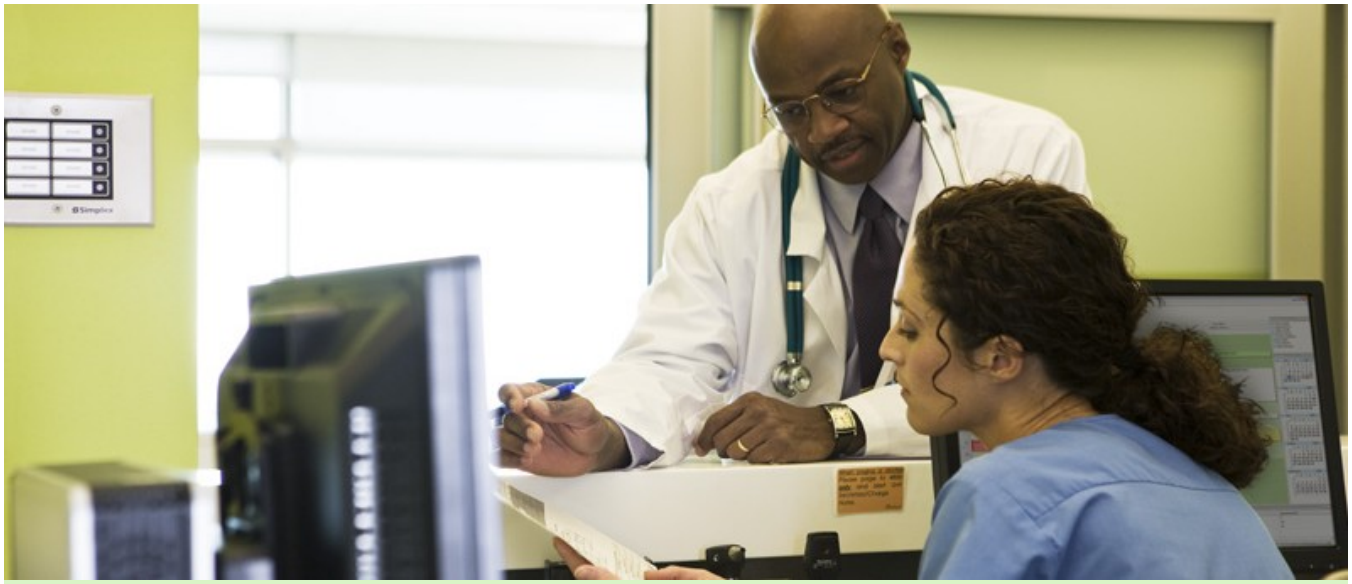
IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT201062 DECEMBER 30, 2010



Coverage determinations for the new 2011 HCPCS codes

Overview

The purpose of this bulletin is to notify providers of the coverage determinations for the new 2011 Annual Healthcare Common Procedure Coding System (HCPCS) codes. The Indiana Health Coverage Programs (IHCP) has reviewed the new 2011 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 Terminology (CPT®[1]) codes for the 2011 annual HCPCS update by procedure code, description, allowed modifiers, and program coverage determination.
- Table 2: A listing of the codes that are deleted and the replacement codes for 2011.
- Table 3: 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 4: 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.

[1] *Current Procedural Terminology (CPT®) copyright 2008 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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New HCPCS codes

The new 2011 annual HCPCS codes in this bulletin are identified by code, description, and coverage. The IHCP is advising providers of these determinations so the appropriate codes can be billed beginning with dates of service on or after January 1, 2011. Description changes have not been published in this bulletin. The new 2011 HCPCS codes, including description changes, are available for download on the Centers for Medicare & Medicaid Services (CMS) Web site.

These codes have been added to the Indiana*AIM* claims processing system and fees are posted on indianamedicaid.com with an effective date of January 1, 2011. Providers may bill these codes for dates of service on or after January 1, 2011. 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 billable under another code or as part of a global procedure code.

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0234T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; RENAL ARTERY	No for All Programs, No for Package C	51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NA
0235T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; VISCERAL ARTERY (EXCEPT RENAL), EACH VESSEL	No for All Programs, No for Package C	51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NA
0236T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; ABDOMINAL AORTA	No for All Programs, No for Package C	51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NA
0237T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; BRACHIOCEPHALIC TRUNK AND BRANCHES, EACH VESSEL	No for All Programs, No for Package C	51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NA
0238T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; ILIAC ARTERY, EACH VESSEL	No for All Programs, No for Package C	51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NA
0239T	BIOIMPEDANCE SPECTROSCOPY (BIS), MEASURING 100 FREQUENCIES OR GREATER, DIRECT MEASUREMENT OF EXTRACELLULAR FLUID DIFFERENCES BETWEEN THE LIMBS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0240T	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	JUNCTION) STUDY WITH INTERPRETATION AND REPORT; WITH 3-DIMENSIONAL HIGH RESOLUTION ESOPHAGEAL PRESSURE TOPOGRAPHY				
0241T	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY WITH INTERPRETATION AND REPORT; WITH STIMULATION OR PERFUSION DURING 3-DIMENSIONAL HIGH RESOLUTION ESOPHAGEAL PRESSURE TOPOGRAPHY STUDY, (E.G., STIMULANT, AC	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0242T	GASTROINTESTINAL TRACT TRANSIT AND PRESSURE MEASUREMENT, STOMACH THROUGH COLON, WIRELESS CAPSULE, WITH INTERPRETATION AND REPORT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0243T	INTERMITTENT MEASUREMENT OF WHEEZE RATE FOR BRONCHODILATOR OR BRONCHIAL-CHALLENGE DIAGNOSTIC EVALUATION(S), WITH INTERPRETATION AND REPORT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0244T	CONTINUOUS MEASUREMENT OF WHEEZE RATE DURING TREATMENT ASSESSMENT OR DURING SLEEP FOR DOCUMENTATION OF NOCTURNAL WHEEZE AND COUGH FOR DIAGNOSTIC EVALUATION 3 TO 24 HOURS, WITH INTERPRETATION AND REPORT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0245T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 1-2 RIBS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0246T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 3-4 RIBS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0247T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 5-6 RIBS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0248T	OPEN TREATMENT OF RIB FRACTURE REQUIRING INTERNAL FIXATION, UNILATERAL; 7 OR MORE RIBS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0249T	LIGATION, HEMORRHOIDAL VASCULAR BUNDLE(S), INCLUDING ULTRASOUND GUIDANCE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0250T	AIRWAY SIZING AND INSERTION OF BRONCHIAL VALVE(S), EACH LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0251T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), INITIAL LOBE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0252T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH REMOVAL OF BRONCHIAL VALVE(S), EACH ADDITIONAL LOBE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0253T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR; INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0254T	ENDOVASCULAR REPAIR OF ILIAC ARTERY BIFURCATION (E.G., ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA) USING BIFURCATED ENDOPROSTHESIS FROM THE COMMON ILIAC ARTERY INTO BOTH THE EXTERNAL AND INTERNAL ILIAC ARTERY, UNILATERAL	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0255T	ENDOVASCULAR REPAIR OF ILIAC ARTERY BIFURCATION (E.G., ANEURYSM, PSEUDOANEURYSM, ARTERIOVENOUS MALFORMATION, TRAUMA) USING BIFURCATED ENDOPROSTHESIS FROM THE COMMON ILIAC ARTERY INTO BOTH THE EXTERNAL AND INTERNAL ILIAC ARTERY, UNILATERAL; RADIOLOGICAL	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0256T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE; ENDOVASCULAR APPROACH	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0257T	IMPLANTATION OF CATHETER-DELIVERED PROSTHETIC AORTIC HEART VALVE; OPEN THORACIC APPROACH (E.G., TRANSAPICAL, TRANSVENTRICULAR)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0258T	TRANSTHORACIC CARDIAC EXPOSURE (E.G., STERNOTOMY, THORACOTOMY, SUBXIPHOID) FOR CATHETER-DELIVERED AORTIC VALVE REPLACEMENT; WITHOUT CARDIOPULMONARY BYPASS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
0259T	TRANSTHORACIC CARDIAC EXPOSURE (E.G., STERNOTOMY, THORACOTOMY, SUBXIPHOID) FOR CATHETER-DELIVERED AORTIC VALVE REPLACEMENT; WITH CARDIOPULMONARY BYPASS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0260T	TOTAL BODY SYSTEMIC HYPOTHERMIA, PER DAY, IN THE NEONATE 28 DAYS OF AGE OR YOUNGER	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
0261T	SELECTIVE HEAD HYPOTHERMIA, PER DAY, IN THE NEONATE 28 DAYS OF AGE OR YOUNGER	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
11045	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED); EACH ADDITIONAL 20 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
11046	DEBRIDEMENT, MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS, DERMIS, AND SUBCUTANEOUS TISSUE, IF PERFORMED); EACH ADDITIONAL 20 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
11047	DEBRIDEMENT, BONE (INCLUDES EPIDERMIS, DERMIS, SUBCUTANEOUS TISSUE, MUSCLE AND/OR FASCIA, IF PERFORMED); EACH ADDITIONAL 20 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

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
1400F	PARKINSON'S DISEASE DIAGNOSIS REVIEWED (PRKNS) 8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
22551	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2	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
22552	ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2, EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR SEPARATE PROCEDURE)	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
29914	ARTHROSCOPY, HIP, SURGICAL; WITH FEMOROPLASTY (I.E., TREATMENT OF CAM LESION)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 76, 77, 78, 80, 81, 82, AS, LT, RT, G8, G9,	Covered for All Programs, Covered for Package C	NO
29915	ARTHROSCOPY, HIP, SURGICAL; WITH ACETABULOPLASTY (I.E., TREATMENT OF PINCER LESION)	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 76, 77, 78, 80, 81, 82, AS, LT, RT, G8, G9,	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
29916	ARTHROSCOPY, HIP, SURGICAL; WITH LABRAL REPAIR	No for All Programs, No for Package C	50, 51, 54, 55, 56, 62, 76, 77, 78, 80, 81, 82, AS, LT, RT, G8, G9,	Covered for All Programs, Covered for Package C	NO
31295	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF MAXILLARY SINUS OSTIUM (E.G., BALLOON DILATION), TRANSNASAL OR VIA CANINE FOSSA	No for All Programs, No for Package C	50, G8, G9	Covered for All Programs, Covered for Package C	NO
31296	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF FRONTAL SINUS OSTIUM (E.G., BALLOON DILATION)	No for All Programs, No for Package C	50, G8, G9	Covered for All Programs, Covered for Package C	NO
31297	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DILATION OF SPHENOID SINUS OSTIUM (E.G., BALLOON DILATION)	No for All Programs, No for Package C	50, 51, G8, G9	Covered for All Programs, Covered for Package C	NO
31634	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BALLOON OCCLUSION, WITH ASSESSMENT OF AIR LEAK, WITH ADMINISTRATION OF OCCLUSIVE SUBSTANCE (E.G., FIBRIN GLUE), IF PERFORMED	No for All Programs, No for Package C	51, G8, G9	Covered for All Programs, Covered for Package C	NO
33620	APPLICATION OF RIGHT AND LEFT PULMONARY ARTERY BANDS (E.G., HYBRID APPROACH STAGE 1)	No for All Programs, No for Package C	80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
33621	TRANSTHORACIC INSERTION OF CATHETER FOR STENT PLACEMENT WITH CATHETER REMOVAL AND CLOSURE (E.G., HYBRID APPROACH STAGE 1)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
33622	RECONSTRUCTION OF COMPLEX CARDIAC ANOMALY (E.G., SINGLE VENTRICLE OR HYPOPLASTIC LEFT HEART)	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8,	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	WITH PALLIATION OF SINGLE VENTRICLE WITH AORTIC OUTFLOW OBSTRUCTION AND AORTIC ARCH HYPOPLASIA, CREATION OF CAVOPULMONARY ANASTOMOSIS, AND REMOVAL OF RIGHT AND LEFT		G9		
3700F	PSYCHIATRIC DISORDERS OR DISTURBANCES ASSESSED (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
3720F	COGNITIVE IMPAIRMENT OR DYSFUNCTION ASSESSED (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
37220	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL ANGIOPLASTY	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37221	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN SAME VESSEL, WHEN PERFORMED	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37222	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL; WITH TRANSLUMINAL ANGIOPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37223	REVASCULARIZATION,	No for All	50, 51, 62,	Covered for All	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ENDOVASCULAR, OPEN OR PERCUTANEOUS, ILIAC ARTERY, EACH ADDITIONAL IPSILATERAL ILIAC VESSEL; WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO CODE FOR	Programs, No for Package C	80, 81, AS, G8, G9	Programs, Covered for Package C	
37224	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL ANGIOPLASTY	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37225	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37226	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37227	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, FEMORAL/POPLITEAL ARTERY(S), UNILATERAL; WITH TRANSLUMINAL STENT PLACEMENT(S) AND ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE	No for All Programs, No for Package C	50, 51, 62, 80, 81, AS, 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
	SAME VESSEL, WHEN PERFORMED				
37228	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL ANGIOPLASTY	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37229	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, INITIAL VESSEL; WITH ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37230	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37231	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, INITIAL VESSEL; WITH TRANSLUMINAL STENT PLACEMENT(S) AND ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, 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
37232	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, EACH ADDITIONAL VESSEL; WITH TRANSLUMINAL ANGIOPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37233	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, EACH ADDITIONAL VESSEL; WITH ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37234	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, EACH ADDITIONAL VESSEL; WITH TRANSLUMINAL STENT PLACEMENT(S), INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO CODE	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
37235	REVASCULARIZATION, ENDOVASCULAR, OPEN OR PERCUTANEOUS, TIBIAL/PERONEAL ARTERY, UNILATERAL, EACH ADDITIONAL VESSEL; WITH TRANSLUMINAL STENT PLACEMENT(S) AND	No for All Programs, No for Package C	50, 51, 62, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ATHERECTOMY, INCLUDES ANGIOPLASTY WITHIN THE SAME VESSEL, WHEN PERFORMED (LIST SEPARATELY IN A				
38900	INTRAOPERATIVE IDENTIFICATION (E.G., MAPPING) OF SENTINEL LYMPH NODE(S), INCLUDES INJECTION OF NON-RADIOACTIVE DYE, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	50, 51, G8, G9, LT, RT	Covered for All Programs, Covered for Package C	NO
4324F	PATIENT (OR CAREGIVER) QUERIED ABOUT PARKINSON'S DISEASE MEDICATION RELATED MOTOR COMPLICATIONS (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4325F	MEDICAL AND SURGICAL TREATMENT OPTIONS REVIEWED WITH PATIENT (OR CAREGIVER) (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
4326F	PATIENT (OR CAREGIVER) QUERIED ABOUT SYMPTOMS OF AUTONOMIC DYSFUNCTION (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
43283	LAPAROSCOPY, SURGICAL, ESOPHAGEAL LENGTHENING PROCEDURE (E.G., COLLIS GASTROPLASTY OR WEDGE GASTROPLASTY) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	10, 54, 55, 56, 62, 76, 77, 78, 79, 80, 81, 82, AS	Covered for All Programs, Covered for Package C	NO
4328F	PATIENT (OR CAREGIVER) QUERIED ABOUT SLEEP DISTURBANCES (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
43327	ESOPHAGOGASTRIC FUNDOPLASTY PARTIAL OR COMPLETE; LAPAROTOMY	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

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
43328	ESOPHAGOGASTRIC FUNDOPLASTY, PARTIAL OR COMPLETE; THORACOTOMY	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
43332	REPAIR, PARAESOPHAGEAL HIATAL HERNIA (INCLUDING FUNDOPLICATION), VIA LAPAROTOMY, EXCEPT NEONATAL; WITHOUT IMPLANTATION OF MESH OR OTHER PROSTHESIS	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
43333	REPAIR, PARAESOPHAGEAL HIATAL HERNIA (INCLUDING FUNDOPLICATION), VIA LAPAROTOMY, EXCEPT NEONATAL; WITH IMPLANTATION OF MESH OR OTHER PROSTHESIS	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
43334	REPAIR, PARAESOPHAGEAL HIATAL HERNIA (INCLUDING FUNDOPLICATION), VIA THORACOTOMY, EXCEPT NEONATAL; WITHOUT IMPLANTATION OF MESH OR OTHER PROSTHESIS	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
43335	REPAIR, PARAESOPHAGEAL HIATAL HERNIA (INCLUDING FUNDOPLICATION), VIA THORACOTOMY, EXCEPT NEONATAL; WITH IMPLANTATION OF MESH OR OTHER PROSTHESIS	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
43336	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, (INCLUDING FUNDOPLICATION), VIA THORACOABDOMINAL INCISION, EXCEPT NEONATAL; WITHOUT IMPLANTATION OF MESH OR OTHER PROSTHESIS	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
43337	REPAIR, PARAESOPHAGEAL HIATAL HERNIA, (INCLUDING FUNDOPLICATION), VIA THORACOABDOMINAL	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8,	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INCISION, EXCEPT NEONATAL; WITH IMPLANTATION OF MESH OR OTHER PROSTHESIS		G9		
43338	ESOPHAGEAL LENGTHENING PROCEDURE (E.G., COLLIS GASTROPLASTY OR WEDGE GASTROPLASTY) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	51, 54, 55, 56, 62, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
43753	GASTRIC INTUBATION AND ASPIRATION(S) THERAPEUTIC, NECESSITATING PHYSICIAN'S SKILL (E.G., FOR GASTROINTESTINAL HEMORRHAGE), INCLUDING LAVAGE IF PERFORMED	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
43754	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC; SINGLE SPECIMEN (E.G., ACID ANALYSIS)	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
43755	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC; COLLECTION OF MULTIPLE FRACTIONAL SPECIMENS WITH GASTRIC STIMULATION, SINGLE OR DOUBLE LUMEN TUBE (GASTRIC SECRETORY STUDY) (E.G., HISTAMINE, INSULIN, PENTAGASTRIN, CALCIUM, SECRETIN), INCLUDES DRUG ADMINISTRATION	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
43756	DUODENAL INTUBATION AND ASPIRATION, DIAGNOSTIC, INCLUDES IMAGE GUIDANCE; SINGLE SPECIMEN (E.G., BILE STUDY FOR CRYSTALS OR AFFERENT LOOP CULTURE)	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
43757	DUODENAL INTUBATION AND ASPIRATION, DIAGNOSTIC, INCLUDES IMAGE GUIDANCE; COLLECTION OF MULTIPLE FRACTIONAL SPECIMENS WITH PANCREATIC OR	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	GALLBLADDER STIMULATION, SINGLE OR DOUBLE LUMEN TUBE, INCLUDES DRUG ADMINISTRATION				
4400F	REHABILITATIVE THERAPY OPTIONS DISCUSSED WITH PATIENT (OR CAREGIVER) (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
49327	LAPAROSCOPY, SURGICAL; WITH PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), INTRA-ABDOMINAL, INTRAPELVIC, AND/OR RETROPERITONEUM, INCLUDING IMAGING GUIDANCE, IF PERFORMED, SINGLE OR MULTIPLE(LIST SEPARATELY IN ADDITION)	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 62, 76, 77, 78, 80, 81, 82, AS, G8, G9	Covered for All Programs, Covered for Package C	NO
49412	PLACEMENT OF INTERSTITIAL DEVICE(S) FOR RADIATION THERAPY GUIDANCE (E.G., FIDUCIAL MARKERS, DOSIMETER), OPEN, INTRA-ABDOMINAL, INTRAPELVIC, AND/OR RETROPERITONEUM, INCLUDING IMAGE GUIDANCE, IF PERFORMED, SINGLE OR MULTIPLE (LIST SEPARATELY IN ADDITION	No for All Programs, No for Package C	51	Covered for All Programs, Covered for Package C	NO
49418	INSERTION OF TUNNELED INTRAPERITONEAL CATHETER (E.G., DIALYSIS, INTRAPERITONEAL CHEMOTHERAPY INSTILLATION, MANAGEMENT OF ASCITES), COMPLETE PROCEDURE, INCLUDING IMAGING GUIDANCE, CATHETER PLACEMENT, CONTRAST INJECTION WHEN PERFORMED	No for All Programs, No for Package C	51, 54, 55, 56, 78, G8, G9	Covered for All Programs, Covered for Package C	NO
53860	TRANSURETHRAL RADIOFREQUENCY MICRO-	No for All Programs, No	26, G8, G9, TC	Covered for All Programs, Covered	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE	for Package C		for Package C	
57156	INSERTION OF A VAGINAL RADIATION AFTERLOADING APPARATUS FOR CLINICAL BRACHYTHERAPY	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 79, QY	Covered for All Programs, Covered for Package C	NO
6080F	PATIENT (OR CAREGIVER) QUERIED ABOUT FALLS (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
6090F	PATIENT (OR CAREGIVER) COUNSELED ABOUT SAFETY ISSUES APPROPRIATE TO PATIENT'S STAGE OF DISEASE (PRKNS)8	NA	NA	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA
61781	STEREOTACTIC COMPUTER-ASSISTED (NAVIGATIONAL) PROCEDURE; CRANIAL, INTRADURAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	G8, G9	Covered for All Programs, Covered for Package C	NO
61782	STEREOTACTIC COMPUTER-ASSISTED (NAVIGATIONAL) PROCEDURE; CRANIAL, EXTRADURAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	G8, G9	Covered for All Programs, Covered for Package C	NO
61783	STEREOTACTIC COMPUTER-ASSISTED (NAVIGATIONAL) PROCEDURE; SPINAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	G8, G9	Covered for All Programs, Covered for Package C	NO
64566	POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE TREATMENT, INCLUDES PROGRAMMING	No for All Programs, No for Package C	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
64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (E.G., VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR	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
64569	REVISION OR REPLACEMENT OF CRANIAL NERVE (E.G., VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR	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
64570	REMOVAL OF CRANIAL NERVE (E.G., VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR	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
64611	CHEMODENERVATION OF PAROTID AND SUBMANDIBULAR SALIVARY GLANDS, BILATERAL	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
65778	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE FOR WOUND HEALING; SELF-RETAINING	No for All Programs, No for Package C	50, 51, 54, 55, 57, 58, 62, 76, 77, 78, 79, 80, 81, 82, AS, LT, RT	Covered for All Programs, Covered for Package C	NO
65779	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE FOR WOUND HEALING; SINGLE LAYER, SUTURED	No for All Programs, No for Package C	50, 51, 54, 55, 57, 58, 62, 76, 77, 78, 79, 80, 81, 82, AS, LT, RT	Covered for All Programs, Covered for Package C	NO
66174	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITHOUT RETENTION OF DEVICE OR STENT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
66175	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITH RETENTION OF DEVICE OR STENT	NA	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
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
76881	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL-TIME WITH IMAGE DOCUMENTATION; COMPLETE	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
76882	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL-TIME WITH IMAGE DOCUMENTATION; LIMITED, ANATOMIC SPECIFIC	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
80104	DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE	No for All Programs, No for Package C	91, QW	Covered for All Programs, Covered for Package C	NA
82930	GASTRIC ACID ANALYSIS, INCLUDES PH IF PERFORMED, EACH SPECIMEN	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
83861	MICROFLUIDIC ANALYSIS UTILIZING AN INTEGRATED COLLECTION AND ANALYSIS DEVICE, TEAR OSMOLARITY	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
84112	PLACENTAL ALPHA MICROGLOBULIN-1 (PAMG-1), CERVICOVAGINAL SECRETION, QUALITATIVE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
85598	PHOSPHOLIPID NEUTRALIZATION; HEXAGONAL	No for All Programs, No	91	Covered for All Programs, Covered	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PHOSPHOLIPID	for Package C		for Package C	
86481	TUBERCULOSIS TEST, CELL MEDIATED IMMUNITY ANTIGEN RESPONSE MEASUREMENT; ENUMERATION OF GAMMA INTERFERON-PRODUCING T-CELLS IN CELL SUSPENSION	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
86902	BLOOD TYPING; ANTIGEN TESTING OF DONOR BLOOD USING REAGENT SERUM, EACH ANTIGEN TEST	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
87501	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); INFLUENZA VIRUS, REVERSE TRANSCRIPTION AND AMPLIFIED PROBE TECHNIQUE, EACH TYPE OR SUBTYPE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
87502	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); INFLUENZA VIRUS, FOR MULTIPLE TYPES OR SUB-TYPES, REVERSE TRANSCRIPTION AND AMPLIFIED PROBE TECHNIQUE, FIRST 2 TYPES OR SUB-TYPES	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
87503	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); INFLUENZA VIRUS, FOR MULTIPLE TYPES OR SUB-TYPES, MULTIPLEX REVERSE TRANSCRIPTION AND AMPLIFIED PROBE TECHNIQUE, EACH ADDITIONAL INFLUENZA VIRUS TYPE OR SUB-TYPE BEYOND 2 (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
87906	INFECTIOUS AGENT GENOTYPE ANALYSIS BY NUCLEIC ACID (DNA OR RNA); HIV-1, OTHER REGION (E.G., INTEGRASE, FUSION)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
88120	CYTOPATHOLOGY, IN SITU HYBRIDIZATION (E.G., FISH), URINARY TRACT SPECIMEN WITH MORPHOMETRIC ANALYSIS, 3-5 MOLECULAR PROBES, EACH SPECIMEN; MANUAL	No for All Programs, No for Package C	26, 91, TC	Covered for All Programs, Covered for Package C	NO
88121	CYTOPATHOLOGY, IN SITU HYBRIDIZATION (E.G., FISH), URINARY TRACT SPECIMEN WITH MORPHOMETRIC ANALYSIS, 3-5 MOLECULAR PROBES, EACH SPECIMEN; USING COMPUTER-ASSISTED TECHNOLOGY	No for All Programs, No for Package C	26, 91, TC	Covered for All Programs, Covered for Package C	NO
88177	CYTOPATHOLOGY, EVALUATION OF FINE NEEDLE ASPIRATE; IMMEDIATE CYTOHISTOLOGIC STUDY TO DETERMINE ADEQUACY FOR DIAGNOSIS, EACH SEPARATE ADDITIONAL EVALUATION EPISODE, SAME SITE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	26, 91, TC	Covered for All Programs, Covered for Package C	NO
88363	EXAMINATION AND SELECTION OF RETRIEVED ARCHIVAL (I.E., PREVIOUSLY DIAGNOSED) TISSUE(S) FOR MOLECULAR ANALYSIS (E.G., KRAS MUTATIONAL ANALYSIS)	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
88749	UNLISTED IN VIVO (E.G., TRANSCUTANEOUS) LABORATORY SERVICE	No for All Programs, No for Package C	91	Covered for All Programs, Covered for Package C	NO
90460	IMMUNIZATION ADMINISTRATION THROUGH 18 YEARS OF AGE VIA ANY ROUTE OF ADMINISTRATION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; FIRST VACCINE/TOXOID COMPONENT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
90461	IMMUNIZATION	NA	NA	Non-Covered for All	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	ADMINISTRATION THROUGH 18 YEARS OF AGE VIA ANY ROUTE OF ADMINISTRATION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; EACH ADDITIONAL VACCINE/TOXOID COMPONENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)			Programs, Non-Covered for Package C	
90654	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR INTRADERMAL USE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
90867	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION TREATMENT; PLANNING	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NO
90868	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION TREATMENT; DELIVERY AND MANAGEMENT, PER SESSION	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NO
91013	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY WITH INTERPRETATION AND REPORT; WITH STIMULATION OR PERFUSION DURING 2-DIMENSIONAL DATA STUDY (E.G., STIMULANT, ACID OR ALKALI PERFUSION)	No for All Programs, No for Package C	26, TC	Covered for All Programs, Covered for Package C	NO
91117	COLON MOTILITY (MANOMETRIC) STUDY, MINIMUM 6 HOURS CONTINUOUS RECORDING (INCLUDING PROVOCATION TESTS, E.G., MEAL, INTRACOLONIC BALLOON DISTENSION, PHARMACOLOGIC AGENTS, IF PERFORMED), WITH INTERPRETATION AND REPORT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
92132	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL	No for All Programs, No for Package C	26, LT, RT, TC	Covered for All Programs, Covered for Package C	NO
92133	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; OPTIC NERVE	No for All Programs, No for Package C	26, 50, LT, RT, TC	Covered for All Programs, Covered for Package C	NO
92134	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; RETINA	No for All Programs, No for Package C	26, 50, LT, RT, TC	Covered for All Programs, Covered for Package C	NO
92227	REMOTE IMAGING FOR DETECTION OF RETINAL DISEASE (E.G., RETINOPATHY IN A PATIENT WITH DIABETES) WITH ANALYSIS AND REPORT UNDER PHYSICIAN SUPERVISION, UNILATERAL OR BILATERAL	No for All Programs, No for Package C	26, 50	Covered for All Programs, Covered for Package C	NO
92228	REMOTE IMAGING FOR MONITORING AND MANAGEMENT OF ACTIVE RETINAL DISEASE (E.G., DIABETIC RETINOPATHY) WITH PHYSICIAN REVIEW, INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL	No for All Programs, No for Package C	26, 50	Covered for All Programs, Covered for Package C	NO
93451	RIGHT HEART CATHETERIZATION INCLUDING MEASUREMENT(S) OF OXYGEN SATURATION AND CARDIAC OUTPUT, WHEN PERFORMED	No for All Programs, No for Package C	26, 51, 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
93452	LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93453	COMBINED RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION, WHEN PERFORMED	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93454	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93455	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93456	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT HEART CATHETERIZATION				
93457	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH CATHETER PLACEMENT(S) IN BYPASS GRAFT(S) (INTERNAL MAMMARY, FREE ARTERIAL	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93458	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93459	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93460	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION				
93461	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH RIGHT AND LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION	No for All Programs, No for Package C	26, TC, 51	Covered for All Programs, Covered for Package C	NO
93462	LEFT HEART CATHETERIZATION BY TRANSSEPTAL PUNCTURE THROUGH INTACT SEPTUM OR BY TRANSAPICAL PUNCTURE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	26, 51, TC	Covered for All Programs, Covered for Package C	NO
93463	PHARMACOLOGIC AGENT ADMINISTRATION (E.G., INHALED NITRIC OXIDE, INTRAVENOUS INFUSION OF NITROPRUSSIDE, DOBUTAMINE, MILRINONE, OR OTHER AGENT) INCLUDING ASSESSING HEMODYNAMIC MEASUREMENTS BEFORE, DURING, AFTER AND REPEAT PHARMACOLOGIC AGENT ADMINISTRATION	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
93464	PHYSIOLOGIC EXERCISE STUDY (E.G., BICYCLE OR ARM ERGOMETRY) INCLUDING ASSESSING HEMODYNAMIC MEASUREMENTS BEFORE AND AFTER (LIST SEPARATELY IN ADDITION TO CODE FOR	NA	26, 51, TC	Covered for All Programs, Covered for Package C	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PRIMARY PROCEDURE)				
93563	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR SELECTIVE CORONARY ANGIOGRAPHY DURING CONGENITAL HEART CATHETERIZATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
93564	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR SELECTIVE OPACIFICATION OF AORTOCORONARY VENOUS OR ARTERIAL BYPASS GRAFT(S) (E.G., AORTOCORONARY SAPHENOUS VEIN, FREE RADIAL ARTERY	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
93565	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR SELECTIVE LEFT VENTRICULAR OR LEFT ATRIAL ANGIOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
93566	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR SELECTIVE RIGHT VENTRICULAR OR RIGHT ATRIAL ANGIOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PRIMARY PROCEDURE)				
93567	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR SUPRAVALVULAR AORTOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
93568	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; FOR PULMONARY ANGIOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
95800	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		Non-Covered for All Programs, Non-Covered for Package C	NO
95801	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		Non-Covered for All Programs, Non-Covered for Package C	NO
96446	CHEMOTHERAPY ADMINISTRATION INTO THE PERITONEAL CAVITY VIA INDWELLING PORT OR CATHETER	No for All Programs, No for Package C	TC	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
99224	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: PROBLEM FOCUSED INTERVAL HISTORY; PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING THAT IS STRAIGHT FORWARD	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
99225	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED INTERVAL HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
99226	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
A4566	SHOULDER SLING OR VEST DESIGN, ABDUCTION RESTRAINER, WITH OR WITHOUT SWATHE CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
C9274	CROTALIDAE POLYVALENT IMMUNE FAB (OVINE), 1 VIAL	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
C9275	INJECTION, HEXAMINOLEVULINATE HYDROCHLORIDE, 100 MG, PER STUDY DOSE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
C9276	INJECTION, CABAZITAXEL, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
C9277	INJECTION, ALGLUCOSIDASE ALFA (LUMIZYME), 1 MG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
C9278	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
C9279	INJECTION, IBUPROFEN, 100 MG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT – PERMANENT TOOTH	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
D3354	PULPAL REGENERATION (COMPLETION OF REGENERATIVE TREATMENT IN AN IMMATURE PERMANENT TOOTH WITH A NECROTIC PULP); DOES NOT INCLUDE FINAL RESTORATION	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
D5993	MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
D6254	INTERIM PONTIC	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
D6795	INTERIM RETAINER CROWN	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NA
D7295	HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE	No for All Programs, No for Package C	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	Yes for All Programs, Yes for Package C	RR	Covered for All Programs, Covered for Package C	NA
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NA
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NA
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NA
G0157	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0158	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0159	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE PHYSICAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0160	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE OCCUPATIONAL THERAPY	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	MAINTENANCE PROGRAM, EACH 15 MINUTES				
G0161	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE SPEECH-LANGUAGE PATHOLOGY MAINTENANCE PROGRAM, EACH 15 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0162	SKILLED SERVICES BY A REGISTERED NURSE (RN) FOR MANAGEMENT AND EVALUATION OF THE PLAN OF CARE; EACH 15 MINUTES (THE PATIENT'S UNDERLYING CONDITION OR COMPLICATION REQUIRES AN RN TO ENSURE THAT ESSENTIAL NON-SKILLED CARE ACHIEVES ITS PURPOSE IN THE HOME)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0163	SKILLED SERVICES BY A LICENSED NURSE (LPN OR RN) FOR THE OBSERVATION AND ASSESSMENT OF THE PATIENT'S CONDITION, EACH 15 MINUTES (THE CHANGE IN THE PATIENT'S CONDITION REQUIRES SKILLED NURSING PERSONNEL TO IDENTIFY AND EVALUATE THE PATIENT'S NEEDS)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0164	SKILLED SERVICES OF A LICENSED NURSE (LPN OR RN), IN THE TRAINING AND/OR EDUCATION OF A PATIENT OR FAMILY MEMBER, IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0434	DRUG SCREEN, OTHER THAN CHROMATOGRAPHIC; ANY NUMBER OF DRUG CLASSES, BY CLIA WAIVED TEST OR	No for All Programs, No for Package C	91, QW	Covered for All Programs, Covered for Package C	NO

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	MODERATE COMPLEXITY TEST, PER PATIENT ENCOUNTER				
G0436	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTERMEDIATE, GREATER THAN 3 MINUTES, UP TO 10 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NO
G0437	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTENSIVE, GREATER THAN 10 MINUTES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NO
G0438	ANNUAL WELLNESS VISIT; INCLUDES A PERSONALIZED PREVENTION PLAN OF SERVICE (PPS), INITIAL VISIT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0439	ANNUAL WELLNESS VISIT, INCLUDES A PERSONALIZED PREVENTION PLAN OF SERVICE (PPS), SUBSEQUENT VISIT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0440	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE PREPARATION AND DEBRIDEMENT IF PERFORMED; FIRST 25 SQ CM OR LESS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G0441	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE PREPARATION AND DEBRIDEMENT IF PERFORMED; EACH ADDITIONAL 25 SQ CM	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8629	DOCUMENTATION OF ORDER FOR PROPHYLACTIC PARENTERAL ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF FLUOROQUINOLONE OR VANCOMYCIN, TWO HOURS)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)				
G8630	DOCUMENTATION THAT ADMINISTRATION OF PROPHYLACTIC PARENTERAL ANTIBIOTICS WAS INITIATED WITHIN ONE HOUR (IF FLUOROQUINOLONE OR VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED), AS ORDERED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8631	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ORDERING PROPHYLACTIC PARENTERAL 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	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8632	PROPHYLACTIC PARENTERAL ANTIBIOTICS WERE NOT ORDERED TO BE GIVEN OR GIVEN WITHIN ONE HOUR (IF FLUOROQUINOLONE OR VANCOMYCIN, TWO HOURS) PRIOR TO THE SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED), REASON NOT OTHERWISE SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8633	PHARMACOLOGIC THERAPY (OTHER THAN	NA	NA	Non-Covered for All Programs, Non-	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	MINERALS/VITAMINS) FOR OSTEOPOROSIS PRESCRIBED			Covered for Package C	
G8634	CLINICIAN DOCUMENTED PATIENT NOT AN ELIGIBLE CANDIDATE TO RECEIVE PHARMACOLOGIC THERAPY FOR OSTEOPOROSIS	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8635	PHARMACOLOGIC THERAPY FOR OSTEOPOROSIS WAS NOT PRESCRIBED, REASON NOT OTHERWISE SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8636	INFLUENZA IMMUNIZATION ADMINISTERED OR PREVIOUSLY RECEIVED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8637	CLINICIAN DOCUMENTED THAT PATIENT IS NOT ELIGIBLE TO RECEIVE THE INFLUENZA IMMUNIZATION	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8638	INFLUENZA IMMUNIZATION NOT ADMINISTERED OR PREVIOUSLY RECEIVED, REASON NOT OTHERWISE SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8639	INFLUENZA IMMUNIZATION WAS ADMINISTERED OR PREVIOUSLY RECEIVED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8640	CLINICIAN HAS DOCUMENTED THAT PATIENT IS NOT ELIGIBLE TO RECEIVE THE INFLUENZA IMMUNIZATION	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8641	INFLUENZA IMMUNIZATION WAS NOT ADMINISTERED OR PREVIOUSLY RECEIVED, REASON NOT OTHERWISE SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8642	THE ELIGIBLE PROFESSIONAL PRACTICES IN A RURAL AREA WITHOUT SUFFICIENT HIGH SPEED INTERNET ACCESS AND REQUESTS A HARDSHIP EXEMPTION FROM THE APPLICATION OF THE PAYMENT ADJUSTMENT UNDER SECTION 1848(A)(5)(A) OF THE SOCIAL SECURITY ACT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8643	THE ELIGIBLE PROFESSIONAL PRACTICES IN AN AREA WITHOUT SUFFICIENT AVAILABLE PHARMACIES FOR ELECTRONIC PRESCRIBING AND REQUESTS A HARDSHIP EXEMPTION FOR THE APPLICATION OF THE PAYMENT ADJUSTMENT UNDER SECTION 1848(A)(5)(A) OF THE SOCIAL SECURITY ACT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8644	ELIGIBLE PROFESSIONAL DOES NOT HAVE PRESCRIBING PRIVILEGES	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8645	I INTEND TO REPORT THE ASTHMA MEASURES GROUP	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8646	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE ASTHMA MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8647	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE KNEE SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO (>0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8648	RISK-ADJUSTED FUNCTIONAL	NA	NA	Non-Covered for All	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	STATUS CHANGE RESIDUAL SCORE FOR THE KNEE SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)			Programs, Non-Covered for Package C	
G8649	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE KNEE NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, PATIENT NOT ELIGIBLE/NOT APPROPRIATE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8650	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE KNEE NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8651	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE HIP SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO (>0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8652	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE HIP SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8653	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE HIP NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR	NA	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
	FOLLOW UP STATUS SURVEY NEAR DISCHARGE, PATIENT NOT ELIGIBLE/NOT APPROPRIATE				
G8654	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE HIP NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8655	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE LOWER LEG, FOOT OR ANKLE SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO(>0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8656	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE LOWER LEG, FOOT OR ANKLE SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8657	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE LOWER LEG, FOOT OR ANKLE NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, PATIENT NOT ELIGIBLE/NOT APPROPRIATE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8658	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE LOWER LEG,	NA	NA	Non-Covered for All Programs, Non-Covered for Package	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	FOOT OR ANKLE NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, REASON NOT SPECIFIED			C	
G8659	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE LUMBAR SPINE SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO (>0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8660	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE LUMBAR SPINE SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8661	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE LUMBAR SPINE NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, PATIENT NOT ELIGIBLE/NOT APPROPRIATE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8662	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE LUMBAR SPINE NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8663	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE SHOULDER	NA	NA	Non-Covered for All Programs, Non-Covered for Package	NA

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Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO (>0)			C	
G8664	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE SHOULDER SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8665	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE SHOULDER NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, PATIENT NOT ELIGIBLE/NOT APPROPRIATE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8666	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE SHOULDER NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8667	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE ELBOW, WRIST OR HAND SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO (>0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8668	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE ELBOW, WRIST OR HAND SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)	NA	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
G8669	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE ELBOW, WRIST OR HAND NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, PATIENT NOT ELIGIBLE/NOT APPROPRIATE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8670	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE ELBOW, WRIST OR HAND NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION AND/OR FOLLOW UP STATUS SURVEY NEAR DISCHARGE, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8671	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE NECK, CRANIUM, MANDIBLE, THORACIC SPINE, RIBS, OR OTHER GENERAL ORTHOPEDIC IMPAIRMENT SUCCESSFULLY CALCULATED AND THE SCORE WAS EQUAL TO ZERO (0) OR GREATER THAN ZERO (>0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8672	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORE FOR THE NECK, CRANIUM, MANDIBLE, THORACIC SPINE, RIBS, OR OTHER GENERAL ORTHOPEDIC IMPAIRMENT SUCCESSFULLY CALCULATED AND THE SCORE WAS LESS THAN ZERO (<0)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8673	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE NECK, CRANIUM, MANDIBLE,	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	THORACIC SPINE, RIBS, OR OTHER GENERAL ORTHOPEDIC IMPAIRMENT NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION				
G8674	RISK-ADJUSTED FUNCTIONAL STATUS CHANGE RESIDUAL SCORES FOR THE NECK, CRANIUM, MANDIBLE, THORACIC SPINE, RIBS, OR OTHER GENERAL ORTHOPEDIC IMPAIRMENT NOT MEASURED BECAUSE THE PATIENT DID NOT COMPLETE FOTO'S FUNCTIONAL INTAKE ON ADMISSION	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8675	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MM HG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8676	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MM HG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8677	MOST RECENT SYSTOLIC BLOOD PRESSURE < 130 MM HG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8678	MOST RECENT SYSTOLIC BLOOD PRESSURE 130 TO 139 MM HG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8679	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8680	MOST RECENT DIASTOLIC BLOOD PRESSURE 80 - 89 MM HG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
G8681	PATIENT HOSPITALIZED WITH PRINCIPAL DIAGNOSIS OF HEART FAILURE DURING THE MEASUREMENT PERIOD	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8682	LEFT VENTRICULAR FUNCTION TESTING PERFORMED DURING THE MEASUREMENT PERIOD	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8683	CLINICIAN DOCUMENTED THAT PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR LEFT VENTRICULAR FUNCTION TESTING DURING THE MEASUREMENT PERIOD	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8684	PATIENT NOT HOSPITALIZED WITH PRINCIPAL DIAGNOSIS OF HEART FAILURE DURING THE MEASUREMENT PERIOD	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8685	LEFT VENTRICULAR FUNCTION TESTING NOT PERFORMED DURING THE MEASUREMENT PERIOD, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8686	CURRENTLY A TOBACCO SMOKER OR CURRENT EXPOSURE TO SECONDHAND SMOKE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8687	CURRENTLY A TOBACCO NON-USER AND NO EXPOSURE TO SECONDHAND SMOKE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8688	CURRENTLY A SMOKELESS TOBACCO USER (E.G., CHEW, SNUFF) AND NO EXPOSURE TO SECONDHAND SMOKE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8689	TOBACCO USE NOT ASSESSED, REASON NOT OTHERWISE SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8690	CURRENT TOBACCO SMOKER OR CURRENT EXPOSURE TO	NA	NA	Non-Covered for All Programs, Non-	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	SECONDHAND SMOKE			Covered for Package C	
G8691	CURRENT TOBACCO NON-USER AND NO EXPOSURE TO SECONDHAND SMOKE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8692	CURRENT SMOKELESS TOBACCO USER (E.G., CHEW, SNUFF) AND NO EXPOSURE TO SECONDHAND SMOKE	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
G8693	TOBACCO USE NOT ASSESSED, REASON NOT SPECIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
J0171	INJECTION, ADRENALIN, EPINEPHRINE, 0.1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0558	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, 100,000 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0561	INJECTION, PENICILLIN G BENZATHINE, 100,000 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0597	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0638	INJECTION, CANAKINUMAB, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J0775	INJECTION, COLLAGENASE, CLOSTRIDIUM HISTOLYTICUM, 0.01 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J1290	INJECTION, ECALLANTIDE, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J1559	INJECTION, IMMUNE GLOBULIN (HIZENTRA), 100 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J1599	INJECTION, IMMUNE GLOBULIN,	No for All	NA	Covered for All	YES

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), NOT OTHERWISE SPECIFIED, 500 MG	Programs, No for Package C		Programs, Covered for Package C	
J1786	INJECTION, IMIGLUCERASE, 10 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J1826	INJECTION, INTERFERON BETA-1A, 30 MCG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J2358	INJECTION, OLANZAPINE, LONG-ACTING, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J2426	INJECTION, PALIPERIDONE PALMITATE EXTENDED RELEASE, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J3095	INJECTION, TELEVANCIN, 10 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J3262	INJECTION, TOCILIZUMAB, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J3357	INJECTION, USTEKINUMAB, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J3385	INJECTION, VELAGLUCERASE ALFA, 100 UNITS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7184	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, PER 100 IU VWF:RCO	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7196	INJECTION, ANTITHROMBIN RECOMBINANT, 50 I.U.	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7309	METHYL AMINOLEVULINATE (MAL) FOR TOPICAL ADMINISTRATION, 16.8%, 1 GRAM	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7312	INJECTION, DEXAMETHASONE,	No for All	NA	Covered for All	YES

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	INTRAVITREAL IMPLANT, 0.1 MG	Programs, No for Package C		Programs, Covered for Package C	
J7335	CAPSAICIN 8% PATCH, PER 10 SQUARE CENTIMETERS	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J8562	FLUDARABINE PHOSPHATE, ORAL, 10 MG	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NO
J9302	INJECTION, OFATUMUMAB, 10 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J9307	INJECTION, PRALATREXATE, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J9315	INJECTION, ROMIDEPSIN, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
J9351	INJECTION, TOPOTECAN, 0.1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	YES
L3674	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITH OR WITHOUT NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
L4631	ANKLE FOOT ORTHOSIS, WALKING BOOT TYPE, VARUS/VALGUS CORRECTION, ROCKER BOTTOM, ANTERIOR	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
	TIBIAL SHELL, SOFT INTERFACE, CUSTOM ARCH SUPPORT, PLASTIC OR OTHER MATERIAL, INCLUDES STRAPS AND CLOSURES, CUSTOM FABRICATED				
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
L8693	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY	Yes for All Programs, Yes for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q0478	POWER ADAPTER FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, VEHICLE TYPE	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NO
Q0479	POWER MODULE FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY	Yes for All Programs, Yes for Package C	NU	Covered for All Programs, Covered for Package C	NO
Q2035	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE (AFLURIA)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
Q2036	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE (FLULAVAL)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 1 – New 2011 Annual HCPCS Codes, Effective January 1, 2011

Procedure Code	Description	Prior Authorization Requirements	Modifiers	Program Coverage	NDC Required
Q2037	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE (FLUVIRIN)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
Q2038	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE (FLUZONE)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
Q2039	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE (NOT OTHERWISE SPECIFIED)	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q4118	MATRISTEM MICROMATRIX, 1 MG	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q4119	MATRISTEM WOUND MATRIX, PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q4120	MATRISTEM BURN MATRIX, PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
Q4121	THERASKIN, PER SQUARE CENTIMETER	No for All Programs, No for Package C	NA	Covered for All Programs, Covered for Package C	NO
T1505	ELECTRONIC MEDICATION COMPLIANCE MANAGEMENT DEVICE, INCLUDES ALL COMPONENTS AND ACCESSORIES, NOT OTHERWISE CLASSIFIED	NA	NA	Non-Covered for All Programs, Non-Covered for Package C	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
0016T	DESTRUCTION OF LOCALIZED LESION OF CHOROID (E.G., CHOROIDAL NEOVASCULARIZATION), TRANSPUPILLARY THERMOTHERAPY	67299
0017T	DESTRUCTION OF MACULAR DRUSEN, PHOTOCOAGULATION	67299
0104T	INERT GAS REBREATHING FOR CARDIAC OUTPUT MEASUREMENT; DURING REST	93799
0105T	INERT GAS REBREATHING FOR CARDIAC OUTPUT MEASUREMENT; DURING EXERCISE	93799
0130T	VALIDATED, STATISTICALLY RELIABLE, RANDOMIZED, CONTROLLED, SINGLE-PATIENT CLINICAL INVESTIGATION OF FDA APPROVED CHRONIC CARE DRUGS, PROVIDED BY A PHARMACIST, INTERPRETATION AND REPORT TO THE PRESCRIBING HEALTH CARE PROFESSIONAL	99199
0140T	EXHALED BREATH CONDENSATE PH	83987
0160T	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION TREATMENT PLANNING	N/A
0161T	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION TREATMENT DELIVERY AND MANAGEMENT, PER SESSION	N/A
0176T	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITHOUT RETENTION OF DEVICE OR STENT	66174
0177T	TRANSLUMINAL DILATION OF AQUEOUS OUTFLOW CANAL; WITH RETENTION OF DEVICE OR STENT	66175
0187T	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL	92132
0193T	TRANSURETHRAL, RADIOFREQUENCY MICRO-REMODELING OF THE FEMALE BLADDER NECK AND PROXIMAL URETHRA FOR STRESS URINARY INCONTINENCE	53860

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
0203T	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS (E.G., BY AIRFLOW OR PERIPHERAL ARTERIAL TONE) AND SLEEP TIME	95800
0204T	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; MINIMUM OF HEART RATE, OXYGEN SATURATION, AND RESPIRATORY ANALYSIS (E.G., BY AIRFLOW OR PERIPHERAL ARTERIAL TONE)	95801
11040	DEBRIDEMENT; SKIN, PARTIAL THICKNESS	97597, 97598, 97597, 97598, 16020-16030
11041	DEBRIDEMENT; SKIN, FULL THICKNESS	97597, 97598, 97597, 97598, 16020-16030
20000	INCISION OF SOFT TISSUE ABSCESS (E.G., SECONDARY TO OSTEOMYELITIS); SUPERFICIAL	10060, 10061
33861	ASCENDING AORTA GRAFT, WITH CARDIOPULMONARY BYPASS, WITH OR WITHOUT VALVE SUSPENSION; WITH CORONARY RECONSTRUCTION	33864
35454	TRANSLUMINAL BALLOON ANGIOPLASTY, OPEN; ILIAC	37220 - 37227
35456	TRANSLUMINAL BALLOON ANGIOPLASTY, OPEN; FEMORAL-POPLITEAL	37220 - 37227
35459	TRANSLUMINAL BALLOON ANGIOPLASTY, OPEN; TIBIOPERONEAL TRUNK AND BRANCHES	37228 - 37235
35470	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; TIBIOPERONEAL TRUNK OR BRANCHES, EACH VESSEL	37228 - 37235
35473	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; ILIAC	37220 - 37227
35474	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FEMORAL-POPLITEAL	37220 - 37227
35480	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN; RENAL OR OTHER VISCERAL ARTERY	0234T, 0235T
35481	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN; AORTIC	0236T
35482	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN;	0238T

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
	ILIAC	
35483	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN; FEMORAL-POPLITEAL	37225, 37227
35484	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN; BRACHIOCEPHALIC TRUNK OR BRANCHES, EACH VESSEL	0237T
35485	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN; TIBIOPERONEAL TRUNK AND BRANCHES	37229, 37231, 37233, 37235
35490	TRANSLUMINAL PERIPHERAL ATHERECTOMY, PERCUTANEOUS; RENAL OR OTHER VISCERAL ARTERY	0234T, 0235T
35491	TRANSLUMINAL PERIPHERAL ATHERECTOMY, PERCUTANEOUS; AORTIC	0236T
35492	TRANSLUMINAL PERIPHERAL ATHERECTOMY, PERCUTANEOUS; ILIAC	0238T
35493	TRANSLUMINAL PERIPHERAL ATHERECTOMY, PERCUTANEOUS; FEMORAL-POPLITEAL	0236T
35494	TRANSLUMINAL PERIPHERAL ATHERECTOMY, PERCUTANEOUS; BRACHIOCEPHALIC TRUNK OR BRANCHES, EACH VESSEL	0237T
35495	TRANSLUMINAL PERIPHERAL ATHERECTOMY, PERCUTANEOUS; TIBIOPERONEAL TRUNK AND BRANCHES	37229, 37231, 27233, 37235
39502	REPAIR, PARAESOPHAGEAL HIATUS HERNIA, TRANSABDOMINAL, WITH OR WITHOUT FUNDOPLASTY, VAGOTOMY, AND/OR PYLOROPLASTY, EXCEPT NEONATAL	43332, 43333, 43335, 43337, 43281, 43282
39520	REPAIR, DIAPHRAGMATIC HERNIA (ESOPHAGEAL HIATAL); TRANSTHORACIC	43334, 43335
39530	REPAIR, DIAPHRAGMATIC HERNIA (ESOPHAGEAL HIATAL); COMBINED, THORACOABDOMINAL	43336, 43337
39531	REPAIR, DIAPHRAGMATIC HERNIA (ESOPHAGEAL HIATAL); COMBINED, THORACOABDOMINAL, WITH DILATION OF STRICTURE (WITH OR WITHOUT GASTROPLASTY)	43336, 43337
43324	ESOPHAGOGASTRIC FUNDOPLASTY (E.G., NISSEN, BELSEY IV, HILL PROCEDURES)	43327, 43328, 43280
43326	ESOPHAGOGASTRIC FUNDOPLASTY; WITH	43327, 43328, 43332-43338

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
	GASTROPLASTY (E.G., COLLIS)	
43600	BIOPSY OF STOMACH; BY CAPSULE, TUBE, PERORAL (1 OR MORE SPECIMENS)	43605
49420	INSERTION OF INTRAPERITONEAL CANNULA OR CATHETER FOR DRAINAGE OR DIALYSIS; TEMPORARY	49060, 49061, 49062, 49080, 49081, 49418
61795	STEREOTACTIC COMPUTER-ASSISTED VOLUMETRIC (NAVIGATIONAL) PROCEDURE, INTRACRANIAL, EXTRACRANIAL, OR SPINAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	61781, 61782, 61783
64573	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; CRANIAL NERVE	64568
75992	TRANSLUMINAL ATHERECTOMY, PERIPHERAL ARTERY, RADIOLOGICAL SUPERVISION AND INTERPRETATION	37225, 37227, 37229, 37231, 0238T
75993	TRANSLUMINAL ATHERECTOMY, EACH ADDITIONAL PERIPHERAL ARTERY, RADIOLOGICAL SUPERVISION AND INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	37233, 37235, 0238T
75994	TRANSLUMINAL ATHERECTOMY, RENAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	0234T
75995	TRANSLUMINAL ATHERECTOMY, VISCERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION	0235T
75996	TRANSLUMINAL ATHERECTOMY, EACH ADDITIONAL VISCERAL ARTERY, RADIOLOGICAL SUPERVISION AND INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	0235T
76150	XERORADIOGRAPHY	NA
76350	SUBTRACTION IN CONJUNCTION WITH CONTRAST STUDIES	NA
76880	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL TIME WITH IMAGE DOCUMENTATION	76881, 76882
82926	GASTRIC ACID, FREE AND TOTAL, EACH SPECIMEN	89230
82928	GASTRIC ACID, FREE OR TOTAL, EACH SPECIMEN	89230
86903	BLOOD TYPING; ANTIGEN SCREENING FOR COMPATIBLE BLOOD UNIT USING REAGENT SERUM, PER UNIT SCREENED	86902

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
89100	DUODENAL INTUBATION AND ASPIRATION; SINGLE SPECIMEN (E.G., SIMPLE BILE STUDY OR AFFERENT LOOP CULTURE) PLUS APPROPRIATE TEST PROCEDURE	43756, 43757
89105	DUODENAL INTUBATION AND ASPIRATION; COLLECTION OF MULTIPLE FRACTIONAL SPECIMENS WITH PANCREATIC OR GALLBLADDER STIMULATION, SINGLE OR DOUBLE LUMEN TUBE	43757
89130	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC, EACH SPECIMEN, FOR CHEMICAL ANALYSES OR CYTOPATHOLOGY	43753, 43754
89132	GASTRIC INTUBATION AND ASPIRATION, DIAGNOSTIC, EACH SPECIMEN, FOR CHEMICAL ANALYSES OR CYTOPATHOLOGY; AFTER STIMULATION	43755
89135	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (E.G., GASTRIC SECRETORY STUDY); 1 HOUR	43754, 43755
89136	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (E.G., GASTRIC SECRETORY STUDY); 2 HOURS	43754, 43755
89140	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (E.G., GASTRIC SECRETORY STUDY); 2 HOURS INCLUDING GASTRIC STIMULATION (E.G., HISTALOG, PENTAGASTRIN)	43754, 43755
89141	GASTRIC INTUBATION, ASPIRATION, AND FRACTIONAL COLLECTIONS (E.G., GASTRIC SECRETORY STUDY); 3 HOURS, INCLUDING GASTRIC STIMULATION	43754, 43755
89225	STARCH GRANULES, FECES	NA
89235	WATER LOAD TEST	NA
90465	IMMUNIZATION ADMINISTRATION YOUNGER THAN 8 YEARS OF AGE (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS) WHEN THE PHYSICIAN COUNSELS THE PATIENT/FAMILY; FIRST INJECTION (SINGLE OR COMBINATION VACCINE/TOXOID), PER DAY	90460, 90461, 90471-90474

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
90466	IMMUNIZATION ADMINISTRATION YOUNGER THAN 8 YEARS OF AGE (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS) WHEN THE PHYSICIAN COUNSELS THE PATIENT/FAMILY; EACH ADDITIONAL INJECTION (SINGLE OR COMBINATION VACCINE/TOXOID),	90460, 90461, 90471-90474
90467	IMMUNIZATION ADMINISTRATION YOUNGER THAN AGE 8 YEARS (INCLUDES INTRANASAL OR ORAL ROUTES OF ADMINISTRATION) WHEN THE PHYSICIAN COUNSELS THE PATIENT/FAMILY; FIRST ADMINISTRATION (SINGLE OR COMBINATION VACCINE/TOXOID), PER DAY	NA
90468	IMMUNIZATION ADMINISTRATION YOUNGER THAN AGE 8 YEARS (INCLUDES INTRANASAL OR ORAL ROUTES OF ADMINISTRATION) WHEN THE PHYSICIAN COUNSELS THE PATIENT/FAMILY; EACH ADDITIONAL ADMINISTRATION (SINGLE OR COMBINATION VACCINE/ TOXOID), PER DAY	NA
91000	ESOPHAGEAL INTUBATION AND COLLECTION OF WASHINGS FOR CYTOLOGY, INCLUDING PREPARATION OF SPECIMENS (SEPARATE PROCEDURE)	NA
91011	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/OR GASTROESOPHAGEAL JUNCTION) STUDY; WITH MECHOLYL OR SIMILAR STIMULANT	91013
91012	ESOPHAGEAL MOTILITY (MANOMETRIC STUDY OF THE ESOPHAGUS AND/ OR GASTROESOPHAGEAL JUNCTION) STUDY; WITH ACID PERFUSION STUDIES	91013
91052	GASTRIC ANALYSIS TEST WITH INJECTION OF STIMULANT OF GASTRIC SECRETION (E.G., HISTAMINE, INSULIN, PENTAGASTRIN, CALCIUM AND SECRETIN)	43754
91055	GASTRIC INTUBATION, WASHINGS, AND PREPARING SLIDES FOR CYTOLOGY (SEPARATE PROCEDURE)	43755
91105	GASTRIC INTUBATION, AND ASPIRATION OR LAVAGE FOR TREATMENT (E.G., FOR INGESTED POISONS)	43753
91123	PULSED IRRIGATION OF FECAL IMPACTION	NA
92135	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT (E.G., SCANNING LASER) WITH INTERPRETATION AND REPORT, UNILATERAL	92132, 92133, 92134

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
93012	TELEPHONIC TRANSMISSION OF POST-SYMPTOM ELECTROCARDIOGRAM RHYTHM STRIP(S), 24-HOUR ATTENDED MONITORING, PER 30 DAY PERIOD OF TIME; TRACING ONLY	93268-93272
93014	TELEPHONIC TRANSMISSION OF POST-SYMPTOM ELECTROCARDIOGRAM RHYTHM STRIP(S), 24-HOUR ATTENDED MONITORING, PER 30 DAY PERIOD OF TIME; PHYSICIAN REVIEW WITH INTERPRETATION AND REPORT ONLY	93268-93272
93230	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; INCLUDES RECORDING	93224-93227
93231	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; RECORDING	93224-93227
93232	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT; MICROPROCESSOR-BASED ANA	93224-93227
93233	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS ORIGINAL WAVEFORM RECORDING AND STORAGE WITHOUT SUPERIMPOSITION SCANNING UTILIZING A DEVICE CAPABLE OF PRODUCING A FULL MINIATURIZED PRINTOUT	93224-93227
93235	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS	93224-93227
93236	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING	93224-93227

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
	A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS	
93237	WEARABLE ELECTROCARDIOGRAPHIC RHYTHM DERIVED MONITORING FOR 24 HOURS BY CONTINUOUS COMPUTERIZED MONITORING AND NON-CONTINUOUS RECORDING, AND REAL-TIME DATA ANALYSIS UTILIZING A DEVICE CAPABLE OF PRODUCING INTERMITTENT FULL-SIZED WAVEFORM TRACINGS	93224-93227
93501	RIGHT HEART CATHETERIZATION	93451-93461
93508	CATHETER PLACEMENT IN CORONARY ARTERY(S), ARTERIAL CORONARY CONDUIT(S), AND/OR VENOUS CORONARY BYPASS GRAFT(S) FOR CORONARY ANGIOGRAPHY WITHOUT CONCOMITANT LEFT HEART CATHETERIZATION	93451-93461
93510	LEFT HEART CATHETERIZATION, RETROGRADE, FROM THE BRACHIAL ARTERY, AXILLARY ARTERY OR FEMORAL ARTERY; PERCUTANEOUS	93451-93461
93511	LEFT HEART CATHETERIZATION, RETROGRADE, FROM THE BRACHIAL ARTERY, AXILLARY ARTERY OR FEMORAL ARTERY; BY CUTDOWN	93451-93461
93514	LEFT HEART CATHETERIZATION BY LEFT VENTRICULAR PUNCTURE	93451-93461
93524	COMBINED TRANSSEPTAL AND RETROGRADE LEFT HEART CATHETERIZATION	93451-93461
93526	COMBINED RIGHT HEART CATHETERIZATION AND RETROGRADE LEFT HEART CATHETERIZATION	93451-93461
93527	COMBINED RIGHT HEART CATHETERIZATION AND TRANSSEPTAL LEFT HEART CATHETERIZATION THROUGH INTACT SEPTUM (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)	93451-93461
93528	COMBINED RIGHT HEART CATHETERIZATION WITH LEFT VENTRICULAR PUNCTURE (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)	93451-93461
93529	COMBINED RIGHT HEART CATHETERIZATION AND LEFT HEART CATHETERIZATION THROUGH EXISTING SEPTAL OPENING (WITH OR WITHOUT RETROGRADE LEFT HEART CATHETERIZATION)	93451-93461

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
93539	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR SELECTIVE OPACIFICATION OF ARTERIAL CONDUITS (E.G., INTERNAL MAMMARY), WHETHER NATIVE OR USED FOR BYPASS	93451-93461
93540	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR SELECTIVE OPACIFICATION OF AORTOCORONARY VENOUS BYPASS GRAFTS, 1 OR MORE CORONARY ARTERIES	93451-93461
93541	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR PULMONARY ANGIOGRAPHY	93451-93461
93542	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR SELECTIVE RIGHT VENTRICULAR OR RIGHT ATRIAL ANGIOGRAPHY	93451-93461
93543	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR SELECTIVE LEFT VENTRICULAR OR LEFT ATRIAL ANGIOGRAPHY	93451-93461
93544	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR AORTOGRAPHY	93451-93461
93545	INJECTION PROCEDURE DURING CARDIAC CATHETERIZATION; FOR SELECTIVE CORONARY ANGIOGRAPHY (INJECTION OF RADIOPAQUE MATERIAL MAY BE BY HAND)	93451-93461
93555	IMAGING SUPERVISION, INTERPRETATION AND REPORT FOR INJECTION PROCEDURE(S) DURING CARDIAC CATHETERIZATION; VENTRICULAR AND/OR ATRIAL ANGIOGRAPHY	NA
93556	IMAGING SUPERVISION, INTERPRETATION AND REPORT FOR INJECTION PROCEDURE(S) DURING CARDIAC CATHETERIZATION; PULMONARY ANGIOGRAPHY, AORTOGRAPHY, AND/OR SELECTIVE CORONARY ANGIOGRAPHY INCLUDING VENOUS BYPASS GRAFTS AND ARTERIAL CONDUITS	NA
96445	CHEMOTHERAPY ADMINISTRATION INTO PERITONEAL CAVITY, REQUIRING AND INCLUDING PERITONEOCENTESIS	96446
C9255	INJECTION, PALIPERIDONE PALMITATE, 1 MG	J2426
C9256	INJECTION, DEXAMETHASONE INTRAVITREAL IMPLANT, 0.1 MG	J7312

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Procedure Code	Description	Alternate Codes for Consideration
C9258	INJECTION, TELAVANCIN, 10 MG	J3095
C9259	INJECTION, PRALATREXATE, 1 MG	J9307
C9260	INJECTION, OFATUMUMAB, 10 MG	J9302
C9261	INJECTION, USTEKINUMAB, 1 MG	J3357
C9262	FLUDARABINE PHOSPHATE, ORAL, 1 MG	Q2025
C9263	INJECTION, ECALLANTIDE, 1 MG	J1290
C9264	INJECTION, TOCILIZUMAB, 1 MG	J3262
C9265	INJECTION, ROMIDEPSIN, 1 MG	93152
C9266	INJECTION, COLLAGENASE CLOSTRIDIUM HISTOLYTICUM, 0.1 MG	J0775
C9267	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, PER 100 IU VWF: RCO	J7184
C9268	CAPSAICIN, PATCH, 10CM2	J7375
C9269	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS	J9315
C9271	INJECTION, VELAGLUCERASE ALFA, 100 UNITS	J3385
C9801	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTERMEDIATE, GREATER THAN 3 MINUTES, UP TO 10 MINUTES	S9075
C9802	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTENSIVE, GREATER THAN 10 MINUTES	S9075
E0220	HOT WATER BOTTLE	A9273
E0230	ICE CAP OR COLLAR	A9273
E0238	NON-ELECTRIC HEAT PAD, MOIST	A9273
G0430	DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE	G0434
G8006	ACUTE MYOCARDIAL INFARCTION: PATIENT DOCUMENTED TO HAVE RECEIVED ASPIRIN AT ARRIVAL	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8007	ACUTE MYOCARDIAL INFARCTION: PATIENT NOT DOCUMENTED TO HAVE RECEIVED ASPIRIN AT ARRIVAL	NA
G8008	CLINICIAN DOCUMENTED THAT ACUTE MYOCARDIAL INFARCTION PATIENT WAS NOT AN ELIGIBLE CANDIDATE TO RECEIVE ASPIRIN AT ARRIVAL MEASURE	NA
G8009	ACUTE MYOCARDIAL INFARCTION: PATIENT DOCUMENTED TO HAVE RECEIVED BETA-BLOCKER AT ARRIVAL	NA
G8010	ACUTE MYOCARDIAL INFARCTION: PATIENT NOT DOCUMENTED TO HAVE RECEIVED BETA-BLOCKER AT ARRIVAL	NA
G8011	CLINICIAN DOCUMENTED THAT ACUTE MYOCARDIAL INFARCTION PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR BETA-BLOCKER AT ARRIVAL MEASURE	NA
G8012	PNEUMONIA: PATIENT DOCUMENTED TO HAVE RECEIVED ANTIBIOTIC WITHIN 4 HOURS OF PRESENTATION	NA
G8013	PNEUMONIA: PATIENT NOT DOCUMENTED TO HAVE RECEIVED ANTIBIOTIC WITHIN 4 HOURS OF PRESENTATION	NA
G8014	CLINICIAN DOCUMENTED THAT PNEUMONIA PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIBIOTIC WITHIN 4 HOURS OF PRESENTATION MEASURE	NA
G8015	DIABETIC PATIENT WITH MOST RECENT HEMOGLOBIN A1C LEVEL (WITHIN THE LAST 6 MONTHS) DOCUMENTED AS GREATER THAN 9%	NA
G8016	DIABETIC PATIENT WITH MOST RECENT HEMOGLOBIN A1C LEVEL (WITHIN THE LAST 6 MONTHS) DOCUMENTED AS LESS THAN OR EQUAL TO 9%	NA
G8017	CLINICIAN DOCUMENTED THAT DIABETIC PATIENT WAS NOT ELIGIBLE CANDIDATE FOR HEMOGLOBIN A1C MEASURE	NA
G8018	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC PATIENT FOR THE REQUIRED TIME FOR HEMOGLOBIN A1C MEASURE (6 MONTHS)	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8019	DIABETIC PATIENT WITH MOST RECENT LOW-DENSITY LIPOPROTEIN (WITHIN THE LAST 12 MONTHS) DOCUMENTED AS GREATER THAN OR EQUAL TO 100 MG/DL	NA
G8020	DIABETIC PATIENT WITH MOST RECENT LOW-DENSITY LIPOPROTEIN (WITHIN THE LAST 12 MONTHS) DOCUMENTED AS LESS THAN 100 MG/DL	NA
G8021	CLINICIAN DOCUMENTED THAT DIABETIC PATIENT WAS NOT ELIGIBLE CANDIDATE FOR LOW-DENSITY LIPOPROTEIN MEASURE	NA
G8022	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC PATIENT FOR THE REQUIRED TIME FOR LOW-DENSITY LIPOPROTEIN MEASURE (12 MONTHS)	NA
G8023	DIABETIC PATIENT WITH MOST RECENT BLOOD PRESSURE (WITHIN THE LAST 6 MONTHS) DOCUMENTED AS EQUAL TO OR GREATER THAN 140 SYSTOLIC OR EQUAL TO OR GREATER THAN 80 MMHG DIASTOLIC	NA
G8024	DIABETIC PATIENT WITH MOST RECENT BLOOD PRESSURE (WITHIN THE LAST 6 MONTHS) DOCUMENTED AS LESS THAN 140 SYSTOLIC AND LESS THAN 80 DIASTOLIC	NA
G8025	CLINICIAN DOCUMENTED THAT THE DIABETIC PATIENT WAS NOT ELIGIBLE CANDIDATE FOR BLOOD PRESSURE MEASURE	NA
G8026	CLINICIAN HAS NOT PROVIDED CARE FOR THE DIABETIC PATIENT FOR THE REQUIRED TIME FOR BLOOD PRESSURE MEASURE (WITHIN THE LAST 6 MONTHS)	NA
G8027	HEART FAILURE PATIENT WITH LEFT VENTRICULAR SYSTOLIC DYSFUNCTION (LVSD) DOCUMENTED TO BE ON EITHER ANGIOTENSIN-CONVERTING ENZYME INHIBITOR OR ANGIOTENSIN-RECEPTOR BLOCKER (ACE-I OR ARB) THERAPY	NA
G8028	HEART FAILURE PATIENT WITH LEFT VENTRICULAR SYSTOLIC DYSFUNCTION (LVSD) NOT DOCUMENTED TO BE ON EITHER ANGIOTENSIN-CONVERTING ENZYME INHIBITOR OR ANGIOTENSIN-RECEPTOR BLOCKER (ACE-I OR ARB) THERAPY	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8029	CLINICIAN DOCUMENTED THAT HEART FAILURE PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR EITHER ANGIOTENSIN-CONVERTING ENZYME INHIBITOR OR ANGIOTENSIN-RECEPTOR BLOCKER (ACE-I OR ARB) THERAPY MEASURE	NA
G8030	HEART FAILURE PATIENT WITH LEFT VENTRICULAR SYSTOLIC DYSFUNCTION (LVSD) DOCUMENTED TO BE ON BETA-BLOCKER THERAPY	NA
G8031	HEART FAILURE PATIENT WITH LEFT VENTRICULAR SYSTOLIC DYSFUNCTION (LVSD) NOT DOCUMENTED TO BE ON BETA-BLOCKER THERAPY	NA
G8032	CLINICIAN DOCUMENTED THAT HEART FAILURE PATIENT WAS NOT ELIGIBLE CANDIDATE FOR BETA-BLOCKER THERAPY MEASURE	NA
G8033	PRIOR MYOCARDIAL INFARCTION – CORONARY ARTERY DISEASE PATIENT DOCUMENTED TO BE ON BETA-BLOCKER THERAPY	NA
G8034	PRIOR MYOCARDIAL INFARCTION – CORONARY ARTERY DISEASE PATIENT NOT DOCUMENTED TO BE ON BETA-BLOCKER THERAPY	NA
G8035	CLINICIAN DOCUMENTED THAT PRIOR MYOCARDIAL INFARCTION – CORONARY ARTERY DISEASE PATIENT WAS NOT ELIGIBLE CANDIDATE FOR BETA-BLOCKER THERAPY MEASURE	NA
G8036	CORONARY ARTERY DISEASE PATIENT DOCUMENTED TO BE ON ANTIPLATELET THERAPY	NA
G8037	CORONARY ARTERY DISEASE PATIENT NOT DOCUMENTED TO BE ON ANTIPLATELET THERAPY	NA
G8038	CLINICIAN DOCUMENTED THAT CORONARY ARTERY DISEASE PATIENT WAS NOT ELIGIBLE CANDIDATE FOR ANTIPLATELET THERAPY MEASURE	NA
G8039	CORONARY ARTERY DISEASE – PATIENT WITH LOW-DENSITY LIPOPROTEIN DOCUMENTED TO BE GREATER THAN 100MG/DL	NA
G8040	CORONARY ARTERY DISEASE – PATIENT WITH LOW-DENSITY LIPOPROTEIN DOCUMENTED TO BE LESS THAN OR EQUAL TO 100MG/DL	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8041	CLINICIAN DOCUMENTED THAT CORONARY ARTERY DISEASE PATIENT WAS NOT ELIGIBLE CANDIDATE FOR LOW-DENSITY LIPOPROTEIN MEASURE	NA
G8051	PATIENT (FEMALE) DOCUMENTED TO HAVE BEEN ASSESSED FOR OSTEOPOROSIS	NA
G8052	PATIENT (FEMALE) NOT DOCUMENTED TO HAVE BEEN ASSESSED FOR OSTEOPOROSIS	NA
G8053	CLINICIAN DOCUMENTED THAT (FEMALE) PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR OSTEOPOROSIS ASSESSMENT MEASURE	NA
G8054	PATIENT NOT DOCUMENTED FOR THE ASSESSMENT FOR FALLS WITHIN LAST 12 MONTHS	NA
G8055	PATIENT DOCUMENTED FOR THE ASSESSMENT FOR FALLS WITHIN LAST 12 MONTHS	NA
G8056	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR THE FALLS ASSESSMENT MEASURE WITHIN THE LAST 12 MONTHS	NA
G8057	PATIENT DOCUMENTED TO HAVE RECEIVED HEARING ASSESSMENT	NA
G8058	PATIENT NOT DOCUMENTED TO HAVE RECEIVED HEARING ASSESSMENT	NA
G8059	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR HEARING ASSESSMENT MEASURE	NA
G8060	PATIENT DOCUMENTED FOR THE ASSESSMENT OF URINARY INCONTINENCE	NA
G8061	PATIENT NOT DOCUMENTED FOR THE ASSESSMENT OF URINARY INCONTINENCE	NA
G8062	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR URINARY INCONTINENCE ASSESSMENT MEASURE	NA
G8075	END STAGE RENAL DISEASE PATIENT WITH DOCUMENTED DIALYSIS DOSE OF URR GREATER THAN OR EQUAL TO 65% (OR KT/V GREATER THAN OR EQUAL TO 1.2)	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8076	END STAGE RENAL DISEASE PATIENT WITH DOCUMENTED DIALYSIS DOSE OF URR LESS THAN 65% (OR KT/V LESS THAN 1.2)	NA
G8077	CLINICIAN DOCUMENTED THAT END STAGE RENAL DISEASE PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR URR OR KT/V MEASURE	NA
G8078	END STAGE RENAL DISEASE PATIENT WITH DOCUMENTED HEMATOCRIT GREATER THAN OR EQUAL TO 33 (OR HEMOGLOBIN GREATER THAN OR EQUAL TO 11)	NA
G8079	END STAGE RENAL DISEASE PATIENT WITH DOCUMENTED HEMATOCRIT LESS THAN 33 (OR HEMOGLOBIN LESS THAN 11)	NA
G8080	CLINICIAN DOCUMENTED THAT END STAGE RENAL DISEASE PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR HEMATOCRIT (HEMOGLOBIN) MEASURE	NA
G8081	END STAGE RENAL DISEASE PATIENT REQUIRING HEMODIALYSIS VASCULAR ACCESS DOCUMENTED TO HAVE RECEIVED AUTOGENOUS AV FISTULA	NA
G8082	END STAGE RENAL DISEASE PATIENT REQUIRING HEMODIALYSIS DOCUMENTED TO HAVE RECEIVED VASCULAR ACCESS OTHER THAN AUTOGENOUS AV FISTULA	NA
G8085	END-STAGE RENAL DISEASE PATIENT REQUIRING HEMODIALYSIS VASCULAR ACCESS WAS NOT AN ELIGIBLE CANDIDATE FOR AUTOGENOUS AV FISTULA	NA
G8093	NEWLY DIAGNOSED CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PATIENT DOCUMENTED TO HAVE RECEIVED SMOKING CESSATION INTERVENTION, WITHIN 3 MONTHS OF DIAGNOSIS	NA
G8094	NEWLY DIAGNOSED CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PATIENT NOT DOCUMENTED TO HAVE RECEIVED SMOKING CESSATION INTERVENTION, WITHIN 3 MONTHS OF DIAGNOSIS	NA
G8099	OSTEOPOROSIS PATIENT DOCUMENTED TO HAVE BEEN PRESCRIBED CALCIUM AND VITAMIN D SUPPLEMENTS	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8100	CLINICIAN DOCUMENTED THAT OSTEOPOROSIS PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR CALCIUM AND VITAMIN D SUPPLEMENT MEASURE	NA
G8103	NEWLY DIAGNOSED OSTEOPOROSIS PATIENTS DOCUMENTED TO HAVE BEEN TREATED WITH ANTIRESORPTIVE THERAPY AND/OR PTH WITHIN 3 MONTHS OF DIAGNOSIS	NA
G8104	CLINICIAN DOCUMENTED THAT NEWLY DIAGNOSED OSTEOPOROSIS PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIRESORPTIVE THERAPY AND/OR PTH TREATMENT MEASURE WITHIN 3 MONTHS OF DIAGNOSIS	NA
G8106	WITHIN 6 MONTHS OF SUFFERING A NONTRAUMATIC FRACTURE, FEMALE PATIENT 65 YEARS OF AGE OR OLDER DOCUMENTED TO HAVE UNDERGONE BONE MINERAL DENSITY TESTING OR TO HAVE BEEN PRESCRIBED A DRUG TO TREAT OR PREVENT OSTEOPOROSIS	NA
G8107	CLINICIAN DOCUMENTED THAT FEMALE PATIENT 65 YEARS OF AGE OR OLDER WHO SUFFERED A NONTRAUMATIC FRACTURE WITHIN THE LAST 6 MONTHS WAS NOT AN ELIGIBLE CANDIDATE FOR MEASURE TO TEST BONE MINERAL DENSITY OR DRUG TO TREAT OR PREVENT OSTEOPOROSIS	NA
G8108	PATIENT DOCUMENTED TO HAVE RECEIVED INFLUENZA VACCINATION DURING INFLUENZA SEASON	NA
G8109	PATIENT NOT DOCUMENTED TO HAVE RECEIVED INFLUENZA VACCINATION DURING INFLUENZA SEASON	NA
G8110	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR INFLUENZA VACCINATION MEASURE	NA
G8111	PATIENT (FEMALE) DOCUMENTED TO HAVE RECEIVED A MAMMOGRAM DURING THE MEASUREMENT YEAR OR PRIOR YEAR TO THE MEASUREMENT YEAR	NA
G8112	PATIENT (FEMALE) NOT DOCUMENTED TO HAVE RECEIVED A MAMMOGRAM DURING THE MEASUREMENT YEAR OR PRIOR YEAR TO THE MEASUREMENT YEAR	NA
G8113	CLINICIAN DOCUMENTED THAT FEMALE PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MAMMOGRAPHY MEASURE	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8114	CLINICIAN DID NOT PROVIDE CARE TO PATIENT FOR THE REQUIRED TIME OF MAMMOGRAPHY MEASURE (I.E., MEASUREMENT YEAR OR PRIOR YEAR)	NA
G8115	PATIENT DOCUMENTED TO HAVE RECEIVED PNEUMOCOCCAL VACCINATION	NA
G8116	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PNEUMOCOCCAL VACCINATION	NA
G8117	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR PNEUMOCOCCAL VACCINATION MEASURE	NA
G8129	PATIENT DOCUMENTED AS BEING TREATED WITH ANTIDEPRESSANT MEDICATION FOR AT LEAST 6 MONTHS CONTINUOUS TREATMENT PHASE	NA
G8130	PATIENT NOT DOCUMENTED AS BEING TREATED WITH ANTIDEPRESSANT MEDICATION FOR AT LEAST 6 MONTHS CONTINUOUS TREATMENT PHASE	NA
G8131	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIDEPRESSANT MEDICATION FOR CONTINUOUS TREATMENT PHASE	NA
G8152	PATIENT DOCUMENTED TO HAVE RECEIVED ANTIBIOTIC PROPHYLAXIS ONE HOUR PRIOR TO INCISION TIME (TWO HOURS FOR VANCOMYCIN)	NA
G8153	PATIENT NOT DOCUMENTED TO HAVE RECEIVED ANTIBIOTIC PROPHYLAXIS ONE HOUR PRIOR TO INCISION TIME (TWO HOURS FOR VANCOMYCIN)	NA
G8154	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIBIOTIC PROPHYLAXIS ONE HOUR PRIOR TO INCISION TIME (TWO HOURS FOR VANCOMYCIN) MEASURE	NA
G8155	PATIENT WITH DOCUMENTED RECEIPT OF THROMBOEMBOLISM PROPHYLAXIS	NA
G8156	PATIENT WITHOUT DOCUMENTED RECEIPT OF THROMBOEMBOLISM PROPHYLAXIS	NA
G8157	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR THROMBOEMBOLISM PROPHYLAXIS MEASURE	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8159	PATIENT DOCUMENTED TO HAVE RECEIVED CORONARY ARTERY BYPASS GRAFT WITHOUT USE OF INTERNAL MAMMARY ARTERY	NA
G8162	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT NOT DOCUMENTED TO HAVE RECEIVED PRE-OPERATIVE BETA-BLOCKADE	NA
G8164	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT DOCUMENTED TO HAVE PROLONGED INTUBATION	NA
G8165	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT NOT DOCUMENTED TO HAVE PROLONGED INTUBATION	NA
G8166	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT DOCUMENTED TO HAVE REQUIRED SURGICAL RE-EXPLORATION	NA
G8167	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT DID NOT REQUIRE SURGICAL RE-EXPLORATION	NA
G8170	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT DOCUMENTED TO HAVE BEEN DISCHARGED ON ASPIRIN OR CLOPIDOGREL	NA
G8171	PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT NOT DOCUMENTED TO HAVE BEEN DISCHARGED ON ASPIRIN OR CLOPIDOGREL	NA
G8172	CLINICIAN DOCUMENTED THAT PATIENT WITH ISOLATED CORONARY ARTERY BYPASS GRAFT WAS NOT AN ELIGIBLE CANDIDATE FOR ANTIPLATELET THERAPY AT DISCHARGE MEASURE	NA
G8182	CLINICIAN HAS NOT PROVIDED CARE FOR THE CARDIAC PATIENT FOR THE REQUIRED TIME FOR LOW-DENSITY LIPOPROTEIN MEASURE (6 MONTHS)	NA
G8183	PATIENT WITH HEART FAILURE AND ATRIAL FIBRILLATION DOCUMENTED TO BE ON WARFARIN THERAPY	NA
G8184	CLINICIAN DOCUMENTED THAT PATIENT WITH HEART FAILURE AND ATRIAL FIBRILLATION WAS NOT AN ELIGIBLE CANDIDATE FOR WARFARIN THERAPY MEASURE	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8185	PATIENTS DIAGNOSED WITH SYMPTOMATIC OSTEOARTHRITIS WITH DOCUMENTED ANNUAL ASSESSMENT OF FUNCTION AND PAIN	NA
G8186	CLINICIAN DOCUMENTED THAT SYMPTOMATIC OSTEOARTHRITIS PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANNUAL ASSESSMENT OF FUNCTION AND PAIN MEASURE	NA
G8193	CLINICIAN DID NOT DOCUMENT THAT AN ORDER FOR PROPHYLACTIC ANTIBIOTIC TO BE GIVEN WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	NA
G8196	CLINICIAN DID NOT DOCUMENT A PROPHYLACTIC ANTIBIOTIC WAS ADMINISTERED WITHIN ONE HOUR (IF VANCOMYCIN, TWO HOURS) PRIOR TO SURGICAL INCISION (OR START OF PROCEDURE WHEN NO INCISION IS REQUIRED)	NA
G8200	ORDER FOR CEFAZOLIN OR CEFUROXIME FOR ANTIMICROBIAL PROPHYLAXIS NOT DOCUMENTED	NA
G8204	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 24 HOURS OF SURGICAL END TIME	NA
G8209	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN TO DISCONTINUE PROPHYLACTIC ANTIBIOTICS WITHIN 48 HOURS OF SURGICAL END TIME	NA
G8214	CLINICIAN DID NOT DOCUMENT AN ORDER WAS GIVEN FOR APPROPRIATE VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS TO BE GIVEN WITHIN 24 HRS PRIOR TO INCISION TIME OR 24 HOURS AFTER SURGERY END TIME	NA
G8217	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2	NA
G8219	PATIENT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2	NA
G8220	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DVT PROPHYLAXIS BY END OF HOSPITAL DAY 2	NA
G8221	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR DVT PROPHYLAXIS BY THE END OF HOSPITAL DAY 2, INCLUDING PHYSICIAN DOCUMENTATION THAT PATIENT IS AMBULATORY	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8223	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PRESCRIPTION FOR ANTIPLATELET THERAPY AT DISCHARGE	NA
G8226	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PRESCRIPTION FOR ANTICOAGULANT THERAPY AT DISCHARGE	NA
G8231	PATIENT NOT DOCUMENTED TO HAVE RECEIVED T-PA OR NOT DOCUMENTED TO HAVE BEEN CONSIDERED A CANDIDATE FOR T-PA ADMINISTRATION	NA
G8234	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DYSPHAGIA SCREENING	NA
G8238	PATIENT NOT DOCUMENTED TO HAVE RECEIVED ORDER FOR OR CONSIDERATION FOR REHABILITATION SERVICES	NA
G8240	INTERNAL CAROTID STENOSIS PATIENT IN THE 30-99% RANGE, AND NO DOCUMENTATION OF REFERENCE TO MEASUREMENTS OF DISTAL INTERNAL CAROTID DIAMETER AS THE DENOMINATOR FOR STENOSIS MEASUREMENT	NA
G8243	PATIENT NOT DOCUMENTED TO HAVE RECEIVED CT OR MRI AND THE PRESENCE OR ABSENCE OF HEMORRHAGE, MASS LESION AND ACUTE INFARCTION NOT DOCUMENTED IN THE FINAL REPORT	NA
G8246	PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR MEDICAL HISTORY REVIEW WITH ASSESSMENT OF NEW OR CHANGING MOLES	NA
G8248	PATIENT WITH AT LEAST ONE ALARM SYMPTOM NOT DOCUMENTED TO HAVE HAD UPPER ENDOSCOPY OR REFERRAL FOR UPPER ENDOSCOPY	NA
G8251	PATIENT NOT DOCUMENTED TO HAVE RECEIVED AN ESOPHAGEAL BIOPSY WHEN SUSPICION OF BARRETT'S ESOPHAGUS IS INDICATED IN THE ENDOSCOPY REPORT	NA
G8254	PATIENT WITH NO DOCUMENTATION ORDER FOR BARIUM SWALLOW TEST	NA
G8257	CLINICIAN HAS NOT DOCUMENTED RECONCILIATION OF DISCHARGE MEDICATIONS WITH CURRENT MEDICATION LIST IN MEDICAL RECORD	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8260	PATIENT NOT DOCUMENTED TO HAVE SURROGATE DECISION MAKER OR ADVANCE CARE PLAN IN MEDICAL RECORD	NA
G8263	PATIENT NOT DOCUMENTED TO HAVE BEEN ASSESSED FOR PRESENCE OR ABSENCE OF URINARY INCONTINENCE	NA
G8266	PATIENT NOT DOCUMENTED TO HAVE RECEIVED CHARACTERIZATION OF URINARY INCONTINENCE	NA
G8268	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PLAN OF CARE FOR URINARY INCONTINENCE	NA
G8271	PATIENT WITH NO DOCUMENTATION OF SCREENING FOR FALL RISKS (2 OR MORE FALLS IN THE PAST YEAR OR ANY FALL WITH INJURY IN THE PAST YEAR)	NA
G8274	CLINICIAN HAS NOT DOCUMENTED PRESENCE OR ABSENCE OF ALARM SYMPTOMS	NA
G8276	PATIENT NOT DOCUMENTED TO HAVE RECEIVED MEDICAL HISTORY WITH ASSESSMENT OF NEW OR CHANGING MOLES	NA
G8279	PATIENT NOT DOCUMENTED TO HAVE RECEIVED A COMPLETE PHYSICAL SKIN EXAM	NA
G8282	PATIENT NOT DOCUMENTED TO HAVE RECEIVED COUNSELING TO PERFORM A SELF-EXAMINATION	NA
G8285	PATIENT NOT DOCUMENTED TO HAVE RECEIVED PHARMACOLOGIC THERAPY	NA
G8289	PATIENT WITH NO DOCUMENTATION OF CALCIUM AND VITAMIN D USE OR COUNSELING REGARDING BOTH CALCIUM AND VITAMIN D USE, OR EXERCISE	NA
G8293	COPD PATIENT WITHOUT SPIROMETRY RESULTS DOCUMENTED	NA
G8296	COPD PATIENT NOT DOCUMENTED TO HAVE INHALED BRONCHODILATOR THERAPY PRESCRIBED	NA
G8298	PATIENT DOCUMENTED TO HAVE RECEIVED OPTIC NERVE HEAD EVALUATION	NA
G8299	PATIENT NOT DOCUMENTED TO HAVE RECEIVED OPTIC NERVE HEAD EVALUATION	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8302	PATIENT DOCUMENTED TO HAVE A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL	NA
G8303	PATIENT NOT DOCUMENTED TO HAVE A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL	NA
G8304	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR A SPECIFIC TARGET INTRAOCULAR PRESSURE RANGE GOAL	NA
G8305	CLINICIAN HAS NOT PROVIDED CARE FOR THE PRIMARY OPEN-ANGLE GLAUCOMA PATIENT FOR THE REQUIRED TIME FOR TREATMENT RANGE GOAL DOCUMENTATION MEASUREMENT	NA
G8306	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE ABOVE THE TARGET RANGE GOAL DOCUMENTED TO HAVE RECEIVED PLAN OF CARE	NA
G8307	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE AT OR BELOW GOAL, NO PLAN OF CARE NECESSARY	NA
G8308	PRIMARY OPEN-ANGLE GLAUCOMA PATIENT WITH INTRAOCULAR PRESSURE ABOVE THE TARGET RANGE GOAL, AND NOT DOCUMENTED TO HAVE RECEIVED PLAN OF CARE DURING THE REPORTING YEAR	NA
G8310	PATIENT NOT DOCUMENTED TO HAVE BEEN PRESCRIBED/RECOMMENDED AT LEAST ONE ANTIOXIDANT VITAMIN OR MINERAL SUPPLEMENT DURING THE REPORTING YEAR	NA
G8314	PATIENT NOT DOCUMENTED TO HAVE RECEIVED MACULAR EXAM WITH DOCUMENTATION OF PRESENCE OR ABSENCE OF MACULAR THICKENING OR HEMORRHAGE AND NO DOCUMENTATION OF LEVEL OF MACULAR DEGENERATION SEVERITY	NA
G8318	PATIENT DOCUMENTED NOT TO HAVE VISUAL FUNCTIONAL STATUS ASSESSED	NA
G8322	PATIENT NOT DOCUMENTED TO HAVE HAD PRE-SURGICAL AXIAL LENGTH, CORNEAL POWER MEASUREMENT AND METHOD OF INTRAOCULAR LENS POWER CALCULATION	NA
G8326	PATIENT NOT DOCUMENTED TO HAVE RECEIVED FUNDUS EVALUATION WITHIN SIX MONTHS PRIOR TO CATARACT SURGERY	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8330	PATIENT NOT DOCUMENTED TO HAVE RECEIVED DILATED MACULAR OR FUNDUS EXAM WITH LEVEL OF SEVERITY OF RETINOPATHY AND THE PRESENCE OR ABSENCE OF MACULAR EDEMA NOT DOCUMENTED	NA
G8334	DOCUMENTATION OF FINDINGS OF MACULAR OR FUNDUS EXAM NOT COMMUNICATED TO THE PHYSICIAN MANAGING THE PATIENT'S ONGOING DIABETES CARE	NA
G8338	CLINICIAN HAS NOT DOCUMENTED THAT COMMUNICATION WAS SENT TO THE PHYSICIAN MANAGING ONGOING CARE OF PATIENT THAT A FRACTURE OCCURRED AND THAT THE PATIENT WAS OR SHOULD BE TESTED OR TREATED FOR OSTEOPOROSIS	NA
G8341	PATIENT NOT DOCUMENTED TO HAVE HAD CENTRAL DEXA MEASUREMENT OR PHARMACOLOGIC THERAPY	NA
G8345	PATIENT NOT DOCUMENTED TO HAVE HAD CENTRAL DEXA MEASUREMENT ORDERED OR PERFORMED OR PHARMACOLOGIC THERAPY	NA
G8351	PATIENT NOT DOCUMENTED TO HAVE HAD ECG	NA
G8354	PATIENT NOT DOCUMENTED TO HAVE RECEIVED OR TAKEN ASPIRIN 24 HOURS BEFORE EMERGENCY DEPARTMENT ARRIVAL OR DURING EMERGENCY DEPARTMENT STAY	NA
G8357	PATIENT NOT DOCUMENTED TO HAVE HAD ECG	NA
G8360	PATIENT NOT DOCUMENTED TO HAVE VITAL SIGNS RECORDED AND REVIEWED	NA
G8362	PATIENT NOT DOCUMENTED TO HAVE OXYGEN SATURATION ASSESSED	NA
G8365	PATIENT NOT DOCUMENTED TO HAVE MENTAL STATUS ASSESSED	NA
G8367	PATIENT NOT DOCUMENTED TO HAVE APPROPRIATE EMPIRIC ANTIBIOTIC PRESCRIBED	NA
G8370	ASTHMA PATIENTS WITH NUMERIC FREQUENCY OF SYMPTOMS OR PATIENT COMPLETION OF AN ASTHMA ASSESSMENT TOOL/SURVEY/QUESTIONNAIRE NOT DOCUMENTED	NA
G8371	CHEMOTHERAPY DOCUMENTED AS NOT RECEIVED OR PRESCRIBED FOR STAGE III COLON CANCER PATIENTS	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8372	CHEMOTHERAPY DOCUMENTED AS RECEIVED OR PRESCRIBED FOR STAGE III COLON CANCER PATIENTS	NA
G8373	CHEMOTHERAPY PLAN DOCUMENTED PRIOR TO CHEMOTHERAPY ADMINISTRATION	NA
G8374	CHEMOTHERAPY PLAN NOT DOCUMENTED PRIOR TO CHEMOTHERAPY ADMINISTRATION	NA
G8375	CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) PATIENT WITH NO DOCUMENTATION OF BASELINE FLOW CYTOMETRY PERFORMED	NA
G8376	CLINICIAN DOCUMENTATION THAT BREAST CANCER PATIENT WAS NOT ELIGIBLE FOR TAMOXIFEN OR AROMATASE INHIBITOR THERAPY MEASURE	NA
G8377	CLINICIAN DOCUMENTATION THAT COLON CANCER PATIENT IS NOT ELIGIBLE FOR CHEMOTHERAPY MEASURE	NA
G8378	CLINICIAN DOCUMENTATION THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR RADIATION THERAPY MEASURE	NA
G8379	DOCUMENTATION OF RADIATION THERAPY RECOMMENDED WITHIN 12 MONTHS OF FIRST OFFICE VISIT	NA
G8380	FOR PATIENTS WITH ER OR PR POSITIVE, STAGE IC-III BREAST CANCER, CLINICIAN DID NOT DOCUMENT THAT THE PATIENT RECEIVED OR WAS PRESCRIBED TAMOXIFEN OR AROMATASE INHIBITOR	NA
G8381	FOR PATIENTS WITH ER OR PR POSITIVE, STAGE IC-III BREAST CANCER, CLINICIAN DOCUMENTED OR PRESCRIBED THAT THE PATIENT IS RECEIVING TAMOXIFEN OR AROMATASE INHIBITOR	NA
G8382	MULTIPLE MYELOMA PATIENTS WITH NO DOCUMENTATION OF PRESCRIBED OR RECEIVED INTRAVENOUS BISPHOSPHONATE THERAPY	NA
G8383	NO DOCUMENTATION OF RADIATION THERAPY RECOMMENDED WITHIN 12 MONTHS OF FIRST OFFICE VISIT	NA
G8384	BASELINE CYTOGENETIC TESTING NOT PERFORMED IN PATIENTS WITH MYELODYSPLASTIC SYNDROME (MDS) OR ACUTE LEUKEMIAS	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8385	DIABETIC PATIENTS WITH NO DOCUMENTATION OF HEMOGLOBIN A1C LEVEL (WITHIN THE LAST 12 MONTHS)	NA
G8386	DIABETIC PATIENTS WITH NO DOCUMENTATION OF LOW-DENSITY LIPOPROTEIN (WITHIN THE LAST 12 MONTHS)	NA
G8387	END-STAGE RENAL DISEASE PATIENT WITH A HEMATOCRIT OR HEMOGLOBIN NOT DOCUMENTED	NA
G8388	END-STAGE RENAL DISEASE PATIENT WITH URR OR KT/V VALUE NOT DOCUMENTED, BUT OTHERWISE ELIGIBLE FOR MEASURE	NA
G8389	MYELODYSPLASTIC SYNDROME (MDS) PATIENTS WITH NO DOCUMENTATION OF IRON STORES PRIOR TO RECEIVING ERYTHROPOIETIN THERAPY	NA
G8390	DIABETIC PATIENTS WITH NO DOCUMENTATION OF BLOOD PRESSURE MEASUREMENT (WITHIN THE LAST 12 MONTHS)	NA
G8391	PATIENTS WITH PERSISTENT ASTHMA, NO DOCUMENTATION OF PREFERRED LONG TERM CONTROL MEDICATION OR ACCEPTABLE ALTERNATIVE TREATMENT PRESCRIBED	NA
G8402	TOBACCO (SMOKE) USE CESSATION INTERVENTION, COUNSELING	NA
G8403	TOBACCO (SMOKE) USE CESSATION INTERVENTION NOT COUNSELED	NA
G8407	ABI MEASURED AND DOCUMENTED	NA
G8408	ABI MEASUREMENT WAS NOT OBTAINED	NA
G8409	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ABI MEASUREMENT MEASURE	NA
G8423	DOCUMENTED THAT PATIENT WAS SCREENED AND EITHER INFLUENZA VACCINATION STATUS IS CURRENT OR PATIENT WAS COUNSELED	NA
G8424	INFLUENZA VACCINE STATUS WAS NOT SCREENED	NA
G8425	INFLUENZA VACCINE STATUS SCREENED, PATIENT NOT CURRENT AND COUNSELING WAS NOT PROVIDED	NA
G8426	DOCUMENTED THAT PATIENT WAS NOT APPROPRIATE FOR SCREENING AND/OR COUNSELING ABOUT THE INFLUENZA VACCINE (E.G., ALLERGY TO EGGS)	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8429	INCOMPLETE OR NO PROVIDER DOCUMENTATION THAT PATIENT'S CURRENT MEDICATIONS WITH DOSAGES (INCLUDES PRESCRIPTION, OVER-THE-COUNTER, HERBALS, VITAMIN/MINERAL/DIETARY [NUTRITIONAL] SUPPLEMENTS) WERE ASSESSED	NA
G8434	DOCUMENTATION OF COGNITIVE IMPAIRMENT SCREENING USING A STANDARDIZED TOOL	NA
G8435	NO DOCUMENTATION OF COGNITIVE IMPAIRMENT SCREENING USING A STANDARDIZED TOOL	NA
G8436	PATIENT NOT ELIGIBLE/NOT APPROPRIATE FOR COGNITIVE IMPAIRMENT SCREENING	NA
G8437	DOCUMENTATION OF CLINICIAN AND PATIENT INVOLVEMENT WITH THE DEVELOPMENT OF A PLAN OF CARE INCLUDING SIGNATURE BY THE PRACTITIONER/THERAPIST AND EITHER A CO-SIGNATURE BY THE PATIENT OR DOCUMENTED VERBAL AGREEMENT OBTAINED FROM THE PATIENT OR, WHEN NEC	NA
G8438	NO DOCUMENTATION OF CLINICIAN AND PATIENT INVOLVEMENT WITH THE DEVELOPMENT OF A PLAN OF CARE INCLUDING SIGNATURE BY THE PRACTITIONER/THERAPIST AND EITHER A CO-SIGNATURE BY THE PATIENT OR DOCUMENTED VERBAL AGREEMENT OBTAINED FROM THE PATIENT	NA
G8439	DOCUMENTATION THAT PATIENT IS NOT ELIGIBLE FOR CO-DEVELOPING A PLAN OF CARE INCLUDING SIGNATURE BY THE PRACTITIONER/THERAPIST AND EITHER A CO-SIGNATURE BY THE PATIENT OR DOCUMENTED VERBAL AGREEMENT OBTAINED FROM THE PATIENT OR, WHEN NECESSARY	NA
G8443	ALL PRESCRIPTIONS CREATED DURING THE ENCOUNTER WERE GENERATED USING A QUALIFIED E-PRESCRIBING SYSTEM	NA
G8445	NO PRESCRIPTIONS WERE GENERATED DURING THE ENCOUNTER, PROVIDER DOES HAVE ACCESS TO A QUALIFIED E-PRESCRIBING SYSTEM	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8446	PROVIDER DOES HAVE ACCESS TO A QUALIFIED E-PRESCRIBING SYSTEM AND SOME OR ALL OF THE PRESCRIPTIONS GENERATED DURING THE ENCOUNTER WERE PRINTED OR PHONED IN AS REQUIRED BY STATE OR FEDERAL LAW OR REGULATIONS,	NA
G8449	PATIENT ENCOUNTER WAS NOT DOCUMENTED USING AN EMR DUE TO SYSTEM REASONS SUCH AS THE SYSTEM BEING INOPERABLE AT THE TIME OF THE VISIT; USE OF THIS CODE IMPLIES THAT AN EMR IS IN PLACE AND GENERALLY AVAILABLE	NA
G8453	TOBACCO USE CESSATION INTERVENTION, COUNSELING	NA
G8454	TOBACCO USE CESSATION INTERVENTION NOT COUNSELED, REASON NOT SPECIFIED	NA
G8455	CURRENT TOBACCO SMOKER	NA
G8456	CURRENT SMOKELESS TOBACCO USER	NA
G8457	CURRENT TOBACCO NON-USER	NA
G8466	CLINICIAN DOCUMENTED THAT PATIENT IS NOT AN ELIGIBLE CANDIDATE FOR SUICIDE RISK ASSESSMENT; MAJOR DEPRESSIVE DISORDER, IN REMISSION	NA
G8467	DOCUMENTATION OF NEW DIAGNOSIS OF INITIAL OR RECURRENT EPISODE OF MAJOR DEPRESSIVE DISORDER	NA
G8479	CLINICIAN PRESCRIBED ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	NA
G8480	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT AN ELIGIBLE CANDIDATE FOR ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY	NA
G8481	CLINICIAN DID NOT PRESCRIBE ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY, REASON NOT SPECIFIED	NA
G8488	CLINICIAN INTENDS TO REPORT THE END STAGE RENAL DISEASE (ESRD) MEASURE GROUP	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
G8507	PROVIDER DOCUMENTATION THAT PATIENT IS NOT ELIGIBLE FOR PATIENT VERIFICATION OF CURRENT MEDICATIONS	NA
G8518	CLINICAL STAGE PRIOR TO SURGERY FOR LUNG CANCER AND ESOPHAGEAL CANCER RESECTION WAS RECORDED	NA
G8519	CLINICIAN DOCUMENTED THAT PATIENT WAS NOT ELIGIBLE FOR CLINICAL STAGE PRIOR TO SURGERY FOR LUNG CANCER AND ESOPHAGEAL CANCER RESECTION MEASURE	NA
G8520	CLINICIAN STAGE PRIOR TO SURGERY FOR LUNG CANCER AND ESOPHAGEAL CANCER RESECTION WAS NOT RECORDED, REASON NOT SPECIFIED	NA
J0128	INJECTION, ABARELIX, 10 MG	NA
J0170	INJECTION, ADRENALIN, EPINEPHRINE, UP TO 1 ML AMPULE	NA
J0559	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, 2500 UNITS	NA
J0560	INJECTION, PENICILLIN G BENZATHINE, UP TO 600,000 UNITS	NA
J0570	INJECTION, PENICILLIN G BENZATHINE, UP TO 1,200,000 UNITS	NA
J0580	INJECTION, PENICILLIN G BENZATHINE, UP TO 2,400,000 UNITS	NA
J0704	INJECTION, BETAMETHASONE SODIUM PHOSPHATE, PER 4 MG	NA
J0970	INJECTION, ESTRADIOL VALERATE, UP TO 40 MG	NA
J1390	INJECTION, ESTRADIOL VALERATE, UP TO 20 MG	NA
J1470	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 2 CC	NA
J1480	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 3 CC	NA
J1490	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 4 CC	NA
J1500	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 5 CC	NA
J1510	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 6 CC	NA

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
J1520	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 7 CC	NA
J1530	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 8 CC	NA
J1540	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 9 CC	NA
J1550	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 10 CC	NA
J1785	INJECTION, IMIGLUCERASE, PER UNIT	NA
J1825	INJECTION, INTERFERON BETA-1A, 33 MCG	NA
J2321	INJECTION, NANDROLONE DECANOATE, UP TO 100 MG	NA
J2322	INJECTION, NANDROLONE DECANOATE, UP TO 200 MG	NA
J9062	CISPLATIN, 50 MG	NA
J9080	CYCLOPHOSPHAMIDE, 200 MG	NA
J9090	CYCLOPHOSPHAMIDE, 500 MG	NA
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM	NA
J9092	CYCLOPHOSPHAMIDE, 2.0 GRAM	NA
J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG	NA
J9094	CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG	NA
J9095	CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG	NA
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM	NA
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM	NA
J9110	INJECTION, CYTARABINE, 500 MG	NA
J9140	DACARBAZINE, 200 MG	NA
J9290	MITOMYCIN, 20 MG	NA
J9291	MITOMYCIN, 40 MG	NA
J9350	INJECTION, TOPOTECAN, 4 MG	NA
J9375	VINCRISTINE SULFATE, 2 MG	NA
J9380	VINCRISTINE SULFATE, 5 MG	NA
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	E2622

Table 2 – Deleted HCPCS Codes, Effective for Dates of Service on or Before December 31, 2010

Procedure Code	Description	Alternate Codes for Consideration
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	E2623
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	E2624
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	E2625
L3660	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4566
L3670	SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4566
L3672	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INLCUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3674
L3673	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, INCLUDES NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3674
L3675	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4566
Q2025	FLUDARABINE PHOSPHATE, ORAL, 1 MG	NA
Q4109	SKIN SUBSTITUTE, TISSUEMEND, PER SQUARE CENTIMETER	NA
S0146	INJECTION, PEGYLATED INTERFERON ALFA-2B, 10 MCG PER 0.5 ML	NA
S0161	CALCITROL, 0.25 MG	NA
S0196	INJECTABLE POLY-L-LACTIC ACID, RESTORATIVE IMPLANT, 1 ML, FACE (DEEP DERMIS, SUBCUTANEOUS LAYERS)	NA

*Table 3 – New 2011 Annual HCPCS Codes Under Review for **Pricing***

Procedure Code	Description
0234T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; RENAL ARTERY
0235T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; VISCERAL ARTERY (EXCEPT RENAL), EACH VESSEL
0236T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; ABDOMINAL AORTA
0237T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; BRACHIOCEPHALIC TRUNK AND BRANCHES, EACH VESSEL
0238T	TRANSLUMINAL PERIPHERAL ATHERECTOMY, OPEN OR PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; ILIAC ARTERY, EACH VESSEL
80104	DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE
88749	UNLISTED IN VIVO (E.G., TRANSCUTANEOUS) LABORATORY SERVICE
A4566	SHOULDER SLING OR VEST DESIGN, ABDUCTION RESTRAINER, WITH OR WITHOUT SWATHE CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE
C9274	CROTALIDAE POLYVALENT IMMUNE FAB (OVINE), 1 VIAL
C9276	INJECTION, CABAZITAXEL, 1 MG
C9278	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT - PERMANENT TOOTH
D3354	PULPAL REGENERATION (COMPLETION OF REGENERATIVE TREATMENT IN AN IMMATURE PERMANENT TOOTH WITH A NECROTIC PULP); DOES NOT INCLUDE FINAL RESTORATION
D5993	MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL
D7295	HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE

*Table 3 – New 2011 Annual HCPCS Codes Under Review for **Pricing***

E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER
Q4118	MATRISTEM MICROMATRIX, 1 MG
Q4119	MATRISTEM WOUND MATRIX, PER SQUARE CENTIMETER
Q4120	MATRISTEM BURN MATRIX, PER SQUARE CENTIMETER
Q4121	THERASKIN, PER SQUARE CENTIMETER

Table 4 – Outpatient Radiology Rates for UB-04 Claims Only

Procedure Code	Description	Outpatient Rate for UB-04 Claims Only	Effective Date of Rate
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL	**$100.87**	**1/1/2011**
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL	**$192.27**	**1/1/2011**
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR BOTH BODY REGIONS, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS IN ONE OR BOTH BODY REGIONS	**$254.30**	**1/1/2011**
76881	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL-TIME WITH IMAGE DOCUMENTATION; COMPLETE	**$65.91**	**1/1/2011**
76882	ULTRASOUND, EXTREMITY, NONVASCULAR, REAL-TIME WITH IMAGE DOCUMENTATION; LIMITED, ANATOMIC SPECIFIC	**$7.66**	**1/1/2011**