND/OR GYROSCOPE(S) (INCLUDING FREQUENCY AND AMPLITUDE), INCLUDING INTERPRETATION AND REPORT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0200T	PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY), UNILATERAL INJECTION(S), INCLUDING THE USE OF A BALLOON OR MECHANICAL DEVICE, WHEN USED, 1 OR MORE NEEDLES	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0201T	PERCUTANEOUS SACRAL AUGMENTATION (SACROPLASTY), BILATERAL INJECTIONS, INCLUDING THE USE OF A BALLOON OR MECHANICAL DEVICE, WHEN USED, 2 OR MORE NEEDLES	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0202T	POSTERIOR VERTEBRAL JOINT(S) ARTHROPLASTY (E.G., FACET JOINT[S] REPLACEMENT), INCLUDING FACETECTOMY, LAMINECTOMY, FORAMINOTOMY, AND VERTEBRAL COLUMN FIXATION, INJECTION OF BONE CEMENT, WHEN PERFORMED, INCLUDING FLUOROSCOPY, SINGLE LEVEL, LUMBAR SPINE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0203T	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS (E.G., BY AIRFLOW OR PERIPHERAL ARTERIAL TONE) AND SLEEP TIME	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0204T	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; MINIMUM OF HEART RATE, OXYGEN SATURATION, AND RESPIRATORY ANALYSIS (E.G., BY AIRFLOW OR PERIPHERAL ARTERIAL TONE)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0205T	INTRAVASCULAR CATHETER-BASED CORONARY VESSEL OR GRAFT SPECTROSCOPY (E.G., INFRARED) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT, EACH VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0206T	ALGORITHMIC ANALYSIS, REMOTE, OF ELECTROCARDIOGRAPHIC-DERIVED DATA WITH COMPUTER PROBABILITY ASSESSMENT, INCLUDING REPORT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0207T	EVACUATION OF MEIBOMIAN GLANDS, AUTOMATED, USING HEAT AND INTERMITTENT PRESSURE, UNILATERAL	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0208T	PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE); AIR ONLY	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0209T	PURE TONE AUDIOMETRY (THRESHOLD), AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE); AIR AND BONE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0210T	SPEECH AUDIOMETRY THRESHOLD, AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0545F	PLAN FOR FOLLOW-UP CARE FOR MAJOR DEPRESSIVE DISORDER, DOCUMENTED (MDD ADOL)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1200F	SEIZURE TYPE(S) AND CURRENT SEIZURE FREQUENCY(IES) DOCUMENTED (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
1205F	ETIOLOGY OF EPILEPSY OR EPILEPSY SYNDROME(S) REVIEWED AND DOCUMENTED (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
14301	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, ANY AREA; DEFECT 30.1 SQ CM TO 60.0 SQ CM	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
14302	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, ANY AREA; EACH ADDITIONAL 30.0 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
2060F	PATIENT INTERVIEWED DIRECTLY BY EVALUATING CLINICIAN ON OR BEFORE DATE OF DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER (MDD ADOL)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
21011	EXCISION, TUMOR, SOFT TISSUE OF FACE OR SCALP,	No for All Programs, No	51, 54, 55, 56, 78, G8,	Covered for All Programs, Covered for	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	SUBCUTANEOUS; LESS THAN 2 CM	for Package C	G9	Package C	
21012	EXCISION, TUMOR, SOFT TISSUE OF FACE OR SCALP, SUBCUTANEOUS; 2 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21013	EXCISION, TUMOR, SOFT TISSUE OF FACE AND SCALP, SUBFASCIAL (E.G., SUBGALEAL, INTRAMUSCULAR); LESS THAN 2 CM	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21014	EXCISION, TUMOR, SOFT TISSUE OF FACE AND SCALP, SUBFASCIAL (E.G., SUBGALEAL, INTRAMUSCULAR); 2 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21016	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF FACE OR SCALP; 2 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21552	EXCISION, TUMOR, SOFT TISSUE OF NECK OR ANTERIOR THORAX, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21554	EXCISION, TUMOR, SOFT TISSUE OF NECK OR ANTERIOR THORAX, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21558	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF NECK OR ANTERIOR THORAX; 5 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
21931	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21932	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK,	No for All Programs, No	51, 54, 55, 56, 78, G8,	Covered for All Programs, Covered for	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	SUBFASCIAL (E.G., INTRAMUSCULAR); LESS THAN 5 CM	for Package C	G9	Package C	
21933	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
21936	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF BACK OR FLANK; 5 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
22901	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
22902	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBCUTANEOUS; LESS THAN 3 CM	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
22903	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
22904	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF ABDOMINAL WALL; LESS THAN 5 CM	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
22905	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF ABDOMINAL WALL; 5 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
23071	EXCISION, TUMOR, SOFT TISSUE OF SHOULDER AREA, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
23073	EXCISION, TUMOR, SOFT TISSUE OF SHOULDER AREA, SUBFASCIAL (E.G.,	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INTRAMUSCULAR); 5 CM OR GREATER				
23078	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF SHOULDER AREA; 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
24071	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
24073	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
24079	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF UPPER ARM OR ELBOW AREA; 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
25071	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND/OR WRIST AREA, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
25073	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND/OR WRIST AREA, SUBFASCIAL (E.G., INTRAMUSCULAR); 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
25078	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF FOREARM AND/OR WRIST AREA; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
26111	EXCISION, TUMOR OR VASCULAR MALFORMATION, SOFT TISSUE OF HAND OR FINGER, SUBCUTANEOUS; 1.5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
26113	EXCISION, TUMOR, SOFT TISSUE, OR VASCULAR MALFORMATION, OF HAND OR FINGER, SUBFASCIAL (E.G., INTRAMUSCULAR); 1.5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
26118	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF HAND OR FINGER; 3 CM OR GREATER	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
27043	EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
27045	EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
27059	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF PELVIS AND HIP AREA; 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 57, 58, 62, 76, 77, 78, 79, G8, G9	Covered for All Programs, Covered for Package C	NO
27337	EXCISION, TUMOR, SOFT TISSUE OF THIGH OR KNEE AREA, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
27339	EXCISION, TUMOR, SOFT TISSUE OF THIGH OR KNEE AREA, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
27364	EXCISION, TUMOR, SOFT TISSUE OF LEG OR ANKLE AREA, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9, QY,	Covered for All Programs, Covered for Package C	NO
27616	RADICAL RESECTION OF TUMOR	No for All	50, 51, 54,	Covered for All	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	(E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF LEG OR ANKLE AREA; 5 CM OR GREATER	Programs, No for Package C	55, 56, 62, 78, G8, G9	Programs, Covered for Package C	
27632	EXCISION, TUMOR, SOFT TISSUE OF LEG OR ANKLE AREA, SUBCUTANEOUS; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
27634	EXCISION, TUMOR, SOFT TISSUE OF LEG OR ANKLE AREA, SUBFASCIAL (E.G., INTRAMUSCULAR); 5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
28039	EXCISION, TUMOR, SOFT TISSUE OF FOOT OR TOE, SUBCUTANEOUS; 1.5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
28041	EXCISION, TUMOR, SOFT TISSUE OF FOOT OR TOE, SUBFASCIAL (E.G., INTRAMUSCULAR); 1.5 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
28047	RADICAL RESECTION OF TUMOR (E.G., MALIGNANT NEOPLASM), SOFT TISSUE OF FOOT OR TOE; 3 CM OR GREATER	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
29581	APPLICATION OF MULTI-LAYER VENOUS WOUND COMPRESSION SYSTEM, BELOW KNEE	No for All Programs, No for Package C	50, 51, G8, G9, HM,	Covered for All Programs, Covered for Package C	NO
3008F	BODY MASS INDEX (BMI), DOCUMENTED (PV)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3015F	CERVICAL CANCER SCREENING RESULTS DOCUMENTED AND REVIEWED (PV)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3038F	PULMONARY FUNCTION TEST PERFORMED WITHIN TWELVE MONTHS PRIOR TO SURGERY (LUNG/ESOP CX)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
31626	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH PLACEMENT OF FIDUCIAL MARKERS, SINGLE OR MULTIPLE	No for All Programs, No for Package C	51, 63, G8, G9	Covered for All Programs, Covered for Package C	NO
31627	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH COMPUTER-ASSISTED, IMAGE-GUIDED NAVIGATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE[S])	No for All Programs, No for Package C	51, 63, G8, G9	Covered for All Programs, Covered for Package C	NO
32552	REMOVAL OF INDWELLING TUNNELED PLEURAL CATHETER WITH CUFF	No for All Programs, No for Package C	54, 55, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
32553	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), PERCUTANEOUS, INTRA-THORACIC, SINGLE OR MULTIPLE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
32561	INSTILLATION(S), VIA CHEST TUBE/CATHETER, AGENT FOR FIBRINOLYSIS (E.G., FIBRINOLYTIC AGENT FOR BREAK UP OF MULTILOCULATED EFFUSION); INITIAL DAY	No for All Programs, No for Package C	50, 51, 54, 55, 62, 78, 80, 81, 82, AS, G8, G9, LT, RT	Covered for All Programs, Covered for Package C	NO
32562	INSTILLATION(S), VIA CHEST TUBE/CATHETER, AGENT FOR FIBRINOLYSIS (E.G., FIBRINOLYTIC AGENT FOR BREAK UP OF MULTILOCULATED EFFUSION); SUBSEQUENT DAY	No for All Programs, No for Package C	50, 51, 54, 55, 62, 78, 80, 81, 82, AS, G8, G9, LT, RT	Covered for All Programs, Covered for Package C	NO
3293F	ABO AND RH BLOOD TYPING DOCUMENTED AS PERFORMED	No for All Programs, No	NA	Non-Reimbursable for All Programs, Non-	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	(PRE-CR)	for Package C		Reimbursable for Package C	
3294F	GROUP B STREPTOCOCCUS (GBS) SCREENING DOCUMENTED AS PERFORMED DURING WEEK 35-37 GESTATION (PRE-CR)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3323F	CLINICAL TUMOR, NODE AND METASTASES (TNM) STAGING DOCUMENTED AND REVIEWED PRIOR TO SURGERY (LUNG/ESOP CX)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3324F	MRI OR CT SCAN ORDERED, REVIEWED OR REQUESTED (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3328F	PERFORMANCE STATUS DOCUMENTED AND REVIEWED WITHIN TWO WEEKS PRIOR TO SURGERY (LUNG/ESOP CX)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
33782	AORTIC ROOT TRANSLOCATION WITH VENTRICULAR SEPTAL DEFECT AND PULMONARY STENOSIS REPAIR (I.E., NIKAIDOH PROCEDURE); WITHOUT CORONARY OSTIUM REIMPLANTATION	No for All Programs, No for Package C	80, 81, 82, AS, G8, G9, LT, RT	Covered for All Programs, Covered for Package C	NO
33783	AORTIC ROOT TRANSLOCATION WITH VENTRICULAR SEPTAL DEFECT AND PULMONARY STENOSIS REPAIR (I.E., NIKAIDOH PROCEDURE); WITH REIMPLANTATION OF 1 OR BOTH CORONARY OSTIA	No for All Programs, No for Package C	80, 81, 82, AS, G8, G9, LT, RT	Covered for All Programs, Covered for Package C	NO
33981	REPLACEMENT OF EXTRACORPOREAL VENTRICULAR ASSIST DEVICE, SINGLE OR BIVENTRICULAR, PUMP(S), SINGLE OR EACH PUMP	No for All Programs, No for Package C	51, 54, 55, 56, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
33982	REPLACEMENT OF VENTRICULAR ASSIST DEVICE	No for All Programs, No	51, 54, 55, 56, 78, 80,	Covered for All Programs, Covered for	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITHOUT CARDIOPULMONARY BYPASS	for Package C	81, 82, AS, G8, G9	Package C	
33983	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITH CARDIOPULMONARY BYPASS	No for All Programs, No for Package C	51, 54, 55, 56, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
36147	INTRODUCTION OF NEEDLE AND/OR CATHETER, ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (GRAFT/FISTULA); INITIAL ACCESS WITH COMPLETE RADIOLOGICAL EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES ACCESS OF SHUNT, INJECTION[S] OF CONTRAST, AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C	NO
36148	INTRODUCTION OF NEEDLE AND/OR CATHETER, ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (GRAFT/FISTULA); ADDITIONAL ACCESS FOR THERAPEUTIC INTERVENTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C		Covered for All Programs, Covered for Package C	NO
3650F	ELECTROENCEPHALOGRAM (EEG) ORDERED, REVIEWED OR REQUESTED (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND GUIDANCE, WHEN PERFORMED, 1 LEG	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82	Covered for All Programs, Covered for Package C	NO
4004F	PATIENT SCREENED FOR TOBACCO USE AND RECEIVED TOBACCO CESSATION COUNSELING, IF IDENTIFIED AS A TOBACCO USER (PV)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4063F	ANTIDEPRESSANT PHARMACOTHERAPY CONSIDERED AND NOT PRESCRIBED (MDD ADOL)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4255F	DURATION OF GENERAL OR NEURAXIAL ANESTHESIA 60 MINUTES OR LONGER, AS DOCUMENTED IN THE ANESTHESIA RECORD	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4256F	DURATION OF GENERAL OR NEURAXIAL ANESTHESIA LESS THAN 60 MINUTES, AS DOCUMENTED IN THE ANESTHESIA RECORD	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
43281	LAPAROSCOPY, SURGICAL, REPAIR OF PARAESOPHAGEAL HERNIA, INCLUDES FUNDOPLASTY, WHEN PERFORMED; WITHOUT IMPLANTATION OF MESH	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
43282	LAPAROSCOPY, SURGICAL, REPAIR OF PARAESOPHAGEAL HERNIA, INCLUDES FUNDOPLASTY, WHEN PERFORMED; WITH IMPLANTATION OF MESH	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
4330F	COUNSELING ABOUT EPILEPSY SPECIFIC SAFETY ISSUES PROVIDED TO PATIENT (OR CAREGIVER(S)) (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
4340F	COUNSELING FOR WOMEN OF CHILDBEARING POTENTIAL WITH EPILEPSY (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (I.E., SLEEVE GASTRECTOMY)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
45171	EXCISION OF RECTAL TUMOR, TRANSANAL APPROACH; NOT INCLUDING MUSCULARIS PROPRIA (I.E., PARTIAL THICKNESS)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
45172	EXCISION OF RECTAL TUMOR, TRANSANAL APPROACH; INCLUDING MUSCULARIS PROPRIA (I.E., FULL THICKNESS)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG (E.G., PORCINE SMALL INTESTINE SUBMUCOSA [SIS])	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
49411	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), PERCUTANEOUS, INTRA-ABDOMINAL, INTRA-PELVIC (EXCEPT PROSTATE), AND/OR RETROPERITONEUM, SINGLE OR MULTIPLE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
51727	COMPLEX CYSTOMETROGRAM (I.E., CALIBRATED ELECTRONIC EQUIPMENT); WITH URETHRAL PRESSURE PROFILE STUDIES (I.E., URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE	No for All Programs, No for Package C	26, 51, G8, G9, TC	Covered for All Programs, Covered for Package C	NO
51728	COMPLEX CYSTOMETROGRAM (I.E., CALIBRATED ELECTRONIC	No for All Programs, No	26, 51, G8, G9, TC	Covered for All Programs, Covered for	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	EQUIPMENT); WITH VOIDING PRESSURE STUDIES (I.E., BLADDER VOIDING PRESSURE), ANY TECHNIQUE	for Package C		Package C	
51729	COMPLEX CYSTOMETROGRAM (I.E., CALIBRATED ELECTRONIC EQUIPMENT); WITH VOIDING PRESSURE STUDIES (I.E., BLADDER VOIDING PRESSURE) AND URETHRAL PRESSURE PROFILE STUDIES (I.E., URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE	No for All Programs, No for Package C	26, 51, G8, G9, TC	Covered for All Programs, Covered for Package C	NO
5200F	CONSIDERATION OF REFERRAL FOR A NEUROLOGICAL EVALUATION OF APPROPRIATENESS FOR SURGICAL THERAPY FOR INTRACTABLE EPILEPSY WITHIN THE PAST 3 YEARS (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
53855	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT, INCLUDING URETHRAL MEASUREMENT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
57426	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT, LAPAROSCOPIC APPROACH	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 62, 76, 77, 78, 79, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NO
6070F	PATIENT QUERIED AND COUNSELED ABOUT ANTI-EPILEPTIC DRUG (AED) SIDE EFFECTS (EPI)	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
63661	REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
63662	REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S)	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, G8, G9	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED				
63663	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
63664	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
64490	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SINGLE LEVEL	No for All Programs, No for Package C	50, 51, 78, G8, G9, QY	Covered for All Programs, Covered for Package C	NO
64491	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, G8, G9, QY	Covered for All Programs, Covered for Package C	NO
64492	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT,	No for All Programs, No	50, G8, G9, QY	Covered for All Programs, Covered for	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	for Package C		Package C	
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL	No for All Programs, No for Package C	50, 51, G8, G9	Covered for All Programs, Covered for Package C	NO
64494	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, G8, G9	Covered for All Programs, Covered for Package C	NO
64495	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, G8, G9	Covered for All Programs, Covered for Package C	NO
74261	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC,	No for All Programs, No	NA	Non-Covered for All Programs, Non-Covered	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INCLUDING IMAGE POSTPROCESSING; WITHOUT CONTRAST MATERIAL	for Package C		for Package C	
74262	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, DIAGNOSTIC, INCLUDING IMAGE POSTPROCESSING; WITH CONTRAST MATERIAL(S) INCLUDING NON-CONTRAST IMAGES, IF PERFORMED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
74263	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY, SCREENING, INCLUDING IMAGE POSTPROCESSING	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
75565	CARDIAC MAGNETIC RESONANCE IMAGING FOR VELOCITY FLOW MAPPING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
75571	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, WITH QUANTITATIVE EVALUATION OF CORONARY CALCIUM	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
75573	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE SETTING OF CONGENITAL HEART DISEASE (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	OF LV CARDIAC FUNCTION, RV STRUCTURE AND FUNCTION AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)				
75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS (WHEN PRESENT), WITH CONTRAST MATERIAL, INCLUDING 3D IMAGE POSTPROCESSING (INCLUDING EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
75791	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (E.G., DIALYSIS PATIENT FISTULA/GRAFT), COMPLETE EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES INJECTIONS OF CONTRAST AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA), RADIOLOGICAL SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
77338	MULTI-LEAF COLLIMATOR (MLC) DEVICE(S) FOR INTENSITY MODULATED RADIATION THERAPY (IMRT), DESIGN AND CONSTRUCTION PER IMRT PLAN	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)				
78452	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
78453	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
78454	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION				
83987	PH; EXHALED BREATH CONDENSATE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
84145	PROCALCITONIN (PCT)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
84431	THROMBOXANE METABOLITE(S), INCLUDING THROMBOXANE IF PERFORMED, URINE	No for All Programs, No for Package C	**91**	Covered for All Programs, Covered for Package C	NO
86305	HUMAN EPIDIDYMIS PROTEIN 4 (HE4)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
86352	CELLULAR FUNCTION ASSAY INVOLVING STIMULATION (E.G., MITOGEN OR ANTIGEN) AND DETECTION OF BIOMARKER (E.G., ATP)	No for All Programs, No for Package C	**91**	Covered for All Programs, Covered for Package C	NO
86780	ANTIBODY; TREPONEMA PALLIDUM	No for All Programs, No for Package C	**91**	Covered for All Programs, Covered for Package C	NO
86825	HUMAN LEUKOCYTE ANTIGEN (HLA) CROSSMATCH, NON-CYTOTOXIC (E.G., USING FLOW CYTOMETRY); FIRST SERUM SAMPLE OR DILUTION	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
86826	HUMAN LEUKOCYTE ANTIGEN (HLA) CROSSMATCH, NON-CYTOTOXIC (E.G., USING FLOW CYTOMETRY); EACH ADDITIONAL SERUM SAMPLE OR SAMPLE DILUTION (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
87150	CULTURE, TYPING; IDENTIFICATION BY NUCLEIC	No for All Programs, No	NA	Covered for All Programs, Covered for	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ACID (DNA OR RNA) PROBE, AMPLIFIED PROBE TECHNIQUE, PER CULTURE OR ISOLATE, EACH ORGANISM PROBED	for Package C		Package C	
87153	CULTURE, TYPING; IDENTIFICATION BY NUCLEIC ACID SEQUENCING METHOD, EACH ISOLATE (E.G., SEQUENCING OF THE 16S RRNA GENE)	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
87493	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CLOSTRIDIUM DIFFICILE, TOXIN GENE(S), AMPLIFIED PROBE TECHNIQUE	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
88387	MACROSCOPIC EXAMINATION, DISSECTION, AND PREPARATION OF TISSUE FOR NON-MICROSCOPIC ANALYTICAL STUDIES (E.G., NUCLEIC ACID-BASED MOLECULAR STUDIES); EACH TISSUE PREPARATION (E.G., A SINGLE LYMPH NODE)	No for All Programs, No for Package C	26, TC, 91	Covered for All Programs, Covered for Package C	NO
88388	MACROSCOPIC EXAMINATION, DISSECTION, AND PREPARATION OF TISSUE FOR NON-MICROSCOPIC ANALYTICAL STUDIES (E.G., NUCLEIC ACID-BASED MOLECULAR STUDIES); IN CONJUNCTION WITH A TOUCH IMPRINT, INTRAOPERATIVE CONSULTATION, OR FROZEN SECTION, EACH TISSUE PREPARATION (E.G., A SINGLE LYMPH NODE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	26, TC, 91	Covered for All Programs, Covered for Package C	NO
88738	HEMOGLOBIN (HGB), QUANTITATIVE, TRANSCUTANEOUS	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
89398	UNLISTED REPRODUCTIVE	No for All	NA	Non-Covered for All	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	MEDICINE LABORATORY PROCEDURE	Programs, No for Package C		Programs, Non-Covered for Package C	
90470	H1N1 IMMUNIZATION ADMINISTRATION (INTRAMUSCULAR, INTRANASAL), INCLUDING COUNSELING WHEN PERFORMED)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
90644	MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS C & Y AND HEMOPHILUS INFLUENZA B VACCINE, TETANUS TOXOID CONJUGATE (HIB-MENCY-TT), 4-DOSE SCHEDULE, WHEN ADMINISTERED TO CHILDREN 2-15 MONTHS OF AGE, FOR INTRAMUSCULAR USE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
90670	PNEUMOCOCCAL CONJUGATE VACCINE, 13 VALENT, FOR INTRAMUSCULAR USE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
92540	BASIC VESTIBULAR EVALUATION, INCLUDES SPONTANEOUS NYSTAGMUS TEST WITH ECCENTRIC GAZE FIXATION NYSTAGMUS, WITH RECORDING, POSITIONAL NYSTAGMUS TEST, MINIMUM OF 4 POSITIONS, WITH RECORDING, OPTOKINETIC NYSTAGMUS TEST, BIDIRECTIONAL FOVEAL AND PERIPHERAL STIMULATION, WITH RECORDING, AND OSCILLATING TRACKING TEST, WITH RECORDING	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS	No for All Programs, No for Package C	52	Covered for All Programs, Covered for Package C	NO
92570	ACOUSTIC IMMITTANCE TESTING, INCLUDES TYMPANOMETRY (IMPEDANCE TESTING), ACOUSTIC REFLEX THRESHOLD TESTING, AND	No for All Programs, No for Package C	52	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ACOUSTIC REFLEX DECAY TESTING				
93750	INTERROGATION OF VENTRICULAR ASSIST DEVICE (VAD), IN PERSON, WITH PHYSICIAN ANALYSIS OF DEVICE PARAMETERS (E.G., DRIVELINES, ALARMS, POWER SURGES), REVIEW OF DEVICE FUNCTION (E.G., FLOW AND VOLUME STATUS, SEPTUM STATUS, RECOVERY), WITH PROGRAMMING, IF PERFORMED, AND REPORT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
94011	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
94012	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS, BEFORE AND AFTER BRONCHODILATOR, IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
94013	MEASUREMENT OF LUNG VOLUMES (I.E., FUNCTIONAL RESIDUAL CAPACITY [FRC], FORCED VITAL CAPACITY [FVC], AND EXPIRATORY RESERVE VOLUME [ERV]) IN AN INFANT OR CHILD THROUGH 2 YEARS OF AGE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
95905	MOTOR AND/OR SENSORY NERVE CONDUCTION, USING PRECONFIGURED ELECTRODE ARRAY(S), AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH LIMB, INCLUDES F-WAVE STUDY WHEN PERFORMED, WITH INTERPRETATION AND REPORT	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
A4264	PERMANENT IMPLANTABLE	No for All	NA	Covered for All	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	CONTRACEPTIVE INTRATUBAL OCCLUSION DEVICE(S) AND DELIVERY SYSTEM	Programs, No for Package C		Programs, Covered for Package C	
A4336	INCONTINENCE SUPPLY, URETHRAL INSERT, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
A4360	DISPOSABLE EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, WITH PAD AND/OR POUCH, EACH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
A9581	INJECTION, GADOXETATE DISODIUM, 1 ML	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A9582	IODINE I-123 IOBENGUANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 15 MILLICURIES	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A9583	INJECTION, GADOFOSVESET TRISODIUM, 1 ML	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
A9604	SAMARIUM SM-153 LEXIDRONAM, THERAPEUTIC, PER TREATMENT DOSE, UP TO 150 MILLICURIES	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
C9254	INJECTION, LACOSAMIDE, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
C9255	INJECTION, PALIPERIDONE PALMITATE, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
C9256	INJECTION, DEXAMETHASONE INTRAVITREAL IMPLANT, 0.1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
C9257	INJECTION, BEVACIZUMAB, 0.25 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
C9360	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, NEONATAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQUARE CENTIMETERS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
C9362	POROUS PURIFIED COLLAGEN MATRIX BONE VOID FILLER (INTEGRA MOZAIK OSTEOCONDUCTIVE SCAFFOLD STRIP), PER 0.5 CC	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
C9363	SKIN SUBSTITUTE, INTEGRA MESHED BILAYER WOUND MATRIX, PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
C9364	PORCINE IMPLANT, PERMACOL, PER SQUARE CENTIMETER	No for All Programs, No for Package C	N/A	Covered for All Programs, Covered for Package C	N/A
E0433	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESERVOIR AND CONTENTS GAUGE	Yes for All Programs, Yes for Package C	RR	Covered for All Programs, Covered for Package C	NO
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY	Yes for All Programs, Yes for Package C	NU, RR	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	GREATER THAN 300 LBS				
G0420	FACE-TO-FACE EDUCATIONAL SERVICES RELATED TO THE CARE OF CHRONIC KIDNEY DISEASE; INDIVIDUAL, PER SESSION, PER ONE HOUR	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0421	FACE-TO-FACE EDUCATIONAL SERVICES RELATED TO THE CARE OF CHRONIC KIDNEY DISEASE; GROUP, PER SESSION, PER ONE HOUR	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0422	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING WITH EXERCISE, PER SESSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0423	INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING; WITHOUT EXERCISE, PER SESSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0424	PULMONARY REHABILITATION, INCLUDING EXERCISE (INCLUDES MONITORING), ONE HOUR, PER SESSION, UP TO TWO SESSIONS PER DAY	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0425	INITIAL INPATIENT TELEHEALTH CONSULTATION, TYPICALLY 30 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0426	INITIAL INPATIENT TELEHEALTH CONSULTATION, TYPICALLY 50 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0427	INITIAL INPATIENT TELEHEALTH CONSULTATION, TYPICALLY 70 MINUTES OR MORE COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G0430	DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0431	DRUG SCREEN, QUALITATIVE; SINGLE DRUG CLASS METHOD (E.G., IMMUNOASSAY, ENZYME ASSAY), EACH DRUG CLASS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8545	I INTEND TO REPORT THE HEPATITIS C MEASURES GROUP	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8546	I INTEND TO REPORT THE COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8547	I INTEND TO REPORT THE ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8548	I INTEND TO REPORT THE HEART FAILURE (HF) MEASURES GROUP	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8549	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE HEPATITIS C MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8550	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8551	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE HEART FAILURE (HF) MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8552	ALL QUALITY ACTIONS FOR THE	No for All	NA	Non-Covered for All	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	APPLICABLE MEASURES IN THE ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Programs, No for Package C		Programs, Non-Covered for Package C	
G8553	AT LEAST ONE PRESCRIPTION CREATED DURING THE ENCOUNTER WAS GENERATED AND TRANSMITTED ELECTRONICALLY USING A QUALIFIED ERX SYSTEM	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8556	REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8557	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION MEASURE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8558	NOT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8559	PATIENT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8560	PATIENT HAS A HISTORY OF ACTIVE DRAINAGE FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8561	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION FOR PATIENTS WITH A HISTORY OF ACTIVE DRAINAGE MEASURE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8562	PATIENT DOES NOT HAVE A HISTORY OF ACTIVE DRAINAGE	No for All Programs, No	NA	Non-Covered for All Programs, Non-Covered	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	FROM THE EAR WITHIN THE PREVIOUS 90 DAYS	for Package C		for Package C	
G8563	PATIENT NOT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8564	PATIENT WAS REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8565	VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8566	PATIENT IS NOT ELIGIBLE FOR THE “REFERRAL FOR OTOLOGIC EVALUATION FOR SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS” MEASURE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8567	PATIENT DOES NOT HAVE VERIFICATION AND DOCUMENTATION OF SUDDEN OR RAPIDLY PROGRESSIVE HEARING LOSS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8568	PATIENT WAS NOT REFERRED TO A PHYSICIAN (PREFERABLY A PHYSICIAN WITH TRAINING IN DISORDERS OF THE EAR) FOR AN OTOLOGIC EVALUATION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8569	PROLONGED INTUBATION (>24 HRS) REQUIRED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8570	PROLONGED INTUBATION (>24 HRS) NOT REQUIRED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8571	DEVELOPMENT OF DEEP STERNAL WOUND INFECTION WITHIN 30 DAYS POSTOPERATIVELY	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8572	NO DEEP STERNAL WOUND INFECTION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8573	STROKE/CBA FOLLOWING ISOLATED CABG SURGERY	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8574	NO STROKE/CVA FOLLOWING ISOLATED CABG SURGERY	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8575	DEVELOPED POSTOPERATIVE RENAL INSUFFICIENCY OR REQUIRED DIALYSIS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8576	NO POSTOPERATIVE RENAL INSUFFICIENCY/DIALYSIS NOT REQUIRED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8577	REOPERATION REQUIRED DUE TO BLEEDING/TAMPONADE, GRAFT OCCLUSION OR OTHER CARDIAC REASON	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8578	REOPERATION NOT REQUIRED DUE TO BLEEDING/TAMPONADE, GRAFT OCCLUSION OR OTHER CARDIAC REASON	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8579	ANTIPLATELET MEDICATION AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8580	ANTIPLATELET MEDICATION CONTRAINDICATED/NOT INDICATED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8581	NO ANTIPLATELET MEDICATION AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8582	BETA-BLOCKER AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8583	BETA-BLOCKER CONTRAINDICATED/NOT INDICATED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8584	NO BETA-BLOCKER AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8585	ANTI-LIPID TREATMENT AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8586	ANTI-LIPID TREATMENT CONTRAINDICATED/NOT INDICATED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8587	NO ANTI-LIPID TREATMENT AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8588	MOST RECENT SYSTOLIC BLOOD PRESSURE < 140 MMHG	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8589	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MMHG	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8590	MOST RECENT DIASTOLIC BLOOD PRESSURE < 90 MMHG	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8591	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MMHG	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8592	NO DOCUMENTATION OF BLOOD PRESSURE MEASUREMENT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8593	LIPID PROFILE RESULTS DOCUMENTED AND REVIEWED (MUST INCLUDE TOTAL CHOLESTEROL, HDL-C,	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	TRIGLYCERIDES AND CALCULATED LDL-C)				
G8594	LIPID PROFILE NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8595	MOST RECENT LDL-C < 100 MG/DL	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8596	LDL-C WAS NOT PERFORMED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8597	MOST RECENT LDL-C >= 100 MG/DL	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8598	ASPIRIN OR ANOTHER ANTITHROMBOTIC THERAPY USED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8599	ASPIRIN OR ANOTHER ANTITHROMBOTIC THERAPY NOT USED, REASON NOT OTHERWISE SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8600	IV T-PA INITIATED WITHIN THREE HOURS (<= 180 MINUTES) OF TIME LAST KNOWN WELL	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8601	IV T-PA NOT INITIATED WITHIN THREE HOURS (<= 180 MINUTES) OF TIME LAST KNOWN WELL FOR REASONS DOCUMENTED BY CLINICIAN	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8602	IV T-PA NOT INITIATED WITHIN THREE HOURS (<= 180 MINUTES) OF TIME LAST KNOWN WELL, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8603	SCORE ON THE SPOKEN LANGUAGE COMPREHENSION FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8604	SCORE ON THE SPOKEN LANGUAGE COMPREHENSION FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8605	PATIENT WAS NOT SCORED ON THE SPOKEN LANGUAGE COMPREHENSION FUNCTIONAL COMMUNICATION MEASURE EITHER AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8606	SCORE ON THE ATTENTION FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8607	SCORE ON THE ATTENTION FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8608	PATIENT WAS NOT SCORED ON THE ATTENTION FUNCTIONAL COMMUNICATION MEASURE EITHER AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8609	SCORE ON THE MEMORY FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8610	SCORE ON THE MEMORY FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8611	PATIENT WAS NOT SCORED ON THE MEMORY FUNCTIONAL COMMUNICATION MEASURE AT	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	EITHER ADMISSION OR AT DISCHARGE				
G8612	SCORE ON THE MOTOR SPEECH FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8613	SCORE ON THE MOTOR SPEECH FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8614	PATIENT WAS NOT SCORED ON THE MOTOR SPEECH FUNCTIONAL COMMUNICATION MEASURE EITHER AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8615	SCORE ON THE READING FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8616	SCORE ON THE READING FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8617	PATIENT WAS NOT SCORED ON THE READING FUNCTIONAL COMMUNICATION MEASURE EITHER AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8618	SCORE ON THE SPOKEN LANGUAGE EXPRESSION FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8619	SCORE ON THE SPOKEN LANGUAGE EXPRESSION FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED				
G8620	PATIENT WAS NOT SCORED ON THE SPOKEN LANGUAGE EXPRESSION FUNCTIONAL COMMUNICATION MEASURE EITHER AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8621	SCORE ON THE WRITING FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8622	SCORE ON THE WRITING FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8623	PATIENT WAS NOT SCORED ON THE WRITING FUNCTIONAL COMMUNICATION MEASURE EITHER AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8624	SCORE ON THE SWALLOWING FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS HIGHER THAN AT ADMISSION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8625	SCORE ON THE SWALLOWING FUNCTIONAL COMMUNICATION MEASURE AT DISCHARGE WAS NOT HIGHER THAN AT ADMISSION, REASON NOT SPECIFIED	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8626	PATIENT WAS NOT SCORED ON THE SWALLOWING FUNCTIONAL COMMUNICATION MEASURE AT ADMISSION OR AT DISCHARGE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8627	SURGICAL PROCEDURE PERFORMED WITHIN 30 DAYS	No for All Programs, No	NA	Non-Covered for All Programs, Non-Covered	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	FOLLOWING CATARACT SURGERY FOR MAJOR COMPLICATIONS (E.G., RETAINED NUCLEAR FRAGMENTS, ENDOPHTHALMITIS, DISLOCATED OR WRONG POWER IOL, RETINAL DETACHMENT, OR WOUND DEHISCENCE)	for Package C		for Package C	
G8628	SURGICAL PROCEDURE NOT PERFORMED WITHIN 30 DAYS FOLLOWING CATARACT SURGERY FOR MAJOR COMPLICATIONS (E.G., RETAINED NUCLEAR FRAGMENTS, ENDOPHTHALMITIS, DISLOCATED OR WRONG POWER IOL, RETINAL DETACHMENT, OR WOUND DEHISCENCE)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G9142	INFLUENZA A (H1N1) VACCINE, ANY ROUTE OF ADMINISTRATION	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G9143	WARFARIN RESPONSIVENESS TESTING BY GENETIC TECHNIQUE USING ANY METHOD, ANY NUMBER OF SPECIMEN(S)	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
J0461	INJECTION, ATROPINE SULFATE, 0.01 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0559	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, 2500 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0598	INJECTION, C1 ESTERASE INHIBITOR (HUMAN), 10 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
J0718	INJECTION, CERTOLIZUMAB PEGOL, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0833	INJECTION, COSYNTROPIN, NOT OTHERWISE SPECIFIED, 0.25 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0834	INJECTION, COSYNTROPIN (CORTROSYN), 0.25 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J1680	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 100 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
J2562	INJECTION, PLERIXAFOR, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J2793	INJECTION, RILONACEPT, 1 MG	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
J2796	INJECTION, ROMIPLOSTIM, 10 MICROGRAMS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7185	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA), PER I.U.	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7325	HYALURONAN OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
J9155	INJECTION, DEGARELIX, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J9171	INJECTION, DOCETAXEL, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J9328	INJECTION, TEMOZOLOMIDE, 1 MG	No for All Programs, No	NA	Covered for All Programs, Covered for	YES

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
		for Package C		Package C	
K0739	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
K0740	REPAIR OR NONROUTINE SERVICE FOR OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
L2861	ADDITION TO LOWER EXTREMITY JOINT, KNEE OR ANKLE, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM FOR CUSTOM FABRICATED ORTHOTICS ONLY, EACH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
L3891	ADDITION TO UPPER EXTREMITY JOINT, WRIST OR ELBOW, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM FOR CUSTOM FABRICATED ORTHOTICS ONLY, EACH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WITH INTEGRAL ADHESIVE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
L8032	NIPPLE PROSTHESIS, REUSABLE, ANY TYPE, EACH	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
L8627	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NO
L8628	COCHLEAR IMPLANT, EXTERNAL CONTROLLER COMPONENT, REPLACEMENT	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NO
L8629	TRANSMITTING COIL AND	Yes for All	NA	Covered for All	NO

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	Programs, Yes for Package C		Programs, Covered for Package C	
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q0138	INJECTION, FERUMOXYTOL, FOR TREATMENT OF IRON DEFICIENCY ANEMIA, 1 MG (NON-ESRD USE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
Q0139	INJECTION, FERUMOXYTOL, FOR TREATMENT OF IRON DEFICIENCY ANEMIA, 1 MG (FOR ESRD ON DIALYSIS)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
Q0506	BATTERY, LITHIUM-ION, FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q4074	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
Q9968	INJECTION, NON-RADIOACTIVE, NON-CONTRAST, VISUALIZATION ADJUNCT (E.G., METHYLENE BLUE, ISOSULFAN BLUE), 1 MG	No for All Programs, No for Package C	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
S0280	MEDICAL HOME PROGRAM, COMPREHENSIVE CARE COORDINATION AND PLANNING, INITIAL PLAN	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
S0281	MEDICAL HOME PROGRAM, COMPREHENSIVE CARE COORDINATION AND	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2010 Annual HCPCS Codes, Effective January 1, 2010

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PLANNING, MAINTENANCE OF PLAN				

Table 2 – New Modifier Codes for the 2010 Annual HCPCS Update

Modifier Code	Description	Type	Date Effective
AI	PRINCIPAL PHYSICIAN OF RECORD	Informational	January 1, 2010
J4	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED BY A HOSPITAL UPON DISCHARGE	Informational	January 1, 2010
PS	POSITRON EMISSION TOMOGRAPHY (PET) OR PET/COMPUTED TOMOGRAPHY (CT) TO INFORM THE SUBSEQUENT TREATMENT STRATEGY OF CANCEROUS TUMORS WHEN THE BENEFICIARY'S TREATING PHYSICIAN DETERMINES THAT THE PET STUDY IS NEEDED TO INFORM SUBSEQUENT ANTI-TUMOR STRATEGY	Informational	January 1, 2010
V5	VASCULAR CATHETER	Informational	January 1, 2010
V6	ARTERIOVENOUS GRAFT	Informational	January 1, 2010
V7	ARTERIOVENOUS FISTULA	Informational	January 1, 2010
V8	INFECTION PRESENT	Informational	January 1, 2010
V9	NO INFECTION PRESENT	Informational	January 1, 2010

Table 3 – **Deleted** HCPCS Codes, Effective for Dates of Service on or Before December 31, 2009

Procedure Code	Description	Alternate Codes for Consideration
01632	ANESTHESIA FOR OPEN OR SURGICAL ARTHROSCOPIC PROCEDURES ON HUMERAL HEAD AND NECK, STERNOCLAVICULAR JOINT, ACROMIOCLAVICULAR JOINT, AND SHOULDER JOINT; RADICAL RESECTION	NA
14300	ADJACENT TISSUE TRANSFER OR REARRANGEMENT, MORE THAN 30 SQ CM, UNUSUAL OR COMPLICATED, ANY AREA	NA
23221	RADICAL RESECTION OF BONE TUMOR, PROXIMAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	NA
23222	RADICAL RESECTION OF BONE TUMOR, PROXIMAL HUMERUS; WITH PROSTHETIC REPLACEMENT	NA
24151	RADICAL RESECTION FOR TUMOR, SHAFT OR DISTAL HUMERUS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	NA
24153	RADICAL RESECTION FOR TUMOR, RADIAL HEAD OR NECK; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	NA
26255	RADICAL RESECTION, METACARPAL (E.G., TUMOR); WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	NA
26261	RADICAL RESECTION, PROXIMAL OR MIDDLE PHALANX OF FINGER (E.G., TUMOR); WITH AUTOGRAFT (INCLUDES OBTAINING GRAFT)	NA
27079	RADICAL RESECTION OF TUMOR OR INFECTION; ISCHIAL TUBEROSITY AND GREATER TROCHANTER OF FEMUR, WITH SKIN FLAPS	NA
29220	STRAPPING; LOW BACK	NA
36145	INTRODUCTION OF NEEDLE OR INTRACATHETER; ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (CANNULA, FISTULA, OR GRAFT)	NA
36834	PLASTIC REPAIR OF ARTERIOVENOUS ANEURYSM (SEPARATE PROCEDURE)	NA

Procedure Code	Description	Alternate Codes for Consideration
45170	EXCISION OF RECTAL TUMOR, TRANSANAL APPROACH	NA
46210	CRYPTECTOMY; SINGLE	NA
46211	CRYPTECTOMY; MULTIPLE (SEPARATE PROCEDURE)	46999
46937	CRYOSURGERY OF RECTAL TUMOR; BENIGN	45190
46938	CRYOSURGERY OF RECTAL TUMOR; MALIGNANT	45190
51772	URETHRAL PRESSURE PROFILE STUDIES (UPP) (URETHRAL CLOSURE PRESSURE PROFILE), ANY TECHNIQUE	51727, 51729
51795	VOIDING PRESSURE STUDIES (VP); BLADDER VOIDING PRESSURE, ANY TECHNIQUE	51728, 51729
63660	REVISION OR REMOVAL OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S) OR PLATE/PADDLE(S)	63661, 63662, 63663, 63664
64470	INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; CERVICAL OR THORACIC, SINGLE LEVEL	64490
64472	INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; CERVICAL OR THORACIC, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	64491, 64492
64475	INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL	64493
64476	INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	64494, 64495
75558	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH	NA

Procedure Code	Description	Alternate Codes for Consideration
	FLOW/VELOCITY QUANTIFICATION	
75560	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL; WITH FLOW/VELOCITY QUANTIFICATION AND STRESS	NA
75562	CARDIAC MAGNETIC RESONANCE IMAGING FOR MORPHOLOGY AND FUNCTION WITHOUT CONTRAST MATERIAL(S), FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; WITH FLOW/VELOCITY QUANTIFICATION	NA
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	NA
75790	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (E.G., DIALYSIS PATIENT), RADIOLOGICAL SUPERVISION AND INTERPRETATION	36147, 75791
78460	MYOCARDIAL PERFUSION IMAGING; (PLANAR) SINGLE STUDY, AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT QUANTIFICATION	78451
78461	MYOCARDIAL PERFUSION IMAGING; MULTIPLE STUDIES (PLANAR), AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT QUANTIFICATION	78452
78464	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), SINGLE STUDY (INCLUDING ATTENUATION CORRECTION WHEN PERFORMED), AT REST OR STRESS (EXERCISE AND/OR PHARMACOLOGIC), WITH OR WITHOUT QUANTIFICATION	78453
78465	MYOCARDIAL PERFUSION IMAGING; TOMOGRAPHIC (SPECT), MULTIPLE STUDIES (INCLUDING ATTENUATION CORRECTION WHEN PERFORMED), AT REST AND/OR STRESS (EXERCISE AND/OR PHARMACOLOGIC) AND REDISTRIBUTION AND/OR REST INJECTION, WITH OR WITHOUT	78454

Procedure Code	Description	Alternate Codes for Consideration
	QUANTIFICATION	
78478	MYOCARDIAL PERFUSION STUDY WITH WALL MOTION, QUALITATIVE OR QUANTITATIVE STUDY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	78451, 78452, 78453, 78454
78480	MYOCARDIAL PERFUSION STUDY WITH EJECTION FRACTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	78451, 78452, 78453, 78454
82307	CALCIFEROL (VITAMIN D)	NA
86781	ANTIBODY; TREPONEMA PALLIDUM, CONFIRMATORY TEST (E.G., FTA-ABS)	NA
90379	RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN (RSV-IGIV), HUMAN, FOR INTRAVENOUS USE	NA
92569	ACOUSTIC REFLEX TESTING; DECAY	92570
99185	HYPOTHERMIA; REGIONAL	NA
99186	HYPOTHERMIA; TOTAL BODY	NA
0062T	PERCUTANEOUS INTRADISCAL ANNULOPLASTY, ANY METHOD EXCEPT ELECTROTHERMAL, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; SINGLE LEVEL	22899
0063T	PERCUTANEOUS INTRADISCAL ANNULOPLASTY, ANY METHOD EXCEPT ELECTROTHERMAL, UNILATERAL OR BILATERAL INCLUDING FLUOROSCOPIC GUIDANCE; 1 OR MORE ADDITIONAL LEVELS (LIST SEPARATELY IN ADDITION TO 0062T FOR PRIMARY PROCEDURE)	22899
0064T	SPECTROSCOPY, EXPIRED GAS ANALYSIS (E.G., NITRIC OXIDE/CARBON DIOXIDE TEST)	94799
0066T	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY (I.E., VIRTUAL COLONOSCOPY); SCREENING	NA
0067T	COMPUTED TOMOGRAPHIC (CT) COLONOGRAPHY (I.E., VIRTUAL COLONOSCOPY); DIAGNOSTIC	NA

Procedure Code	Description	Alternate Codes for Consideration
0068T	ACOUSTIC HEART SOUND RECORDING AND COMPUTER ANALYSIS; WITH INTERPRETATION AND REPORT	93799
0069T	ACOUSTIC HEART SOUND RECORDING AND COMPUTER ANALYSIS; ACOUSTIC HEART SOUND RECORDING AND COMPUTER ANALYSIS ONLY	93799
0070T	ACOUSTIC HEART SOUND RECORDING AND COMPUTER ANALYSIS; INTERPRETATION AND REPORT ONLY	93799
0077T	IMPLANTING AND SECURING CEREBRAL THERMAL PERFUSION PROBE, INCLUDING TWIST DRILL OR BURR HOLE, TO MEASURE ABSOLUTE CEREBRAL TISSUE PERFUSION	NA
0084T	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT	NA
0086T	LEFT VENTRICULAR FILLING PRESSURE INDIRECT MEASUREMENT BY COMPUTERIZED CALIBRATION OF THE ARTERIAL WAVEFORM RESPONSE TO VALSALVA MANEUVER	NA
0087T	SPERM EVALUATION, HYALURONAN SPERM BINDING TEST	NA
0144T	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, INCLUDING IMAGE POSTPROCESSING AND QUANTITATIVE EVALUATION OF CORONARY CALCIUM	75571
0145T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE POSTPROCESSING; CARDIAC STRUCTURE AND MORPHOLOGY	75572
0146T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE POSTPROCESSING; COMPUTED TOMOGRAPHIC ANGIOGRAPHY OF CORONARY ARTERIES (INCLUDING NATIVE AND ANOMALOUS CORONARY ARTERIES, CORONARY BYPASS GRAFTS), WITHOUT QUANTITATIVE EVALUATION OF CORONARY	NA

Procedure Code	Description	Alternate Codes for Consideration
	CALCIUM	
0147T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE POSTPROCESSING; COMPUTED TOMOGRAPHIC ANGIOGRAPHY OF CORONARY ARTERIES (INCLUDING NATIVE AND ANOMALOUS CORONARY ARTERIES, CORONARY BYPASS GRAFTS), WITH QUANTITATIVE EVALUATION OF CORONARY CALCIUM	NA
0148T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE POSTPROCESSING; CARDIAC STRUCTURE AND MORPHOLOGY AND COMPUTED TOMOGRAPHIC ANGIOGRAPHY OF CORONARY ARTERIES (INCLUDING NATIVE AND ANOMALOUS CORONARY ARTERIES, CORONARY BYPASS GRAFTS), WITHOUT QUANTITATIVE EVALUATION OF CORONARY CALCIUM	NA
0149T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE POSTPROCESSING; CARDIAC STRUCTURE AND MORPHOLOGY AND COMPUTED TOMOGRAPHIC ANGIOGRAPHY OF CORONARY ARTERIES (INCLUDING NATIVE AND ANOMALOUS CORONARY ARTERIES, CORONARY BYPASS GRAFTS), WITH QUANTITATIVE EVALUATION OF CORONARY CALCIUM	NA
0150T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE POSTPROCESSING; CARDIAC STRUCTURE AND MORPHOLOGY IN CONGENITAL HEART DISEASE	NA
0151T	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, CARDIAC GATING AND 3D IMAGE	NA

Procedure Code	Description	Alternate Codes for Consideration
	POSTPROCESSING, FUNCTION EVALUATION (LEFT AND RIGHT VENTRICULAR FUNCTION, EJECTION-FRACTION AND SEGMENTAL WALL MOTION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	
0170T	REPAIR OF ANORECTAL FISTULA WITH PLUG (E.G., PORCINE SMALL INTESTINE SUBMUCOSA [SIS])	46707
0194T	PROCALCITONIN (PCT)	84145
1127F	NEW EPISODE FOR CONDITION (ML)5	NA
1128F	SUBSEQUENT EPISODE FOR CONDITION (ML)5	NA
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	NA
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	NA
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	NA
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	NA
A6542	GRADIENT COMPRESSION STOCKING, CUSTOM MADE	NA
A6543	GRADIENT COMPRESSION STOCKING, LYMPHEDEMA	NA
A9535	INJECTION, METHYLENE BLUE, 1 ML	NA
A9605	SAMARIUM SM-153 LEXIDRONAMM, THERAPEUTIC, PER 50 MILLICURIES	A9604
C9245	INJECTION, ROMIPLOSTIM, 10 MCG	NA
C9246	INJECTION, GADOXETATE DISODIUM, PER ML	NA
C9247	IOBENGUANE, I-123, DIAGNOSTIC, PER STUDY DOSE, UP TO 10 MILLICURIES	NA
C9249	INJECTION, CERTOLIZUMAB PEGOL, 1 MG	J0718
C9251	INJECTION, C1 ESTERASE INHIBITOR	J0598

Procedure Code	Description	Alternate Codes for Consideration
	(HUMAN), 10 UNITS	
C9252	INJECTION, PLERIXAFOR, 1 MG	J2562
C9253	INJECTION, TEMOZOLOMIDE, 1 MG	J9328
E1340	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES	NA
E2223	MANUAL WHEELCHAIR ACCESSORY, VALVE, ANY TYPE, REPLACEMENT ONLY, EACH	NA
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH	NA
E2399	POWER WHEELCHAIR ACCESSORY, NOT OTHERWISE CLASSIFIED INTERFACE, INCLUDING ALL RELATED ELECTRONICS AND ANY TYPE MOUNTING HARDWARE	NA
G0392	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FOR MAINTENANCE OF HEMODIALYSIS ACCESS, ARTERIOVENOUS FISTULA OR GRAFT; ARTERIAL	NA
G0393	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FOR MAINTENANCE OF HEMODIALYSIS ACCESS, ARTERIOVENOUS FISTULA OR GRAFT; VENOUS	NA
G8503	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)	NA
G8504	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)	NA
G8505	DOCUMENTATION THAT PROPHYLACTIC ANTIBIOTIC WAS NOT GIVEN WITHIN ONE HOUR (IF FLUOROQUINOLONE OR VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF	NA

Procedure Code	Description	Alternate Codes for Consideration
	PROCEDURE WHEN NO INCISION IS REQUIRED), REASON NOT SPECIFIED	
G8512	PAIN SEVERITY QUANTIFIED; PAIN PRESENT	NA
G8513	ABI MEASURED AND DOCUMENTED	NA
G8514	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ABI MEASUREMENT MEASURE	NA
G8515	ABI MEASUREMENT WAS NOT OBTAINED	NA
G8516	PATIENT SCREENED FOR FUTURE FALLS RISK; DOCUMENTATION OF TWO OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR	NA
G8517	PATIENT SCREENED FOR FUTURE FALL RISK; DOCUMENTATION OF NO FALLS IN THE PAST YEAR OR ONLY ONE FALL WITHOUT INJURY IN THE PAST YEAR	NA
G8521	ANTIPLATELET THERAPY RECEIVED (ASA [81-325 MG/DAY] AND/OR CLOPIDOGREL [75 MG/DAY]) WITHIN 48 HOURS OF THE INITIATION OF SURGERY AND AT DISCHARGE	NA
G8522	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIPLATELET THERAPY	NA
G8523	ANTIPLATELET THERAPY NOT RECEIVED 48 HOURS PRIOR TO CEA AND AT DISCHARGE, REASON NOT SPECIFIED	NA
G8527	DOCUMENTATION OF ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS	NA
G8528	CLINICIAN DOCUMENTED THAT PATIENT WAS INELIGIBLE FOR PROPHYLACTIC ANTIBIOTIC SELECTION MEASURE	NA
G8529	ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS NOT DOCUMENTED, REASON NOT SPECIFIED	NA
G8533	PARTICIPATION BY A PHYSICIAN OR OTHER CLINICIAN IN SYSTEMATIC CLINICAL DATABASE REGISTRY THAT INCLUDES CONSENSUS-ENDORSED QUALITY MEASURES	NA

Procedure Code	Description	Alternate Codes for Consideration
J0460	INJECTION, ATROPINE SULFATE, UP TO 0.3 MG	J0461
J0530	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 600,000 UNITS	J0559
J0540	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 1,200,000 UNITS	J0559
J0550	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 2,400,000 UNITS	J0559
J0835	INJECTION, COSYNTROPIN, PER 0.25 MG	J0833, J0834
J1565	INJECTION, RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN, INTRAVENOUS, 50 MG	NA
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	J7325
J9170	INJECTION, DOCETAXEL, 20 MG	J9171
L0210	THORACIC, RIB BELT	NA
L1800	KNEE ORTHOSIS, ELASTIC WITH STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	NA
L1815	KNEE ORTHOSIS, ELASTIC OR OTHER ELASTIC TYPE MATERIAL WITH CONDYLAR PAD(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	NA
L1825	KNEE ORTHOSIS, ELASTIC KNEE CAP, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	NA
L1901	ANKLE ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G., NEOPRENE, LYCRA)	NA
L2770	ADDITION TO LOWER EXTREMITY ORTHOSIS, ANY MATERIAL – PER BAR OR JOINT	NA
L3651	SHOULDER ORTHOSIS, SINGLE SHOULDER, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G., NEOPRENE, LYCRA)	NA
L3652	SHOULDER ORTHOSIS, DOUBLE SHOULDER,	NA

Procedure Code	Description	Alternate Codes for Consideration
	ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G., NEOPRENE, LYCRA)	
L3700	ELBOW ORTHOSIS, ELASTIC WITH STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	NA
L3701	ELBOW ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G., NEOPRENE, LYCRA)	NA
L3909	WRIST ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G., NEOPRENE, LYCRA)	NA
L3911	WRIST HAND FINGER ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G., NEOPRENE, LYCRA)	NA
L6639	UPPER EXTREMITY ADDITION, HEAVY DUTY FEATURE, ANY ELBOW	NA
Q2023	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA), PER I.U.	J7185
Q2024	INJECTION, BEVACIZUMAB, 0.25 MG	C9257
Q4080	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS	NA
S0162	INJECTION, EFALIZUMAB, 125 MG	NA
S0345	ELECTROCARDIOGRAPHIC MONITORING UTILIZING A HOME COMPUTERIZED TELEMETRY STATION WITH AUTOMATIC ACTIVATION AND REAL-TIME NOTIFICATION OF MONITORING STATION, 24-HOUR ATTENDED MONITORING, INCLUDING RECORDING, MONITORING, RECEIPT OF TRANSMISSIONS, ANALYSIS, AND PHYSICIAN REVIEW AND INTERPRETATION; PER 24-HOUR PERIOD	NA
S0346	ELECTROCARDIOGRAPHIC MONITORING UTILIZING A HOME COMPUTERIZED TELEMETRY STATION WITH AUTOMATIC ACTIVATION AND REAL-TIME NOTIFICATION OF MONITORING STATION, 24-HOUR ATTENDED MONITORING, INCLUDING RECORDING, MONITORING, RECEIPT OF	NA

Procedure Code	Description	Alternate Codes for Consideration
	TRANSMISSIONS, AND ANALYSIS; PER 24-HOUR PERIOD	
S0347	ELECTROCARDIOGRAPHIC MONITORING UTILIZING A HOME COMPUTERIZED TELEMETRY STATION WITH AUTOMATIC ACTIVATION AND REAL-TIME NOTIFICATION OF MONITORING STATION, 24-HOUR ATTENDED MONITORING, INCLUDING PHYSICIAN REVIEW AND INTERPRETATION; 24-HOUR PERIOD	NA
S0605	DIGITAL RECTAL EXAMINATION, MALE, ANNUAL	NA
S8190	ELECTRONIC SPIROMETER (OR MICROSPIROMETER)	NA

Table 4 – New 2010 Annual HCPCS Codes Under Review for Coverage

Procedure Code	Description
0211T	SPEECH AUDIOMETRY THRESHOLD, AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE); WITH SPEECH RECOGNITION
0212T	COMPREHENSIVE AUDIOMETRY THRESHOLD EVALUATION AND SPEECH RECOGNITION, AUTOMATED (INCLUDES USE OF COMPUTER-ASSISTED DEVICE)
0213T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SINGLE LEVEL
0214T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0215T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0216T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL
0217T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0218T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0219T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; CERVICAL
0220T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; THORACIC
0221T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; LUMBAR
0222T	PLACEMENT OF POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL,

Table 4 – New 2010 Annual HCPCS Codes Under Review for Coverage

Procedure Code	Description
	INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
C9361	COLLAGEN MATRIX NERVE WRAP (NEUROMEND COLLAGEN NERVE WRAP), PER 0.5 CENTIMETER LENGTH
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE

Table 5 – New 2010 Annual HCPCS Codes Under Review for Pricing

Procedure Code	Description
33981	REPLACEMENT OF EXTRACORPOREAL VENTRICULAR ASSIST DEVICE, SINGLE OR BIVENTRICULAR, PUMP(S), SINGLE OR EACH PUMP
33982	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITHOUT CARDIOPULMONARY BYPASS
33983	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITH CARDIOPULMONARY BYPASS
A4264	PERMANENT IMPLANTABLE CONTRACEPTIVE INTRATUBAL OCCLUSION DEVICE(S) AND DELIVERY SYSTEM
A9604	SAMARIUM SM-153 LEXIDRONAM, THERAPEUTIC, PER TREATMENT DOSE, UP TO 150 MILLICURIES
C9360	DERMAL SUBSTITUTE, NATIVE, NON-DENATURED COLLAGEN, NEONATAL BOVINE ORIGIN (SURGIMEND COLLAGEN MATRIX), PER 0.5 SQUARE CENTIMETERS
C9362	POROUS PURIFIED COLLAGEN MATRIX BONE VOID FILLER (INTEGRA MOZAIK OSTEOCONDUCTIVE SCAFFOLD STRIP), PER 0.5 CC
C9363	SKIN SUBSTITUTE, INTEGRA MESHED BILAYER WOUND MATRIX, PER SQUARE CENTIMETER
C9364	PORCINE IMPLANT, PERMACOL, PER SQUARE CENTIMETER
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS
J0598	INJECTION, C1 ESTERASE INHIBITOR (HUMAN), 10 UNITS
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WITH INTEGRAL ADHESIVE
L8629	TRANSMITTING COIL AND CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT
Q0506	BATTERY, LITHIUM-ION, FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY
S3865	COMPREHENSIVE GENE SEQUENCE ANALYSIS FOR HYPERTROPHIC CARDIOMYOPATHY
S3866	GENETIC ANALYSIS FOR A SPECIFIC GENE MUTATION FOR HYPERTROPHIC CARDIOMYOPATHY (HCM) IN AN INDIVIDUAL WITH A KNOWN HCM MUTATION IN THE

Table 5 – New 2010 Annual HCPCS Codes Under Review for Pricing

	FAMILY
S3870	COMPARATIVE GENOMIC HYBRIZATION (CGH) MICROARRAY TESTING FOR DEVELOPMENTAL DELAY, AUTISM SPECTRUM DISORDER, AND/OR MENTAL RETARDATION

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

Procedure Code	Description	Outpatient Rate for UB-04 Claims Only	Effective Date of Rate
75571	COMPUTED TOMOGRAPHY, HEART, WITHOUT CONTRAST MATERIAL, WITH QUANTITATIVE EVALUATION OF CORONARY CALCIUM	**$23.15**	**1/1/2010**
75572	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)	**$138.10**	**1/1/2010**
75573	COMPUTED TOMOGRAPHY, HEART, WITH CONTRAST MATERIAL, FOR EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY IN THE SETTING OF CONGENITAL HEART DISEASE (INCLUDING 3D IMAGE POSTPROCESSING, ASSESSMENT OF LV CARDIAC FUNCTION, RV STRUCTURE AND FUNCTION AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)	**$138.10**	**1/1/2010**
75574	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, HEART, CORONARY ARTERIES AND BYPASS GRAFTS (WHEN PRESENT), WITH CONTRAST MATERIAL, INCLUDING 3D IMAGE POSTPROCESSING (INCLUDING EVALUATION OF CARDIAC STRUCTURE AND MORPHOLOGY, ASSESSMENT OF CARDIAC FUNCTION, AND EVALUATION OF VENOUS STRUCTURES, IF PERFORMED)	**$138.10**	**1/1/2010**
75791	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (E.G., DIALYSIS PATIENT FISTULA/GRAFT), COMPLETE EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES INJECTIONS OF CONTRAST AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA), RADIOLOGICAL SUPERVISION AND INTERPRETATION	**$82.85**	**1/1/2010**
77338	MULTI-LEAF COLLIMATOR (MLC) DEVICE(S) FOR INTENSITY MODULATED RADIATION THERAPY (IMRT), DESIGN AND CONSTRUCTION PER IMRT PLAN	**$97.81**	**1/1/2010**

78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)	**$397.71**	**1/1/2010**
78452	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION	**$397.71**	**1/1/2010**
78453	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); SINGLE STUDY, AT REST OR STRESS (EXERCISE OR PHARMACOLOGIC)	**$397.71**	**1/1/2010**
78454	MYOCARDIAL PERFUSION IMAGING, PLANAR (INCLUDING QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION	**$397.71**	**1/1/2010**