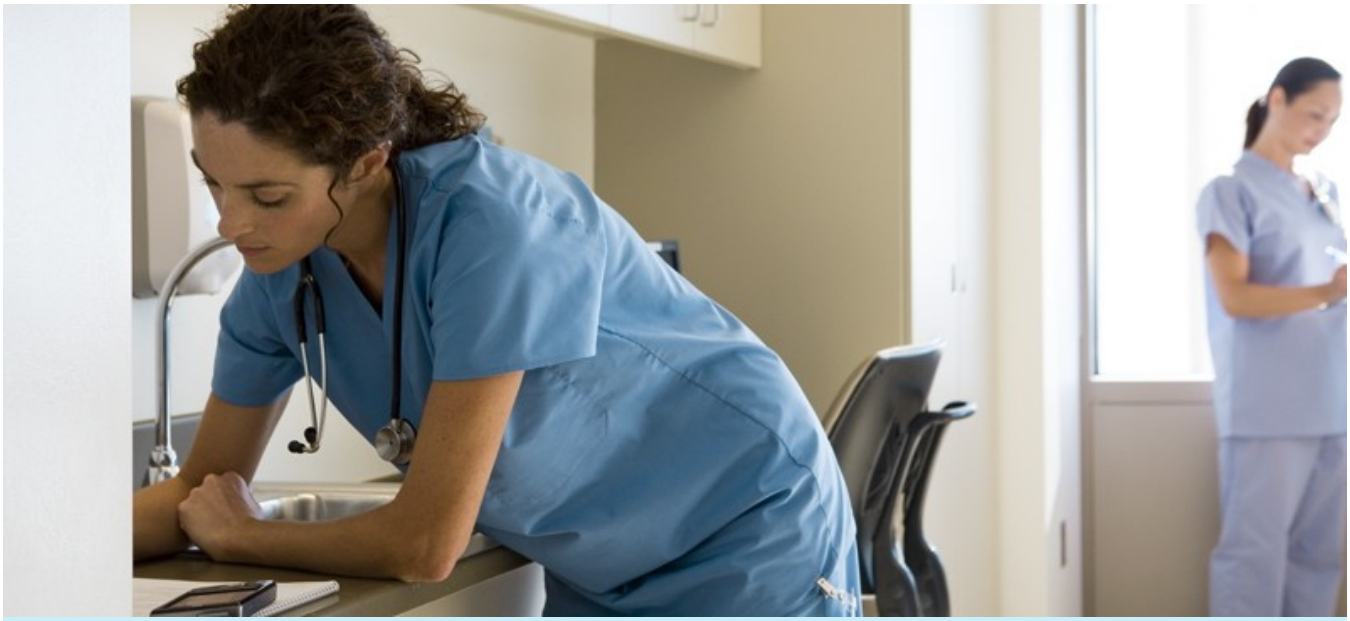
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201164 DECEMBER 29, 2011



Coverage and billing information for the 2012 annual HCPCS codes update

The Indiana Health Coverage Programs (IHCP) has reviewed the 2012 annual Healthcare Common Procedure Coding System (HCPCS) update to determine coverage and billing guidelines. This bulletin serves as notice of the following information:

- **Table 1**: A list of the new alphanumeric and Current Procedural Terminology (CPT®[1]) codes included in the 2012 annual HCPCS update, showing:
  - Procedure code
  - Description
  - Program coverage determination
  - Prior authorization (PA) requirements
  - Allowed modifiers
  - National Drug Code (NDC) requirements
- **Table 2**: A list of the new modifier codes for the 2012 annual HCPCS update by modifier, description, type, and effective date.
- **Table 3**: A list of deleted codes included in the 2012 annual HCPCS update, along with any alternate code considerations.

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- **Table 4**: A list of the new codes that are currently under review by the IHCP for coverage. Claims will deny for Explanation of Benefit 4021 – *Procedure code is not covered for the date of service for the program billed* until program coverage is determined. Updates to coverage determinations will be published in future bulletins and banners.
- **Table 5**: A list of new codes from Table 1 that are now under review by the IHCP for pricing. Until rates are established for these codes, claims including these codes will deny for Explanation of Benefit 4014 – *No pricing on file*. Notice of rates will be published in future bulletins.
- **Table 6**: A list of the outpatient radiology codes billed on the UB-04 Claim Form.

IHCP coverage and billing information in the tables on the following pages is effective January 1, 2012. The 2012 annual HCPCS update also included modifications to descriptions for some existing HCPCS codes. These modifications have not been published in this bulletin but are available for download from the Centers for Medicare & Medicaid Services (CMS) website at cms.gov.

Covered codes have been added to the Indiana*AIM* claims processing system and established rates posted on the Fee Schedule at indianamedicaid.com. Providers may bill these codes for dates of service on or after January 1, 2012. The standard global billing procedures and edits apply when using the new codes. Please note: In the tables on the following pages, "noncovered" indicates that the IHCP does not cover the service described for the code, while "nonreimbursable" indicates that the service described for the code is billable under another code or as part of a global procedure code.

[1] *CPT copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

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Table 1 – New 2012 Annual HCPCS Codes, Effective January 1, 2012

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
0276T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 1 LOBE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0277T	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 2 OR MORE LOBES	Non-Covered for All Programs, Non-Covered for Package C	NA	51	NA
0278T	TRANSCUTANEOUS ELECTRICAL MODULATION PAIN REPROCESSING (EG, SCRAMBLER THERAPY), EACH TREATMENT SESSION (INCLUDES PLACEMENT OF ELECTRODES)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0279T	CELL ENUMERATION USING IMMUNOLOGIC SELECTION AND IDENTIFICATION IN FLUID SPECIMEN (EG, CIRCULATING TUMOR CELLS IN BLOOD);	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0280T	CELL ENUMERATION USING IMMUNOLOGIC SELECTION AND IDENTIFICATION IN FLUID SPECIMEN (EG, CIRCULATING TUMOR CELLS IN BLOOD); INTERPRETATION AND REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0281T	PERCUTANEOUS TRANSCATHETER CLOSURE OF THE LEFT ATRIAL APPENDAGE WITH IMPLANT, INCLUDING FLUOROSCOPY, TRANSSEPTAL PUNCTURE, CATHETER PLACEMENT(S), LEFT ATRIAL ANGIOGRAPHY, LEFT ATRIAL APPENDAGE ANGIOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0282T	PERCUTANEOUS OR OPEN IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY(S), SUBCUTANEOUS (PERIPHERAL SUBCUTANEOUS FIELD STIMULATION), INCLUDING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	IMAGING GUIDANCE, WHEN PERFORMED, CERVICAL, THORACIC OR LUMBAR; FOR TRIAL, INCLUDING REMOVAL AT THE CONCLUSION OF TRIAL PERIOD				
0283T	PERCUTANEOUS OR OPEN IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY(S), SUBCUTANEOUS (PERIPHERAL SUBCUTANEOUS FIELD STIMULATION), INCLUDING IMAGING GUIDANCE, WHEN PERFORMED, CERVICAL, THORACIC OR LUMBAR; PERMANENT, WITH IMPLANTATION OF A PULSE GENERATOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0284T	REVISION OR REMOVAL OF PULSE GENERATOR OR ELECTRODES, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED, INCLUDING ADDITION OF NEW ELECTRODES, WHEN PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0285T	ELECTRONIC ANALYSIS OF IMPLANTED PERIPHERAL SUBCUTANEOUS FIELD STIMULATION PULSE GENERATOR, WITH REPROGRAMMING WHEN PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0286T	NEAR-INFRARED SPECTROSCOPY STUDIES OF LOWER EXTREMITY WOUNDS (EG, FOR OXYHEMOGLOBIN MEASUREMENT)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0287T	NEAR-INFRARED GUIDANCE FOR VASCULAR ACCESS REQUIRING REAL-TIME DIGITAL VISUALIZATION OF SUBCUTANEOUS VASCULATURE FOR EVALUATION OF POTENTIAL ACCESS SITES AND VESSEL PATENCY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0288T	ANOSCOPY, WITH DELIVERY OF THERMAL ENERGY TO THE MUSCLE OF THE ANAL CANAL (EG, FOR FECAL INCONTINENCE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0289T	CORNEAL INCISIONS IN THE	Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DONOR CORNEA CREATED USING A LASER, IN PREPARATION FOR PENETRATING OR LAMELLAR KERATOPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	for All Programs, Non-Covered for Package C			
0290T	CORNEAL INCISIONS IN THE RECIPIENT CORNEA CREATED USING A LASER, IN PREPARATION FOR PENETRATING OR LAMELLAR KERATOPLASTY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0291T	INTRAVASCULAR OPTICAL COHERENCE TOMOGRAPHY (CORONARY NATIVE VESSEL OR GRAFT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; INITIAL VESSEL (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0292T	INTRAVASCULAR OPTICAL COHERENCE TOMOGRAPHY (CORONARY NATIVE VESSEL OR GRAFT DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING IMAGING SUPERVISION, INTERPRETATION, AND REPORT; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0293T	INSERTION OF LEFT ATRIAL HEMODYNAMIC MONITOR; COMPLETE SYSTEM, INCLUDES IMPLANTED COMMUNICATION MODULE AND PRESSURE SENSOR LEAD IN LEFT ATRIUM INCLUDING TRANSSEPTAL ACCESS, RADIOLOGICAL SUPERVISION AND INTERPRETATION, AND ASSOCIATED INJECTION PROCEDURES, WHEN PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
0294T	INSERTION OF LEFT ATRIAL HEMODYNAMIC MONITOR; PRESSURE SENSOR LEAD AT TIME OF INSERTION OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION AND ASSOCIATED INJECTION PROCEDURES, WHEN PERFORMED (LIST SEPARATELY IN ADDITION TO PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0295T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48 HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; INCLUDES RECORDING, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0296T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48 HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; RECORDING (INCLUDES CONNECTION AND INITIAL RECORDING)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0297T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48 HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; SCANNING ANALYSIS WITH REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0298T	EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48 HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; REVIEW AND INTERPRETATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0299T	EXTRACORPOREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, HIGH ENERGY, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; INITIAL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	WOUND				
0300T	EXTRACORPOREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, HIGH ENERGY, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; EACH ADDITIONAL WOUND (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0301T	DESTRUCTION/REDUCTION OF MALIGNANT BREAST TUMOR WITH EXTERNALLY APPLIED FOCUSED MICROWAVE, INCLUDING INTERSTITIAL PLACEMENT OF DISPOSABLE CATHETER WITH COMBINED TEMPERATURE MONITORING PROBE AND MICROWAVE FOCUSING SENSOCATHETER UNDER ULTRASOUND THERMOTHERAPY GUIDANCE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
0550F	CYTOPATHOLOGY REPORT ON ROUTINE NONGYNECOLOGIC SPECIMEN FINALIZED WITHIN TWO WORKING DAYS OF ACCESSION DATE (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
0551F	CYTOPATHOLOGY REPORT ON NONGYNECOLOGIC SPECIMEN WITH DOCUMENTATION THAT THE SPECIMEN WAS NON-ROUTINE (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
0555F	SYMPTOM MANAGEMENT PLAN OF CARE DOCUMENTED (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
0556F	PLAN OF CARE TO ACHIEVE LIPID CONTROL DOCUMENTED (CAD)1	Non-Reimbursable for All Programs, Non-	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Reimbursable for Package C			
0557F	PLAN OF CARE TO MANAGE ANGINAL SYMPTOMS DOCUMENTED (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1010F	SEVERITY OF ANGINA ASSESSED BY LEVEL OF ACTIVITY (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1011F	ANGINA PRESENT (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1012F	ANGINA ABSENT (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1031F	SMOKING STATUS AND EXPOSURE TO SECOND HAND SMOKE IN THE HOME ASSESSED (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1032F	CURRENT TOBACCO SMOKER OR CURRENTLY EXPOSED TO SECONDHAND SMOKE (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1033F	CURRENT TOBACCO NON-SMOKER AND NOT CURRENTLY EXPOSED TO SECONDHAND SMOKE1	Non-Reimbursable for All Programs, Non-Reimbursable	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		for Package C			
1052F	TYPE, ANATOMIC LOCATION, AND ACTIVITY ALL ASSESSED (IBD)	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1127F	NEW EPISODE FOR CONDITION (NMA-NO MEASURE ASSOCIATED)	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1128F	SUBSEQUENT EPISODE FOR CONDITION (NMA-NO MEASURE ASSOCIATED)	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1175F	FUNCTIONAL STATUS FOR DEMENTIA ASSESSED AND RESULTS REVIEWED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1181F	NEUROPSYCHIATRIC SYMPTOMS ASSESSED AND RESULTS REVIEWED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1182F	NEUROPSYCHIATRIC SYMPTOMS, ONE OR MORE PRESENT (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1183F	NEUROPSYCHIATRIC SYMPTOMS, ABSENT (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		C			
1450F	SYMPTOMS IMPROVED OR REMAINED CONSISTENT WITH TREATMENT GOALS SINCE LAST ASSESSMENT (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1451F	SYMPTOMS DEMONSTRATED CLINICALLY IMPORTANT DETERIORATION SINCE LAST ASSESSMENT (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1460F	QUALIFYING CARDIAC EVENT/DIAGNOSIS IN PREVIOUS 12 MONTHS (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1461F	NO QUALIFYING CARDIAC EVENT/DIAGNOSIS IN PREVIOUS 12 MONTHS (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1490F	DEMENTIA SEVERITY CLASSIFIED, MILD (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1491F	DEMENTIA SEVERITY CLASSIFIED, MODERATE (DEM)	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
1493F	DEMENTIA SEVERITY CLASSIFIED, SEVERE (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
1494F	COGNITION ASSESSED AND REVIEWED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
15271	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; FIRST 25 SQ CM OR LESS WOUND SURFACE AREA	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	G8, G9	NO
15272	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; EACH ADDITIONAL 25 SQ CM WOUND SURFACE AREA, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
15273	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE AREA, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
15274	APPLICATION OF SKIN SUBSTITUTE GRAFT TO TRUNK, ARMS, LEGS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	G8, G9	NO
15275	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 78	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DIGITS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; FIRST 25 SQ CM OR LESS WOUND SURFACE AREA				
15276	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA UP TO 100 SQ CM; EACH ADDITIONAL 25 SQ CM WOUND SURFACE AREA, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51, 54, 55, 56, 57, 58, 76, 77, 78, 79	NO
15277	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; FIRST 100 SQ CM WOUND SURFACE AREA, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
15278	APPLICATION OF SKIN SUBSTITUTE GRAFT TO FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS, TOTAL WOUND SURFACE AREA GREATER THAN OR EQUAL TO 100 SQ CM; EACH ADDITIONAL 100 SQ CM WOUND SURFACE AREA, OR PART THEREOF, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
15777	IMPLANTATION OF BIOLOGIC IMPLANT (EG, ACELLULAR DERMAL MATRIX) FOR SOFT TISSUE REINFORCEMENT (EG, BREAST, TRUNK) (LIST SEPARATELY IN ADDITION	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	54,55,56,57,58, 62,76,77,78,79,	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	TO CODE FOR PRIMARY PROCEDURE)				
2015F	ASTHMA IMPAIRMENT ASSESSED (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
2016F	ASTHMA RISK ASSESSED (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
20527	INJECTION, ENZYME (EG, COLLAGENASE), PALMAR FASCIAL CORD (IE, DUPUYTREN'S CONTRACTURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50, 51, QY	NO
22633	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; LUMBAR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	62, 78, 80, 81, 82, AS, G8, G9, QY	NO
22634	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; EACH ADDITIONAL INTERSPACE AND SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	62, 78, 80, 81, 82, AA, AD, AS, G8, G9, QY	NO
26341	MANIPULATION, PALMAR FASCIAL CORD (IE,	Covered for All Programs,	No for All Programs, No for	51, 54, 55, 56, 57, 58, 76, 77,	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DUPUYTREN'S CORD), POST ENZYME INJECTION (EG, COLLAGENASE), SINGLE CORD	Covered for Package C	Package C	78, 79, QY	
29582	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; THIGH AND LEG, INCLUDING ANKLE AND FOOT, WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,G8,G9, HM,LT,RT	NO
29583	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; UPPER ARM AND FOREARM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,G8,G9, HM,LT,RT	NO
29584	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; UPPER ARM, FOREARM, HAND, AND FINGERS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,G8,G9, HM,LT,RT	NO
3019F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) ASSESSMENT PLANNED POST DISCHARGE (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3055F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) LESS THAN OR EQUAL TO 35% (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3056F	LEFT VENTRICULAR EJECTION FRACTION (LVEF) GREATER THAN 35% OR NO LVEF RESULT AVAILABLE (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3115F	QUANTITATIVE RESULTS OF AN EVALUATION OF CURRENT LEVEL OF ACTIVITY AND CLINICAL SYMPTOMS (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3117F	HEART FAILURE DISEASE SPECIFIC STRUCTURED ASSESSMENT TOOL	Non-Reimbursable for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	COMPLETED (HF)1	Programs, Non-Reimbursable for Package C			
3118F	NEW YORK HEART ASSOCIATION (NYHA) CLASS DOCUMENTED (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3119F	NO EVALUATION OF LEVEL OF ACTIVITY OR CLINICAL SYMPTOMS (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3125F	ESOPHAGEAL BIOPSY REPORT WITH STATEMENT ABOUT DYSPLASIA (PRESENT, ABSENT, OR INDEFINITE) (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
32096	THORACOTOMY, WITH DIAGNOSTIC BIOPSY(IES) OF LUNG INFILTRATE(S) (EG, WEDGE, INCISIONAL), UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32097	THORACOTOMY, WITH DIAGNOSTIC BIOPSY(IES) OF LUNG NODULE(S) OR MASS(ES) (EG, WEDGE, INCISIONAL), UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32098	THORACOTOMY, WITH BIOPSY(IES) OF PLEURA	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32505	THORACOTOMY; WITH THERAPEUTIC WEDGE RESECTION (EG, MASS, NODULE), INITIAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32506	THORACOTOMY; WITH THERAPEUTIC WEDGE RESECTION (EG, MASS OR NODULE), EACH ADDITIONAL RESECTION, IPSILATERAL (LIST SEPARATELY IN	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	ADDITION TO CODE FOR PRIMARY PROCEDURE)				
32507	THORACOTOMY; WITH DIAGNOSTIC WEDGE RESECTION FOLLOWED BY ANATOMIC LUNG RESECTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32607	THORACOSCOPY; WITH DIAGNOSTIC BIOPSY(IES) OF LUNG INFILTRATE(S) (EG, WEDGE, INCISIONAL), UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,G8,G9	NO
32608	THORACOSCOPY; WITH DIAGNOSTIC BIOPSY(IES) OF LUNG NODULE(S) OR MASS(ES) (EG, WEDGE, INCISIONAL), UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,G8,G9	NO
32609	THORACOSCOPY; WITH BIOPSY(IES) OF PLEURA	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,G8,G9	NO
32666	THORACOSCOPY, SURGICAL; WITH THERAPEUTIC WEDGE RESECTION (EG, MASS, NODULE), INITIAL UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32667	THORACOSCOPY, SURGICAL; WITH THERAPEUTIC WEDGE RESECTION (EG, MASS OR NODULE), EACH ADDITIONAL RESECTION, IPSILATERAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32668	THORACOSCOPY, SURGICAL; WITH DIAGNOSTIC WEDGE RESECTION FOLLOWED BY ANATOMIC LUNG RESECTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32669	THORACOSCOPY, SURGICAL; WITH REMOVAL OF A SINGLE LUNG SEGMENT (SEGMENTECTOMY)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32670	THORACOSCOPY, SURGICAL; WITH REMOVAL OF TWO LOBES (BILOBECTOMY)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
32671	THORACOSCOPY, SURGICAL; WITH REMOVAL OF LUNG (PNEUMONECTOMY)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32672	THORACOSCOPY, SURGICAL; WITH RESECTION-PLICATION FOR EMPHYSEMATOUS LUNG (BULLOUS OR NON-BULLOUS) FOR LUNG VOLUME REDUCTION (LVRS), UNILATERAL INCLUDES ANY PLEURAL PROCEDURE, WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32673	THORACOSCOPY, SURGICAL; WITH RESECTION OF THYMUS, UNILATERAL OR BILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
32674	THORACOSCOPY, SURGICAL; WITH MEDIASTINAL AND REGIONAL LYMPHADENECTOMY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
3267F	PATHOLOGY REPORT INCLUDES PT CATEGORY, PN CATEGORY, GLEASON SCORE, AND STATEMENT ABOUT MARGIN STATUS (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
33221	INSERTION OF PACEMAKER PULSE GENERATOR ONLY; WITH EXISTING MULTIPLE LEADS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,78, G8,G9	NO
33227	REMOVAL OF PERMANENT PACEMAKER PULSE GENERATOR WITH REPLACEMENT OF PACEMAKER PULSE GENERATOR; SINGLE LEAD SYSTEM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,78, G8,G9	NO
33228	REMOVAL OF PERMANENT PACEMAKER PULSE GENERATOR WITH REPLACEMENT OF PACEMAKER PULSE GENERATOR; DUAL LEAD SYSTEM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,78, G8,G9	NO
33229	REMOVAL OF PERMANENT PACEMAKER PULSE GENERATOR WITH REPLACEMENT OF	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,78, G8,G9	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	PACEMAKER PULSE GENERATOR; MULTIPLE LEAD SYSTEM				
33230	INSERTION OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR ONLY; WITH EXISTING DUAL LEADS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,78, G8,G9	NO
33231	INSERTION OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR ONLY; WITH EXISTING MULTIPLE LEADS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,78, G8,G9	NO
33262	REMOVAL OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR WITH REPLACEMENT OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR; SINGLE LEAD SYSTEM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,G8,G9	NO
33263	REMOVAL OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR WITH REPLACEMENT OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR; DUAL LEAD SYSTEM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,G8,G9	NO
33264	REMOVAL OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR WITH REPLACEMENT OF PACING CARDIOVERTER-DEFIBRILLATOR PULSE GENERATOR; MULTIPLE LEAD SYSTEM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,G8,G9	NO
3394F	QUANTITATIVE HER2 IMMUNOHISTOCHEMISTRY (IHC) EVALUATION OF BREAST CANCER CONSISTENT WITH THE SCORING SYSTEM DEFINED IN THE ASCO/CAP GUIDELINES (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3395F	QUANTITATIVE NON-HER2 IMMUNOHISTOCHEMISTRY (IHC) EVALUATION OF BREAST CANCER (EG, TESTING FOR ESTROGEN OR PROGESTERONE RECEPTORS [ER/PR]) PERFORMED (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
3517F	HEPATITIS B VIRUS (HBV) STATUS ASSESSED AND RESULTS INTERPRETED WITHIN ONE YEAR PRIOR TO RECEIVING A FIRST COURSE OF ANTI-TNF (TUMOR NECROSIS FACTOR) THERAPY (IBD)10	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3520F	CLOSTRIDIUM DIFFICILE TESTING PERFORMED (IBD)10	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
36251	SELECTIVE CATHETER PLACEMENT (FIRST-ORDER), MAIN RENAL ARTERY AND ANY ACCESSORY RENAL ARTERY(S) FOR RENAL ANGIOGRAPHY, INCLUDING ARTERIAL PUNCTURE AND CATHETER PLACEMENT(S), FLUOROSCOPY, CONTRAST INJECTION(S), IMAGE POSTPROCESSING, PERMANENT RECORDING OF IMAGES, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDING PRESSURE GRADIENT MEASUREMENTS WHEN PERFORMED, AND FLUSH AORTOGRAM WHEN PERFORMED; UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,G8,G9	NO
36252	SELECTIVE CATHETER PLACEMENT (FIRST-ORDER), MAIN RENAL ARTERY AND ANY ACCESSORY RENAL ARTERY(S) FOR RENAL ANGIOGRAPHY, INCLUDING ARTERIAL PUNCTURE AND CATHETER PLACEMENT(S), FLUOROSCOPY, CONTRAST INJECTION(S), IMAGE POSTPROCESSING, PERMANENT RECORDING OF IMAGES, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDING PRESSURE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,G8,G9	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	GRADIENT MEASUREMENTS WHEN PERFORMED, AND FLUSH AORTOGRAM WHEN PERFORMED; BILATERAL				
36253	SUPERSELECTIVE CATHETER PLACEMENT (ONE OR MORE SECOND ORDER OR HIGHER RENAL ARTERY BRANCHES) RENAL ARTERY AND ANY ACCESSORY RENAL ARTERY(S) FOR RENAL ANGIOGRAPHY, INCLUDING ARTERIAL PUNCTURE, CATHETERIZATION, FLUOROSCOPY, CONTRAST INJECTION(S), IMAGE POSTPROCESSING, PERMANENT RECORDING OF IMAGES, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDING PRESSURE GRADIENT MEASUREMENTS WHEN PERFORMED, AND FLUSH AORTOGRAM WHEN PERFORMED; UNILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,62,G8,G9	NO
36254	SUPERSELECTIVE CATHETER PLACEMENT (ONE OR MORE SECOND ORDER OR HIGHER RENAL ARTERY BRANCHES) RENAL ARTERY AND ANY ACCESSORY RENAL ARTERY(S) FOR RENAL ANGIOGRAPHY, INCLUDING ARTERIAL PUNCTURE, CATHETERIZATION, FLUOROSCOPY, CONTRAST INJECTION(S), IMAGE POSTPROCESSING, PERMANENT RECORDING OF IMAGES, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INCLUDING PRESSURE GRADIENT MEASUREMENTS WHEN PERFORMED, AND FLUSH AORTOGRAM WHEN PERFORMED; BILATERAL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50,51,62,G8,G9	NO
37191	INSERTION OF INTRAVASCULAR VENA CAVA FILTER, ENDOVASCULAR APPROACH INCLUDING VASCULAR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,G8,G9	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	ACCESS, VESSEL SELECTION, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE (ULTRASOUND AND FLUOROSCOPY), WHEN PERFORMED				
37192	REPOSITIONING OF INTRAVASCULAR VENA CAVA FILTER, ENDOVASCULAR APPROACH INCLUDING VASCULAR ACCESS, VESSEL SELECTION, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE (ULTRASOUND AND FLUOROSCOPY), WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,G8,G9	NO
37193	RETRIEVAL (REMOVAL) OF INTRAVASCULAR VENA CAVA FILTER, ENDOVASCULAR APPROACH INCLUDING VASCULAR ACCESS, VESSEL SELECTION, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE (ULTRASOUND AND FLUOROSCOPY), WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,G8,G9	NO
3725F	SCREENING FOR DEPRESSION PERFORMED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
3750F	PATIENT NOT RECEIVING DOSE OF CORTICOSTEROIDS GREATER THAN OR EQUAL TO 10MG/DAY* FOR 60 OR	Non-Reimbursable for All Programs, Non-	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	GREATER CONSECUTIVE DAYS (IBD)10	Reimbursable for Package C			
37619	LIGATION OF INFERIOR VENA CAVA	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51,54,55,56,62, 78,80,81,82,AS, G8,G9	NO
38232	BONE MARROW HARVESTING FOR TRANSPLANTATION; AUTOLOGOUS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	51,54,55,56,78, G8,G9	NO
4008F	BETA BLOCKER THERAPY PRESCRIBED OR CURRENTLY BEING TAKEN (CAD,HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4010F	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY PRESCRIBED OR CURRENTLY BEING TAKEN (CAD, HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4013F	STATIN THERAPY PRESCRIBED OR CURRENTLY BEING TAKEN (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4069F	VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS RECEIVED (IBD)10	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4086F	ASPIRIN OR CLOPIDOGREL PRESCRIBED OR CURRENTLY BEING TAKEN (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
4140F	INHALED CORTICOSTEROIDS PRESCRIBED (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4142F	CORTICOSTEROID SPARING THERAPY PRESCRIBED (IBD)10	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4144F	ALTERNATIVE LONG-TERM CONTROL MEDICATION PRESCRIBED (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4145F	TWO OR MORE ANTI-HYPERTENSIVE AGENTS PRESCRIBED OR CURRENTLY BEING TAKEN (CAD, HTN)	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4322F	CAREGIVER PROVIDED WITH EDUCATION AND REFERRED TO ADDITIONAL RESOURCES FOR SUPPORT (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4350F	COUNSELING PROVIDED ON SYMPTOM MANAGEMENT, END OF LIFE DECISIONS, AND PALLIATION (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4450F	SELF-CARE EDUCATION PROVIDED TO PATIENT (HF)1	Non-Reimbursable for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Programs, Non-Reimbursable for Package C			
4470F	IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR (ICD) COUNSELING PROVIDED (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4480F	PATIENT RECEIVING ACE INHIBITOR/ARB THERAPY AND BETA-BLOCKER THERAPY FOR 3 MONTHS OR LONGER (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4481F	PATIENT RECEIVING ACE INHIBITOR/ARB THERAPY AND BETA-BLOCKER THERAPY FOR LESS THAN 3 MONTHS OR PATIENT NOT RECEIVING ACE INHIBITOR/ARB THERAPY AND BETA-BLOCKER THERAPY (HF)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4500F	REFERRED TO AN OUTPATIENT CARDIAC REHABILITATION PROGRAM (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4510F	PREVIOUS CARDIAC REHABILITATION FOR QUALIFYING CARDIAC EVENT COMPLETED (CAD)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
4525F	NEUROPSYCHIATRIC INTERVENTION ORDERED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		for Package C			
4526F	NEUROPSYCHIATRIC INTERVENTION RECEIVED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
49082	ABDOMINAL PARACENTESIS (DIAGNOSTIC OR THERAPEUTIC); WITHOUT IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51, G8,G9	NO
49083	ABDOMINAL PARACENTESIS (DIAGNOSTIC OR THERAPEUTIC); WITH IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51, G8,G9	NO
49084	PERITONEAL LAVAGE, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	51, G8,G9	NO
5250F	ASTHMA DISCHARGE PLAN PROVIDED TO PATIENT (ASTHMA)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
6100F	TIMEOUT TO VERIFY CORRECT PATIENT, CORRECT SITE, AND CORRECT PROCEDURE, DOCUMENTED (PATH)9	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
6101F	SAFETY COUNSELING FOR DEMENTIA PROVIDED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
6102F	SAFETY COUNSELING FOR DEMENTIA ORDERED (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		for Package C			
6110F	COUNSELING PROVIDED REGARDING RISKS OF DRIVING AND THE ALTERNATIVES TO DRIVING (DEM)1	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
6150F	PATIENT NOT RECEIVING A FIRST COURSE OF ANTI-TNF (TUMOR NECROSIS FACTOR) THERAPY (IBD)10	Non-Reimbursable for All Programs, Non-Reimbursable for Package C	NA	NA	NA
62369	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL DRUG INFUSION (INCLUDES EVALUATION OF RESERVOIR STATUS, ALARM STATUS, DRUG PRESCRIPTION STATUS); WITH REPROGRAMMING AND REFILL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26, G8, G9	NO
62370	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL DRUG INFUSION (INCLUDES EVALUATION OF RESERVOIR STATUS, ALARM STATUS, DRUG PRESCRIPTION STATUS); WITH REPROGRAMMING AND REFILL (REQUIRING PHYSICIAN'S SKILL)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26, G8, G9	NO
64633	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE FACET JOINT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9, QY	NO
64634	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9, QY	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	(FLUOROSCOPY OR CT); CERVICAL OR THORACIC, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)				
64635	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE FACET JOINT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9, QY	NO
64636	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	50, 51, 54, 55, 56, 78, G8, G9, QY	NO
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26, TC	NO
77424	INTRAOPERATIVE RADIATION TREATMENT DELIVERY, X-RAY, SINGLE TREATMENT SESSION	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC	NO
77425	INTRAOPERATIVE RADIATION TREATMENT DELIVERY, ELECTRONS, SINGLE TREATMENT SESSION	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC	NO
77469	INTRAOPERATIVE RADIATION TREATMENT MANAGEMENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26	NO
78226	HEPATOBILIARY SYSTEM IMAGING, INCLUDING GALLBLADDER WHEN PRESENT;	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26, TC	NO
78227	HEPATOBILIARY SYSTEM IMAGING, INCLUDING GALLBLADDER WHEN PRESENT; WITH PHARMACOLOGIC INTERVENTION, INCLUDING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC, 26	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	QUANTITATIVE MEASUREMENT(S) WHEN PERFORMED				
78579	PULMONARY VENTILATION IMAGING (EG, AEROSOL OR GAS)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC, 26	NO
78582	PULMONARY VENTILATION (EG, AEROSOL OR GAS) AND PERFUSION IMAGING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC, 26	NO
78597	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION, INCLUDING IMAGING WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC, 26	NO
78598	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION AND VENTILATION (EG, AEROSOL OR GAS), INCLUDING IMAGING WHEN PERFORMED	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	TC, 26	NO
81200	ASPA (ASPARTOACYLASE) (EG, CANAVAN DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, E285A, Y231X)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NO	NO
81205	BCKDHB (BRANCHED-CHAIN KETO ACID DEHYDROGENASE E1, BETA POLYPEPTIDE) (EG, MAPLE SYRUP URINE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R183P, G278S, E422X)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81209	BLM (BLOOM SYNDROME, RECQ HELICASE-LIKE) (EG, BLOOM SYNDROME) GENE ANALYSIS, 2281DEL6INS7 VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81210	BRAF (V-RAF MURINE SARCOMA VIRAL ONCOGENE HOMOLOG B1) (EG, COLON CANCER), GENE ANALYSIS, V600E VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81211	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS IN BRCA1 (IE, EXON 13 DEL 3.835KB, EXON	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB)				
81212	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; 185DELAG, 5385INSC, 6174DELT VARIANTS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81213	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; UNCOMMON DUPLICATION/DELETION VARIANTS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81214	BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81215	BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81216	BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81217	BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81220	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; COMMON VARIANTS (EG, ACMG/ACOG GUIDELINES)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81221	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
81222	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81223	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; FULL GENE SEQUENCE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81224	CFTR (CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR) (EG, CYSTIC FIBROSIS) GENE ANALYSIS; INTRON 8 POLY-T ANALYSIS (EG, MALE INFERTILITY)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81225	CYP2C19 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 19) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *8, *17)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81226	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *9, *10,*17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81227	CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *5, *6)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81228	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) MICROARRAY ANALYSIS; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER VARIANTS (EG, BACTERIAL ARTIFICIAL CHROMOSOME [BAC] OR OLIGO-BASED COMPARATIVE GENOMIC HYBRIDIZATION [CGH] MICROARRAY ANALYSIS)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81229	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) MICROARRAY ANALYSIS; INTERROGATION	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	OF GENOMIC REGIONS FOR COPY NUMBER AND SINGLE NUCLEOTIDE POLYMORPHISM (SNP) VARIANTS FOR CHROMOSOMAL ABNORMALITIES				
81240	F2 (PROTHROMBIN, COAGULATION FACTOR II) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, 20210G>A VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81241	F5 (COAGULATION FACTOR V) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, LEIDEN VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81242	FANCC (FANCONI ANEMIA, COMPLEMENTATION GROUP C) (EG, FANCONI ANEMIA, TYPE C) GENE ANALYSIS, COMMON VARIANT (EG, IVS4+4A>T)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81243	FMR1 (FRAGILE X MENTAL RETARDATION 1) (EG, FRAGILE X MENTAL RETARDATION) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81244	FMR1 (FRAGILE X MENTAL RETARDATION 1) (EG, FRAGILE X MENTAL RETARDATION) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE AND METHYLATION STATUS)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81245	FLT3 (FMS-RELATED TYROSINE KINASE 3) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, INTERNAL TANDEM DUPLICATION (ITD) VARIANTS (IE, EXONS 14, 15)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81251	GBA (GLUCOSIDASE, BETA, ACID) (EG, GAUCHER DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, N370S, 84GG, L444P, IVS2+1G>A)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
81255	HEXA (HEXOSAMINIDASE A [ALPHA POLYPEPTIDE]) (EG, TAY-SACHS DISEASE) GENE ANALYSIS, COMMON	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	VARIANTS (EG, 1278INSTATC, 1421+1G>C, G269S)				
81256	HFE (HEMOCHROMATOSIS) (EG, HEREDITARY HEMOCHROMATOSIS) GENE ANALYSIS, COMMON VARIANTS (EG, C282Y, H63D)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81257	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS, FOR COMMON DELETIONS OR VARIANT (EG, SOUTHEAST ASIAN, THAI, FILIPINO, MEDITERRANEAN, ALPHA3.7, ALPHA4.2, ALPHA20.5, AND CONSTANT SPRING)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
81260	IKBKAP (INHIBITOR OF KAPPA LIGHT POLYPEPTIDE GENE ENHANCER IN B-CELLS, KINASE COMPLEX-ASSOCIATED PROTEIN) (EG, FAMILIAL DYSAUTONOMIA) GENE ANALYSIS, COMMON VARIANTS (EG, 2507+6T>C, R696P)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81270	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS, P.VAL617PHE (V617F) VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81275	KRAS (V-KI-RAS2 KIRSTEN RAT SARCOMA VIRAL ONCOGENE) (EG, CARCINOMA) GENE ANALYSIS, VARIANTS IN CODONS 12 AND 13	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81280	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); FULL SEQUENCE ANALYSIS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81281	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); KNOWN FAMILIAL SEQUENCE VARIANT	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
81282	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); DUPLICATION/DELETION VARIANTS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81290	MCOLN1 (MUCOLIPIN 1) (EG, MUCOLIPIDOSIS, TYPE IV) GENE ANALYSIS, COMMON VARIANTS (EG, IVS3-2A>G, DEL6.4KB)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81291	MTHFR (5,10-METHYLENETETRAHYDROFOLATE REDUCTASE) (EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, COMMON VARIANTS (EG, 677T, 1298C)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81292	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81293	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81294	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81295	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
81296	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81297	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81298	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81299	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81300	MSH6 (MUTS HOMOLOG 6 [E. COLI]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81301	MICROSATELLITE INSTABILITY ANALYSIS (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) OF MARKERS FOR MISMATCH REPAIR DEFICIENCY (EG, BAT25, BAT26), INCLUDES COMPARISON OF NEOPLASTIC AND NORMAL TISSUE, IF PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81302	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; FULL SEQUENCE	Non-Covered for All Programs, Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	ANALYSIS	for Package C			
81303	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81304	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81310	NPM1 (NUCLEOPHOSMIN) (EG, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, EXON 12 VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81315	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; COMMON BREAKPOINTS (EG, INTRON 3 AND INTRON 6), QUALITATIVE OR QUANTITATIVE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81316	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA) (EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; SINGLE BREAKPOINT (EG, INTRON 3, INTRON 6 OR EXON 6), QUALITATIVE OR QUANTITATIVE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81317	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81318	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS				
81319	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 [S. CEREVISIAE]) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81330	SMPD1(SPHINGOMYELIN PHOSPHODIESTERASE 1, ACID LYSOSOMAL) (EG, NIEMANN-PICK DISEASE, TYPE A) GENE ANALYSIS, COMMON VARIANTS (EG, R496L, L302P, FSP330)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
81331	SNRPN/UBE3A (SMALL NUCLEAR RIBONUCLEOPROTEIN POLYPEPTIDE N AND UBIQUITIN PROTEIN LIGASE E3A) (EG, PRADER-WILLI SYNDROME AND/OR ANGELMAN SYNDROME), METHYLATION ANALYSIS	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
81332	SERPINA1 (SERPIN PEPTIDASE INHIBITOR, CLADE A, ALPHA-1 ANTIPROTEINASE, ANTITRYPSIN, MEMBER 1) (EG, ALPHA-1-ANTITRYPSIN DEFICIENCY), GENE ANALYSIS, COMMON VARIANTS (EG, *S AND *Z)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81350	UGT1A1 (UDP GLUCURONOSYLTRANSFERASE 1 FAMILY, POLYPEPTIDE A1) (EG, IRINOTECAN METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *28, *36, *37)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
81355	VKORC1 (VITAMIN K EPOXIDE REDUCTASE COMPLEX, SUBUNIT 1) (EG, WARFARIN METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, -1639/3673)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
86386	NUCLEAR MATRIX PROTEIN 22 (NMP22), QUALITATIVE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
87389	INFECTIOUS AGENT ANTIGEN DETECTION BY	Covered for All Programs,	No for All Programs, No for	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVE OR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; HIV-1 ANTIGEN(S), WITH HIV-1 AND HIV-2 ANTIBODIES, SINGLE RESULT	Covered for Package C	Package C		
90869	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; SUBSEQUENT MOTOR THRESHOLD RE-DETERMINATION WITH DELIVERY AND MANAGEMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
92071	FITTING OF CONTACT LENS FOR TREATMENT OF OCULAR SURFACE DISEASE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
92072	FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS, INITIAL FITTING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
92558	EVOKED OTOACOUSTIC EMISSIONS, SCREENING (QUALITATIVE MEASUREMENT OF DISTORTION PRODUCT OR TRANSIENT EVOKED OTOACOUSTIC EMISSIONS), AUTOMATED ANALYSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
92618	EVALUATION FOR PRESCRIPTION OF NON-SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	NO
93998	UNLISTED NONINVASIVE VASCULAR DIAGNOSTIC STUDY	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO
94726	PLETHYSMOGRAPHY FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED, AIRWAY RESISTANCE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
94727	GAS DILUTION OR WASHOUT FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED, DISTRIBUTION OF VENTILATION AND	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	CLOSING VOLUMES				
94728	AIRWAY RESISTANCE BY IMPULSE OSCILLOMETRY	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO
94729	DIFFUSING CAPACITY (EG, CARBON MONOXIDE, MEMBRANE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO
94780	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING OBSERVATION AND CONTINUOUS RECORDING OF PULSE OXIMETRY, HEART RATE AND RESPIRATORY RATE, WITH INTERPRETATION AND REPORT; 60 MINUTES	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
94781	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING OBSERVATION AND CONTINUOUS RECORDING OF PULSE OXIMETRY, HEART RATE AND RESPIRATORY RATE, WITH INTERPRETATION AND REPORT; EACH ADDITIONAL FULL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
95885	NEEDLE ELECTROMYOGRAPHY, EACH EXTREMITY, WITH RELATED PARASPINAL AREAS, WHEN PERFORMED, DONE WITH NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY; LIMITED (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO
95886	NEEDLE ELECTROMYOGRAPHY, EACH EXTREMITY, WITH RELATED PARASPINAL AREAS, WHEN PERFORMED, DONE WITH NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY; COMPLETE, FIVE OR MORE MUSCLES STUDIED,	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	INNERVATED BY THREE OR MORE NERVES OR FOUR OR MORE SPINAL LEVELS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)				
95887	NEEDLE ELECTROMYOGRAPHY, NON-EXTREMITY (CRANIAL NERVE SUPPLIED OR AXIAL) MUSCLE(S) DONE WITH NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO
95938	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL PERIPHERAL NERVES OR SKIN SITES, RECORDING FROM THE CENTRAL NERVOUS SYSTEM; IN UPPER AND LOWER LIMBS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26,TC	NO
95939	CENTRAL MOTOR EVOKED POTENTIAL STUDY (TRANSCRANIAL MOTOR STIMULATION); IN UPPER AND LOWER LIMBS	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	26, TC	NO
A5056	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH FILTER, (1 PIECE), EACH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
A5057	OSTOMY POUCH, DRAINABLE, WITH EXTENDED WEAR BARRIER ATTACHED, WITH BUILT IN CONVEXITY, WITH FILTER, (1 PIECE), EACH	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
A9272	MECHANICAL WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, EACH	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
A9584	IODINE 1-123 IOFLUPANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 5 MILLICURIES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
A9585	INJECTION, GADOBUTROL, 0.1 ML	Non-Covered for All Programs,	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Non-Covered for Package C			
C1886	CATHETER, EXTRAVASCULAR TISSUE ABLATION, ANY MODALITY (INSERTABLE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
C9287	INJECTION, BRENTUXIMAB VEDOTIN, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
C9366	EPIFIX, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
C9732	INSERTION OF OCULAR TELESCOPE PROSTHESIS INCLUDING REMOVAL OF CRYSTALLINE LENS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER-ACTIVATED, WHEEL DRIVE, PAIR	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NU,RR	NO
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NU,RR	NO
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (E.G. GEL CELL, ABSORBED GLASSMAT)	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NU,RR	NO
E2626	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
E2627	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
E2629	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE	Covered for All Programs,	No for All Programs, No for	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)	Covered for Package C	Package C		
E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
E2631	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
G0442	ANNUAL ALCOHOL MISUSE SCREENING, 15 MINUTES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0443	BRIEF FACE-TO-FACE BEHAVIORAL COUNSELING FOR ALCOHOL MISUSE, 15 MINUTES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0444	ANNUAL DEPRESSION SCREENING, 15 MINUTES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0445	HIGH INTENSITY BEHAVIORAL COUNSELING TO PREVENT SEXUALLY TRANSMITTED INFECTION; FACE-TO-FACE, INDIVIDUAL, INCLUDES: EDUCATION, SKILLS TRAINING AND GUIDANCE ON HOW TO CHANGE SEXUAL BEHAVIOR; PERFORMED SEMI-	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	ANNUALLY, 30 MINUTES				
G0446	INTENSIVE BEHAVIORAL THERAPY TO REDUCE CARDIOVASCULAR DISEASE RISK, INDIVIDUAL, FACE-TO-FACE, BI-ANNUAL, 15 MINUTES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0447	FACE-TO-FACE BEHAVIORAL COUNSELING FOR OBESITY, 15 MINUTES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0448	INSERTION OR REPLACEMENT OF A PERMANENT PACING CARDIOVERTER-DEFIBRILLATOR SYSTEM WITH TRANSVENOUS LEAD(S), SINGLE OR DUAL CHAMBER WITH INSERTION OF PACING ELECTRODE, CARDIAC VENOUS SYSTEM, FOR LEFT VENTRICULAR PACING	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0449	ANNUAL FACE-TO-FACE OBESITY SCREENING, 15 MINUTES	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0450	SCREENING FOR SEXUALLY TRANSMITTED INFECTIONS, INCLUDES LABORATORY TESTS FOR CHLAMYDIA, GONORRHEA, SYPHILIS AND HEPATITIS B	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0451	DEVELOPMENT TESTING, WITH INTERPRETATION AND REPORT, PER STANDARDIZED INSTRUMENT FORM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0908	MOST RECENT HEMOGLOBIN (HGB) LEVEL > 12.0 G/DL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0909	HEMOGLOBIN LEVEL MEASUREMENT NOT DOCUMENTED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0910	MOST RECENT HEMOGLOBIN LEVEL <= 12.0	Non-Covered for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	G/DL	Programs, Non-Covered for Package C			
G0911	ASSESSED LEVEL OF ACTIVITY AND SYMPTOMS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0912	LEVEL OF ACTIVITY AND SYMPTOMS NOT ASSESSED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0913	IMPROVEMENT IN VISUAL FUNCTION ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0914	PATIENT CARE SURVEY WAS NOT COMPLETED BY PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0915	IMPROVEMENT IN VISUAL FUNCTION NOT ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0916	SATISFACTION WITH CARE ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0917	PATIENT SATISFACTION SURVEY WAS NOT COMPLETED BY PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0918	SATISFACTION WITH CARE NOT ACHIEVED WITHIN 90 DAYS FOLLOWING CATARACT SURGERY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0919	INFLUENZA IMMUNIZATION ORDERED OR RECOMMENDED (TO BE GIVEN AT ALTERNATE LOCATION OR ALTERNATE	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	PROVIDER); VACCINE NOT AVAILABLE AT TIME OF VISIT	C			
G0920	TYPE, ANATOMIC LOCATION, AND ACTIVITY ALL DOCUMENTED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0921	DOCUMENTATION OF PATIENT REASON(S) FOR NOT BEING ABLE TO ASSESS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G0922	NO DOCUMENTATION OF DISEASE TYPE, ANATOMIC LOCATION, AND ACTIVITY, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8694	LEFT VENTRIUCULAR EJECTION FRACTION (LVEF) < 40%	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8695	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR DOCUMENTATION AS MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION OR NORMAL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8696	ANTITHROMBOTIC THERAPY PRESCRIBED AT DISCHARGE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8697	ANTITHROMBOTIC THERAPY NOT PRESCRIBED FOR DOCUMENTED REASONS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8698	ANTITHROMBOTIC THERAPY WAS NOT PRESCRIBED AT DISCHARGE, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8699	REHABILITATION SERVICES (OCCUPATIONAL, PHYSICAL OR SPEECH) ORDERED AT OR PRIOR TO DISCHARGE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
G8700	REHABILITATION SERVICES (OCCUPATIONAL, PHYSICAL OR SPEECH) NOT INDICATED AT OR PRIOR TO DISCHARGE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8701	REHABILITATION SERVICES WERE NOT ORDERED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8702	DOCUMENTATION THAT PROPHYLACTIC ANTIBIOTICS WERE GIVEN WITHIN 4 HOURS PRIOR TO SURGICAL INCISION OR INTRAOPERATIVELY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8703	DOCUMENTATION THAT PROPHYLACTIC ANTIBIOTICS WERE NEITHER GIVEN WITHIN 4 HOURS PRIOR TO SURGICAL INCISION NOR INTRAOPERATIVELY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8704	12-LEAD ELECTROCARDIOGRAM (ECG) PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8705	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PERFORMING A 12-LEAD ELECTROCARDIOGRAM (ECG)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8706	DOCUMENTATION OF PATIENT REASON(S) FOR NOT PERFORMING A 12-LEAD ELECTROCARDIOGRAM (ECG)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8707	12-LEAD ELECTROCARDIOGRAM (ECG) NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8708	PATIENT NOT PRESCRIBED OR DISPENSED ANTIBIOTIC	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8709	PATIENT PRESCRIBED OR DISPENSED ANTIBIOTIC FOR	Non-Covered for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DOCUMENTED MEDICAL REASON(S)	Programs, Non-Covered for Package C			
G8710	PATIENT PRESCRIBED OR DISPENSED ANTIBIOTIC	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8711	PRESCRIBED OR DISPENSED ANTIBIOTIC	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8712	ANTIBIOTIC NOT PRESCRIBED OR DISPENSED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8713	SPKT/V GREATER THAN OR EQUAL TO 1.2 (SINGLE-POOL CLEARANCE OF UREA [KT] / VOLUME [V])	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8714	HEMODIALYSIS TREATMENT PERFORMED EXACTLY THREE TIMES PER WEEK	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8715	HEMODIALYSIS TREATMENT PERFORMED LESS THAN THREE TIMES PER WEEK OR GREATER THAN THREE TIMES PER WEEK	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8716	DOCUMENTATION OF REASON(S) FOR PATIENT NOT HAVING GREATER THAN OR EQUAL TO 1.2 (SINGLE-POOL CLEARANCE OF UREA [KT] / VOLUME [V])	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8717	SPKT/V LESS THAN 1.2 (SINGLE-POOL CLEARANCE OF UREA [KT] / VOLUME [V]), REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8718	TOTAL KT/V GREATER THAN OR EQUAL TO 1.7 PER WEEK (TOTAL CLEARANCE OF UREA [KT] / VOLUME [V])	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		C			
G8720	TOTAL KT/V LESS THAN 1.7 PER WEEK (TOTAL CLEARANCE OF UREA [KT] / VOLUME [V]), REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8721	PT CATEGORY (PRIMARY TUMOR), PN CATEGORY (REGIONAL LYMPH NODES), AND HISTOLOGIC GRADE WERE DOCUMENTED IN PATHOLOGY REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8722	MEDICAL REASON(S) DOCUMENTED FOR NOT INCLUDING PT CATEGORY, PN CATEGORY AND HISTOLOGIC GRADE IN THE PATHOLOGY REPORT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8723	SPECIMEN SITE IS OTHER THAN ANATOMIC LOCATION OF PRIMARY TUMOR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8724	PT CATEGORY, PN CATEGORY AND HISTOLOGIC GRADE WERE NOT DOCUMENTED IN THE PATHOLOGY REPORT, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8725	FASTING LIPID PROFILE PERFORMED (TRIGLYCERIDES, LDL-C, HDL-C AND TOTAL CHOLESTEROL)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8726	CLINICIAN HAS DOCUMENTED REASON FOR NOT PERFORMING FASTING LIPID PROFILE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8727	PATIENT RECEIVING HEMODIALYSIS, PERITONEAL DIALYSIS OR KIDNEY TRANSPLANTATION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8728	FASTING LIPID PROFILE NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8730	PAIN ASSESSMENT	Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DOCUMENTED AS POSITIVE UTILIZING A STANDARDIZED TOOL AND A FOLLOW-UP PLAN IS DOCUMENTED	for All Programs, Non-Covered for Package C			
G8731	PAIN ASSESSMENT DOCUMENTED AS NEGATIVE, NO FOLLOW-UP PLAN IS REQUIRED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8732	NO DOCUMENTATION OF PAIN ASSESSMENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8733	DOCUMENTATION OF A POSITIVE ELDER MALTREATMENT SCREEN AND DOCUMENTED FOLLOW-UP PLAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8734	ELDER MALTREATMENT SCREEN DOCUMENTED AS NEGATIVE, NO FOLLOW-UP REQUIRED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8735	ELDER MALTREATMENT SCREEN DOCUMENTED AS POSITIVE, FOLLOW-UP PLAN NOT DOCUMENTED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8736	MOST CURRENT LDL-C <100MG/DL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8737	MOST CURRENT LDL-C >=100MG/DL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8738	LEFT VENTRICULAR EJECTION FRACTION (LVEF) < 40% OR DOCUMENTATION OF SEVERELY OR MODERATELY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8739	LEFT VENTRICULAR EJECTION FRACTION (LVEF) >= 40% OR	Non-Covered for All Programs,	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DOCUMENTATION AS NORMAL OR MILDLY DEPRESSED LEFT VENTRICULAR SYSTOLIC FUNCTION	Non-Covered for Package C			
G8740	LEFT VENTRICULAR EJECTION FRACTION (LVEF) NOT PERFORMED OR ASSESSED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8741	PATIENT NOT TREATED FOR SPOKEN LANGUAGE COMPREHENSION DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8742	PATIENT NOT TREATED FOR ATTENTION DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8743	PATIENT NOT TREATED FOR MEMORY DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8744	PATIENT NOT TREATED FOR MOTOR SPEECH DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8745	PATIENT NOT TREATED FOR READING DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8746	PATIENT NOT TREATED FOR SPOKEN LANGUAGE EXPRESSION DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8747	PATIENT NOT TREATED FOR WRITING DISORDER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8748	PATIENT NOT TREATED FOR SWALLOWING DISORDER	Non-Covered for All Programs, Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		for Package C			
G8749	ABSENCE OF SIGNS OF MELANOMA (COUGH, DYSPNEA, TENDERNESS, LOCALIZED NEUROLOGIC SIGNS SUCH AS WEAKNESS, JAUNDICE OR ANY OTHER SIGN SUGGESTING SYSTEMIC SPREAD) OR ABSENCE OF SYMPTOMS OF MELANOMA (PAIN, PARESTHESIA, OR ANY OTHER SYMPTOM SUGGESTING THE POSSIBILITY OF SYSTEMIC SPREAD OF MELANOMA)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8750	PRESENCE OF SIGNS OF MELANOMA (COUGH, DYSPNEA, TENDERNESS, LOCALIZED NEUROLOGIC SIGNS SUCH AS WEAKNESS, JAUNDICE OR ANY OTHER SIGN SUGGESTING SYSTEMIC SPREAD) OR PRESENCE OF SYMPTOMS OF MELANOMA (PAIN, PARESTHESIA, OR ANY OTHER SYMPTOM SUGGESTING THE POSSIBILITY OF SYSTEMIC SPREAD OF MELANOMA)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8751	SMOKING STATUS AND EXPOSURE TO SECONDHAND SMOKE IN THE HOME NOT ASSESSED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8752	MOST RECENT SYSTOLIC BLOOD PRESSURE < 140MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8753	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8754	MOST RECENT DIASTOLIC BLOOD PRESSURE < 90MMHG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8755	MOST RECENT DIASTOLIC	Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	BLOOD PRESSURE >= 90MMHG	for All Programs, Non-Covered for Package C			
G8756	NO DOCUMENTATION OF BLOOD PRESSURE MEASUREMENT, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8757	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE CHRONIC OBSTRUCTIVE PULMONARY DISEASE MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8758	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE INFLAMMATORY BOWEL DISEASE MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8759	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE OBSTRUCTIVE SLEEP APNEA MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8760	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE EPILEPSY MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8761	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE DEMENTIA MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8762	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE PARKINSON'S DISEASE MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8763	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE HYPERTENSION MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8764	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES	Non-Covered for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	IN THE CARDIOVASCULAR PREVENTION MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Programs, Non-Covered for Package C			
G8765	ALL QUALITY ACTIONS FOR THE APPLICABLE MEASURES IN THE CATARACT MEASURES GROUP HAVE BEEN PERFORMED FOR THIS PATIENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8767	LIPID PANEL RESULTS DOCUMENTED AND REVIEWED (MUST INCLUDE TOTAL CHOLESTEROL, HDL-C, TRIGLYCERIDES AND CALCULATED LDL-C)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8768	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PERFORMING LIPID PROFILE (E.G. PATIENTS WHO HAVE A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8769	LIPID PROFILE NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8770	URINE PROTEIN TEST RESULT DOCUMENTED AND REVIEWED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8771	DOCUMENTATION OF DIAGNOSIS OF CHRONIC KIDNEY DISEASE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8772	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PERFORMING URINE PROTEIN TEST (E.G. PATIENTS WHO HAVE A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
G8773	URINE PROTEIN TEST WAS NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8774	SERUM CREATININE TEST RESULT DOCUMENTED AND REVIEWED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8775	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PERFORMING SERUM CREATININE TEST (E.G. PATIENTS WHO HAVE A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8776	SERUM CREATININE TEST NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8777	DIABETES SCREENING TEST PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8778	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PERFORMING DIABETES SCREENING TEST (E.G. PATIENTS WHO HAVE A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE, OR PATIENTS WITH A DIAGNOSIS OF DIABETES)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8779	DIABETES SCREENING TEST NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8780	COUNSELING FOR DIET AND PHYSICAL ACTIVITY PERFORMED	Non-Covered for All Programs,	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Non-Covered for Package C			
G8781	DOCUMENTATION OF MEDICAL REASON(S) FOR PATIENT NOT RECEIVING COUNSELING FOR DIET AND PHYSICAL ACTIVITY (E.G. PATIENTS WHO HAVE A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8782	COUNSELING FOR DIET AND PHYSICAL ACTIVITY NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8783	BLOOD PRESSURE SCREENING PERFORMED AS RECOMMENDED BY THE DEFINED SCREENING INTERVAL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8784	BLOOD PRESSURE NOT ASSESSED, PATIENT NOT ELIGIBLE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8785	BLOOD PRESSURE SCREENING NOT PERFORMED AS RECOMMENDED BY SCREENING INTERVAL, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8786	SEVERITY OF ANGINA ASSESSED ACCORDING TO LEVEL OF ACTIVITY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8787	ANGINA ASSESSED AS PRESENT	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8788	ANGINA ASSESSED AS ABSENT	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		C			
G8789	SEVERITY OF ANGINA NOT ASSESSED ACCORDING TO LEVEL OF ACTIVITY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8790	MOST RECENT OFFICE VISIT SYSTOLIC BLOOD PRESSURE <130 MM HG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8791	MOST RECENT OFFICE VISIT SYSTOLIC BLOOD PRESSURE, 130 TO 139 MM HG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8792	MOST RECENT OFFICE VISIT SYSTOLIC BLOOD PRESSURE >=140 MM HG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8793	MOST RECENT OFFICE VISIT DIASTOLIC BLOOD PRESSURE, <80 MM HG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8794	MOST RECENT OFFICE VISIT DIASTOLIC BLOOD PRESSURE, 80 - 89 MM HG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8795	MOST RECENT OFFICE VISIT DIASTOLIC BLOOD PRESSURE >=90 MM HG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8796	BLOOD PRESSURE MEASUREMENT NOT DOCUMENTED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8797	SPECIMEN SITE OTHER THAN ANATOMIC LOCATION OF ESOPHAGUS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8798	SPECIMEN SITE OTHER THAN ANATOMIC LOCATION	Non-Covered for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	OF PROSTATE	Programs, Non-Covered for Package C			
G8799	ANTICOAGULATION ORDERED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8800	ANTICOAGULATION NOT ORDERED FOR REASONS DOCUMENTED BY CLINICIAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8801	ANTICOAGULATION WAS NOT ORDERED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8802	PREGNANCY TEST (URINE OR SERUM) ORDERED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8803	PREGNANCY TEST (URINE OR SERUM) NOT ORDERED FOR REASONS DOCUMENTED BY CLINICIAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8805	PREGNANCY TEST (URINE OR SERUM) WAS NOT ORDERED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8806	PERFORMANCE OF TRANS-ABDOMINAL OR TRANS-VAGINAL ULTRASOUND	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8807	TRANS-ABDOMINAL OR TRANS-VAGINAL ULTRASOUND NOT PERFORMED FOR REASONS DOCUMENTED BY CLINICIAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8808	PERFORMANCE OF TRANS-ABDOMINAL OR TRANS-VAGINAL ULTRASOUND NOT ORDERED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		C			
G8809	RH-IMMUNOGLOBULIN (RHOGAM) ORDERED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8810	R-IMMUNOGLOBULIN (RHOGAM) NOT ORDERED FOR REASONS DOCUMENTED BY CLINICIAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8811	DOCUMENTATION RH-IMMUNOGLOBULIN (RHOGAM) WAS NOT ORDERED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8812	PATIENT IS NOT ELIGIBLE FOR FOLLOW-UP CTA, DUPLEX, OR MRA	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8813	FOLLOW-UP CTA, DUPLEX, OR MRA OF THE ABDOMEN AND PELVIS PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8814	FOLLOW-UP CTA, DUPLEX, OR MRA OF THE ABDOMEN AND PELVIS NOT PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8815	STATIN THERAPY NOT PRESCRIBED FOR DOCUMENTED REASONS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8816	STATIN MEDICATION PRESCRIBED AT DISCHARGE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8817	STATIN THERAPY NOT PRESCRIBED AT DISCHARGE, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8818	PATIENT DISCHARGE TO HOME NO LATER THAN	Non-Covered for All	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	POST-OPERATIVE DAY #7	Programs, Non-Covered for Package C			
G8819	ANEURYSM MINOR DIAMETER <= 5.5 CM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8820	ANEURYSM MINOR DIAMETER 5.6-6.0 CM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8821	ABDOMINAL AORTIC ANEURYSM IS NOT INFARENAL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8822	MALE PATIENTS WITH ANEURYSMS MINOR DIAMETER >6 CM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8823	FEMALE PATIENTS WITH ANEURYSM MINOR DIAMETER >6CM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8824	FEMALE PATIENTS WITH ANEURYSM MINOR DIAMETER 5.6-6.0 CM	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8825	PATIENT NOT DISCHARGED TO HOME BY POST-OPERATIVE DAY #7	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8826	PATIENT DISCHARGE TO HOME NO LATER THAN POST-OPERATIVE DAY #2 FOLLOWING EVAR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8827	ANEURYSM MINOR DIAMETER <= 5.5 CM FOR WOMEN	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		C			
G8828	ANEURYSM MINOR DIAMETER <= 5.5 CM FOR MEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8829	ANEURYSM MINOR DIAMETER 5.6-6.0 CM FOR MEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8830	ANEURYSM MINOR DIAMETER >6CM FOR MEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8831	ANEURYSM MINOR DIAMETER >6CM FOR WOMEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8832	ANEURYSM MINOR DIAMETER 5.6-6.0 CM FOR WOMEN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8833	PATIENT NOT DISCHARGED TO HOME BY POST-OPERATIVE DAY #2 FOLLOWING EVAR	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8834	PATIENT DISCHARGED TO HOME NO LATER THAN POST-OPERATIVE DAY #2 FOLLOWING CEA	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8835	ASYMPTOMATIC PATIENT WITH NO HISTORY OF ANY TRANSIENT ISCHEMIC ATTACK OR STROKE IN ANY CAROTID OR VERTEBROBASILAR TERRITORY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8836	SYMPTOMATIC PATIENT WITH IPSILATERAL STROKE OR TIA WITHIN 120 DAYS PRIOR TO CEA	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8837	OTHER SYMPTOMATIC	Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	PATIENT WITH IPSILATERAL CAROTID TERRITORY TIA OR STROKE > 120 DAYS PRIOR TO CEA, OR CONTRALATERAL CAROTID TERRITORY TIA OR STROKE OR VERTEBROBASILAR TIA OR STROKE	for All Programs, Non-Covered for Package C			
G8838	PATIENT NOT DISCHARGED TO HOME BY POST-OPERATIVE DAY #2	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8839	SLEEP APNEA SYMPTOMS ASSESSED, INCLUDING PRESENCE OR ABSENCE OF SNORING AND DAYTIME SLEEPINESS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8840	DOCUMENTATION OF REASON(S) FOR NOT PERFORMING AN ASSESSMENT OF SLEEP SYMPTOMS (E.G., PATIENT DIDN'T HAVE INITIAL DAYTIME SLEEPINESS, PATIENT VISITS BETWEEN INITIAL TESTING AND INITIATION OF THERAPY)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8841	SLEEP APNEA SYMPTOMS NOT ASSESSED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8842	APNEA HYPOPNEA INDEX (AHI) OR RESPIRATORY DISTURBANCE INDEX (RDI) MEASURED AT THE TIME OF INITIAL DIAGNOSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8843	DOCUMENTATION OF REASON(S) FOR NOT MEASURING AN APNEA HYPOPNEA INDEX (AHI) OR A RESPIRATORY DISTURBANCE INDEX (RDI) AT THE TIME OF INITIAL DIAGNOSIS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8844	APNEA HYPOPNA INDEX (AHI) OR RESPIRATORY DISTURBANCE INDEX (RDI) NOT MEASURED AT THE TIME OF INITIAL DIAGNOSIS, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8845	POSITIVE AIRWAY	Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	PRESSURE THERAPY PRESCRIBED	for All Programs, Non-Covered for Package C			
G8846	MODERATE OR SEVERE OBSTRUCTIVE SLEEP APNEA (APNEA HYPOPNEA INDEX (AHI) OR RESPIRATORY DISTURBANCE INDEX (RDI) OF 15 OR GREATER)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8847	POSITIVE AIRWAY PRESSURE THERAPY NOT PRESCRIBED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8848	MILD OBSTRUCTIVE SLEEP APNEA (APNEA HYPOPNEA INDEX (AHI) OR RESPIRATORY DISTURBANCE INDEX (RDI) OF LESS THAN 15)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8849	DOCUMENTATION OF REASON(S) FOR NOT PRESCRIBING POSITIVE AIRWAY PRESSURE THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8850	POSITIVE AIRWAY PRESSURE THERAPY NOT PRESCRIBED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8851	OBJECTIVE MEASUREMENT OF ADHERENCE TO POSITIVE AIRWAY PRESSURE THERAPY, DOCUMENTED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8852	POSITIVE AIRWAY PRESSURE THERAPY PRESCRIBED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8853	POSITIVE AIRWAY PRESSURE THERAPY NOT PRESCRIBED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8854	DOCUMENTATION OF REASON(S) FOR NOT OBJECTIVELY MEASURING ADHERENCE TO POSITIVE	Non-Covered for All Programs, Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	AIRWAY PRESSURE THERAPY	for Package C			
G8855	OBJECTIVE MEASUREMENT OF ADHERENCE TO POSITIVE AIRWAY PRESSURE THERAPY NOT PERFORMED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8856	REFERRAL TO A PHYSICIAN FOR AN OTOLOGIC EVALUATION PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8857	PATIENT IS NOT ELIGIBLE FOR THE REFERRAL FOR OTOLOGIC EVALUATION MEASURE (E.G., PATIENTS WHO ARE ALREADY UNDER THE CARE OF A PHYSICIAN FOR ACUTE OR CHRONIC DIZZINESS)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8858	REFERRAL TO A PHYSICIAN FOR AN OTOLOGIC EVALUATION NOT PERFORMED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8859	PATIENT RECEIVING CORTICOSTEROIDS GREATER THAN OR EQUAL TO 10MG/DAY FOR 60 OR GREATER CONSECUTIVE DAYS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8860	PATIENTS WHO HAVE RECEIVED DOSE OF CORTICOSTEROIDS GREATER THAN OR EQUAL TO 10MG/DAY FOR 60 OR GREATER CONSECUTIVE DAYS	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8861	CENTRAL DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA) ORDERED OR DOCUMENTED, REVIEW OF SYSTEMS AND MEDICATION HISTORY OR PHARMACOLOGIC THERAPY (OTHER THAN MINERALS/VITAMINS) FOR OSTEOPOROSIS PRESCRIBED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8862	PATIENTS NOT RECEIVING CORTICOSTEROIDS GREATER THAN OR EQUAL TO 10MG/DAY FOR 60 OR GREATER CONSECUTIVE	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	DAYS	C			
G8863	PATIENTS NOT ASSESSED FOR RISK OF BONE LOSS, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8864	PNEUMOCOCCAL VACCINE ADMINISTERED OR PREVIOUSLY RECEIVED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8865	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT ADMINISTERING OR PREVIOUSLY RECEIVING PNEUMOCOCCAL VACCINE (E.G., PATIENT ALLERGIC REACTION, POTENTIAL ADVERSE DRUG REACTION)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8866	DOCUMENTATION OF PATIENT REASON(S) FOR NOT ADMINISTERING OR PREVIOUSLY RECEIVING PNEUMOCOCCAL VACCINE (E.G., PATIENT REFUSAL)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8867	PNEUMOCOCCAL VACCINE NOT ADMINISTERED OR PREVIOUSLY RECEIVED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8868	PATIENTS RECEIVING A FIRST COURSE OF ANTI-TNF THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8869	PATIENT HAS DOCUMENTED IMMUNITY TO HEPATITIS B AND IS RECEIVING A FIRST COURSE OF ANTI-TNF THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8870	HEPATITIS B VACCINE INJECTION ADMINISTERED OR PREVIOUSLY RECEIVED AND IS RECEIVING A FIRST COURSE OF ANTI-TNF THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8871	PATIENT NOT RECEIVING A FIRST COURSE OF ANTI-TNF THERAPY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
G8872	EXCISED TISSUE EVALUATED BY IMAGING INTRAOPERATIVELY TO CONFIRM SUCCESSFUL INCLUSION OF TARGETED LESION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8873	PATIENTS WITH NEEDLE LOCALIZATION SPECIMENS WHICH ARE NOT AMENABLE TO INTRAOPERATIVE IMAGING SUCH AS MRI NEEDLE WIRE LOCALIZATION, OR TARGETS WHICH ARE TENTATIVELY IDENTIFIED ON MAMMOGRAM OR ULTRASOUND WHICH DO NOT CONTAIN A BIOPSY MARKER BUT WHICH CAN BE VERIFIED ON INTRAOPERATIVE INSPECTION OR PATHOLOGY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8874	EXCISED TISSUE NOT EVALUATED BY IMAGING INTRAOPERATIVELY TO CONFIRM SUCCESSFUL INCLUSION OF TARGETED LESION	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8875	CLINICIAN DIAGNOSED BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8876	DOCUMENTATION OF REASON(S) FOR NOT PERFORMING MINIMALLY INVASIVE BIOPSY TO DIAGNOSE BREAST CANCER PROPERATIVELY	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8877	CLINICIAN DID NOT ATTEMPT TO ACHIEVE THE DIAGNOSIS OF BREAST CANCER PREOPERATIVELY BY A MINIMALLY INVASIVE BIOPSY METHOD, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8878	SENTINEL LYMPH NODE BIOPSY PROCEDURE PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8879	CLINICALLY NODE NEGATIVE (T1N0M0) OR T2N0M0) INVASIVE BREAST CANCER	Non-Covered for All Programs,	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Non-Covered for Package C			
G8880	DOCUMENTATION OF REASON(S) SENTINEL LYMPH NODE BIOPSY NOT PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8881	STAGE OF BREAST CANCER IS GREATER THAN T1N0M0 OR T2N0M0	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8882	SENTINEL LYMPH NODE BIOPSY PROCEDURE NOT PERFORMED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8883	BIOPSY RESULTS REVIEWED, COMMUNICATED, TRACKED AND DOCUMENTED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8884	CLINICIAN DOCUMENTED REASON THAT PATIENT'S BIOPSY RESULTS WERE NOT REVIEWED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8885	BIOPSY RESULTS NOT REVIEWED, COMMUNICATED, TRACKED OR DOCUMENTED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8886	MOST RECENT BLOOD PRESSURE UNDER CONTROL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8887	DOCUMENTATION OF MEDICAL REASON(S) FOR MOST RECENT BLOOD PRESSURE NOT BEING UNDER CONTROL (E.G. PATIENTS WITH COMORBID CONDITIONS THAT CAUSE AN INCREASE IN BLOOD PRESSURE OR REQUIRE TREATMENT WITH MEDICATIONS THAT CAUSE AN INCREASE IN BLOOD	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	PRESSURE, OR PATIENTS WHO HAD A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)				
G8888	MOST RECENT BLOOD PRESSURE NOT UNDER CONTROL, RESULTS DOCUMENTED AND REVIEWED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8889	NO DOCUMENTATION OF BLOOD PRESSURE MEASUREMENT, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8890	MOST RECENT LDL-C UNDER CONTROL, RESULTS DOCUMENTED AND REVIEWED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8891	DOCUMENTATION OF MEDICAL REASON(S) FOR MOST RECENT LDL-C NOT UNDER CONTROL (E.G. PATIENTS WHO HAD A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8892	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PERFORMING LDL-C TEST (E.G. PATIENTS WHO HAD A TERMINAL ILLNESS OR FOR WHOM TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8893	MOST RECENT LDL-C NOT UNDER CONTROL, RESULTS DOCUMENTED AND REVIEWED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8894	LDL-C NOT PERFORMED, REASON NOT SPECIFIED	Non-Covered for All Programs, Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		for Package C			
G8895	ORAL ASPIRIN OR OTHER ANTICOAGULANT/ANTIPLATELET THERAPY PRESCRIBED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8896	DOCUMENTATION OF MEDICAL REASON(S) FOR NOT PRESCRIBING ORAL ASPIRIN OR OTHER ANTICOAGULANT/ANTIPLATELET THERAPY (E.G. UNDER AGE 30, PATIENT DOCUMENTED TO BE LOW RISK, PATIENT WITH TERMINAL ILLNESS OR TREATMENT OF HYPERTENSION WITH STANDARD TREATMENT GOALS IS NOT CLINICALLY APPROPRIATE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8897	ORAL ASPIRIN OR OTHER ANTICOAGULANT/ANTIPLATELET THERAPY WAS NOT PRESCRIBED, REASON NOT OTHERWISE SPECIFIED	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8898	I INTEND TO REPORT THE CHRONIC OBSTRUCTIVE PULMONARY DISEASE MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8899	I INTEND TO REPORT THE INFLAMMATORY BOWEL DISEASE MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8900	I INTEND TO REPORT THE OBSTRUCTIVE SLEEP APNEA MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8901	I INTEND TO REPORT THE EPILEPSY MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8902	I INTEND TO REPORT THE DEMENTIA MEASURES GROUP	Non-Covered for All Programs, Non-Covered	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		for Package C			
G8903	I INTEND TO REPORT THE PARKINSON'S DISEASE MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8904	I INTEND TO REPORT THE HYPERTENSION MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8905	I INTEND TO REPORT THE CARDIOVASCULAR PREVENTION MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G8906	I INTEND TO REPORT THE CATARACT MEASURES GROUP	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
G9156	EVALUATION FOR WHEELCHAIR REQUIRING FACE TO FACE VISIT WITH PHYSICIAN	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
J0131	INJECTION, ACETAMINOPHEN, 10 MG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
J0221	INJECTION, ALGLUCOSIDASE ALFA, (LUMIZYME), 10 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J0257	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN), (GLASSIA), 10 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J0490	INJECTION, BELIMUMAB, 10 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J0712	INJECTION, CEFTAROLINE FOSAMIL, 10 MG	Covered for All Programs, Covered for	No for All Programs, No for Package C	NA	YES

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Package C			
J0840	INJECTION, CROTALIDAE POLYVALENT IMMUNE FAB (OVINE), UP TO 1 GRAM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J0897	INJECTION, DENOSUMAB, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J1725	INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
J2265	INJECTION, MINOCYCLINE HYDROCHLORIDE, 1 MG	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
J2507	INJECTION, PEGLOTICASE, 1 MG	Covered for All Programs, Covered for Package C	Yes for All Programs, Yes for Package C	NA	YES
J7131	HYPERTONIC SALINE SOLUTION, 1 ML	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
J7180	INJECTION, FACTOR XIII (ANTIHEMOPHILIC FACTOR, HUMAN), 1 I.U.	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J7183	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J7326	HYALURONAN OR DERIVATIVE, GEL-ONE, FOR INTRA-ARTICULAR INJECTION, PER DOSE	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
J7665	MANNITOL, ADMINISTERED THROUGH AN INHALER, 5 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J8561	EVEROLIMUS, ORAL, 0.25 MG	Non-Covered for All Programs, Non-Covered for Package	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		C			
J9043	INJECTION, CABAZITAXEL, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J9179	INJECTION, ERIBULIN MESYLATE, 0.1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
J9228	INJECTION, IPILIMUMAB, 1 MG	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
L5312	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, SINGLE AXIS KNEE, PYLON, SACH FOOT, ENDOSKELETAL SYSTEM	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
L6715	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
Q0162	ONDANSETRON 1 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	YES
Q4122	DERMACELL, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER	Covered for All Programs,	No for All Programs, No for	NA	NO

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
	SQUARE CENTIMETER	Covered for Package C	Package C		
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
Q4126	MEMODERM, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
Q4127	TALYMED, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
Q4128	FLEXHD OR ALLOPATCH HD, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
Q4129	UNITE BIOMATRIX, PER SQUARE CENTIMETER	Covered for All Programs, Covered for Package C	No for All Programs, No for Package C	NA	NO
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
S0119	ONDANSETRON, ORAL, 4 MG (FOR CIRCUMSTANCES FALLING UNDER THE MEDICARE STATUTE, USE HCPCS Q CODE)	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
S3722	DOSE OPTIMIZATION BY AREA UNDER THE CURVE (AUC) ANALYSIS, FOR INFUSIONAL 5-FLUOROURACIL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	Non-Covered for All Programs, Non-Covered for Package C	NA	NA	NA
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	Non-Covered for All Programs,	NA	NA	NA

Procedure Code	Description	Program Coverage	PA Requirements	Modifiers	NDC Required
		Non-Covered for Package C			

Table 2 – New Modifier Code for the 2012 Annual HCPCS Update

Modifier Code	Description	Type	Date Effective
PD*	DIAGNOSTIC OR RELATED NON DIAGNOSTIC ITEM OR SERVICE PROVIDED IN A WHOLLY OWNED OR OPERATED ENTITY TO A PATIENT WHO IS ADMITTED AS AN INPATIENT WITHIN 3 DAYS	Informational	1/1/2012

*Even though compliance with the Final Rule is delayed until July 1, 2012, entities should begin using modifier PD on applicable claims as soon as possible.

Table 3 – Deleted HCPCS Codes, Effective January 1, 2012

Procedure Code	Description	Alternate Codes for Consideration
0141T	PANCREATIC ISLET CELL TRANSPLANTATION THROUGH PORTAL VEIN, PERCUTANEOUS	NA
0142T	PANCREATIC ISLET CELL TRANSPLANTATION THROUGH PORTAL VEIN, OPEN	NA
0143T	LAPAROSCOPY, SURGICAL, PANCREATIC ISLET CELL TRANSPLANTATION THROUGH PORTAL VEIN	NA
0155T	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE (IE, MORBID OBESITY)	NA
0156T	LAPAROSCOPY, SURGICAL; REVISION OR REMOVAL OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE (IE, MORBID OBESITY)	NA
0157T	LAPAROTOMY, IMPLANTATION OR REPLACEMENT OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE (IE, MORBID OBESITY)	NA
0158T	LAPAROTOMY, REVISION OR REMOVAL OF GASTRIC STIMULATION ELECTRODES, LESSER CURVATURE (IE, MORBID OBESITY)	NA
0166T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITHOUT CARDIOPULMONARY BYPASS	NA
0167T	TRANSMYOCARDIAL TRANSCATHETER CLOSURE OF VENTRICULAR SEPTAL DEFECT, WITH IMPLANT; WITH CARDIOPULMONARY BYPASS	NA
0168T	RHINOPHOTOTHERAPY, INTRANASAL APPLICATION OF ULTRAVIOLET AND VISIBLE LIGHT, BILATERAL	NA
11975	INSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES	11981
11977	REMOVAL WITH REINSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES	11981
15170	ACELLULAR DERMAL REPLACEMENT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15278
15171	ACELLULAR DERMAL REPLACEMENT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15278

Procedure Code	Description	Alternate Codes for Consideration
15175	ACELLULAR DERMAL REPLACEMENT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15278
15176	ACELLULAR DERMAL REPLACEMENT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15278
15300	ALLOGRAFT SKIN FOR TEMPORARY WOUND CLOSURE, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15274
15301	ALLOGRAFT SKIN FOR TEMPORARY WOUND CLOSURE, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15274
15320	ALLOGRAFT SKIN FOR TEMPORARY WOUND CLOSURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15275-15278
15321	ALLOGRAFT SKIN FOR TEMPORARY WOUND CLOSURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15275-15278
15330	ACELLULAR DERMAL ALLOGRAFT, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15274
15331	ACELLULAR DERMAL ALLOGRAFT, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15274
15335	ACELLULAR DERMAL ALLOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15275-15278
15336	ACELLULAR DERMAL ALLOGRAFT, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15275-15278
15340	TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE; FIRST 25 SQ CM OR LESS	15271-15278
15341	TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE; EACH ADDITIONAL 25 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15278
15360	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15274
15361	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15274
15365	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS,	15275-15278

Procedure Code	Description	Alternate Codes for Consideration
	FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	
15366	TISSUE CULTURED ALLOGENEIC DERMAL SUBSTITUTE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15275-15278
15400	XENOGRAFT, SKIN (DERMAL), FOR TEMPORARY WOUND CLOSURE, TRUNK, ARMS, LEGS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15274
15401	XENOGRAFT, SKIN (DERMAL), FOR TEMPORARY WOUND CLOSURE, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15274
15420	XENOGRAFT SKIN (DERMAL), FOR TEMPORARY WOUND CLOSURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15275-15278
15421	XENOGRAFT SKIN (DERMAL), FOR TEMPORARY WOUND CLOSURE, FACE, SCALP, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15275-15278
15430	ACELLULAR XENOGRAFT IMPLANT; FIRST 100 SQ CM OR LESS, OR 1% OF BODY AREA OF INFANTS AND CHILDREN	15271-15278
15431	ACELLULAR XENOGRAFT IMPLANT; EACH ADDITIONAL 100 SQ CM, OR EACH ADDITIONAL 1% OF BODY AREA OF INFANTS AND CHILDREN, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	15271-15278
32095	THORACOTOMY, LIMITED, FOR BIOPSY OF LUNG OR PLEURA	32096, 32097, 32098
32402	BIOPSY, PLEURA; OPEN	32098
32500	REMOVAL OF LUNG, OTHER THAN TOTAL PNEUMONECTOMY; WEDGE RESECTION, SINGLE OR MULTIPLE	32505, 32506, 32507, 19260-19272, 32480, 32482, 32484, 32486, 32488, 32505, 32506, 32507
32602	THORACOSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE); LUNGS AND PLEURAL SPACE, WITH BIOPSY	C32607, 32608, 32609
32603	THORACOSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE); PERICARDIAL SAC, WITHOUT BIOPSY	32601
32605	THORACOSCOPY, DIAGNOSTIC (SEPARATE PROCEDURE); MEDIASTINAL SPACE, WITHOUT BIOPSY	32601, 39010
32657	THORACOSCOPY, SURGICAL; WITH WEDGE RESECTION OF LUNG, SINGLE OR MULTIPLE	32666, 32667, 32668
32660	THORACOSCOPY, SURGICAL; WITH TOTAL PERICARDIECTOMY	NA
35548	BYPASS GRAFT, WITH VEIN; AORTOILIOFEMORAL, UNILATERAL	35537, 35539, 35565
35549	BYPASS GRAFT, WITH VEIN; AORTOILIOFEMORAL, BILATERAL	35537, 35538, 35539, 35540, 35565
35551	BYPASS GRAFT, WITH VEIN; AORTOFEMORAL-POPLITEAL	35539, 35540, 35556, 35583

Procedure Code	Description	Alternate Codes for Consideration
35651	BYPASS GRAFT, WITH OTHER THAN VEIN; AORTOFEMORAL-POPLITEAL	35646, 35647, 35656
37620	INTERRUPTION, PARTIAL OR COMPLETE, OF INFERIOR VENA CAVA BY SUTURE, LIGATION, PLICATION, CLIP, EXTRAVASCULAR, INTRAVASCULAR (UMBRELLA DEVICE)	37191, 37619
4002F	STATIN THERAPY, PRESCRIBED (CAD)1	4013F
4006F	BETA-BLOCKER THERAPY PRESCRIBED (CAD, HF)1	4008F
4009F	ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR OR ANGIOTENSIN RECEPTOR BLOCKER (ARB) THERAPY PRESCRIBED (HF, CAD, CKD)1, (DM)2	NA
4275F	HEPATITIS B VACCINE INJECTION ADMINISTERED OR PREVIOUSLY RECEIVED (HIV)5	4149F
49080	PERITONEOCENTESIS, ABDOMINAL PARACENTESIS, OR PERITONEAL LAVAGE (DIAGNOSTIC OR THERAPEUTIC); INITIAL	49082-49084
49081	PERITONEOCENTESIS, ABDOMINAL PARACENTESIS, OR PERITONEAL LAVAGE (DIAGNOSTIC OR THERAPEUTIC); SUBSEQUENT	49082-49084
64560	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE	NA
64577	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES; AUTONOMIC NERVE	NA
64622	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL	64633-64636
64623	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	64633-64636
64626	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; CERVICAL OR THORACIC, SINGLE LEVEL	64633-64636
64627	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; CERVICAL OR THORACIC, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	64633-64636
69802	LABYRINTHOTOMY, WITH PERFUSION OF VESTIBULOACTIVE DRUG(S); WITH MASTOIDECTOMY	NA
71090	INSERTION PACEMAKER, FLUOROSCOPY AND RADIOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION	33206-33249, 76000
73542	RADIOLOGICAL EXAMINATION, SACROILIAC JOINT ARTHROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION	27096
75722	ANGIOGRAPHY, RENAL, UNILATERAL, SELECTIVE (INCLUDING FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION	36251, 36253
75724	ANGIOGRAPHY, RENAL, BILATERAL, SELECTIVE (INCLUDING FLUSH AORTOGRAM), RADIOLOGICAL SUPERVISION AND INTERPRETATION	36252, 36254
75940	PERCUTANEOUS PLACEMENT OF IVC FILTER, RADIOLOGICAL SUPERVISION AND INTERPRETATION	37191
77079	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)	NA
77083	RADIOGRAPHIC ABSORPTIOMETRY (EG, PHOTODENSITOMETRY, RADIOGRAMMETRY), 1 OR MORE SITES	NA
78220	LIVER FUNCTION STUDY WITH HEPATOBILIARY AGENTS, WITH SERIAL IMAGES	NA
78223	HEPATOBILIARY DUCTAL SYSTEM IMAGING, INCLUDING	78226, 78227

Procedure Code	Description	Alternate Codes for Consideration
	GALLBLADDER, WITH OR WITHOUT PHARMACOLOGIC INTERVENTION, WITH OR WITHOUT QUANTITATIVE MEASUREMENT OF GALLBLADDER FUNCTION	
78584	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION; SINGLE BREATH	78579, 78582-78598
78585	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION; REBREATHING AND WASHOUT, WITH OR WITHOUT SINGLE BREATH	78579, 78582-78598
78586	PULMONARY VENTILATION IMAGING, AEROSOL; SINGLE PROJECTION	78579, 78582-78598
78587	PULMONARY VENTILATION IMAGING, AEROSOL; MULTIPLE PROJECTIONS (EG, ANTERIOR, POSTERIOR, LATERAL VIEWS)	78579, 78582-78598
78588	PULMONARY PERFUSION IMAGING, PARTICULATE, WITH VENTILATION IMAGING, AEROSOL, 1 OR MULTIPLE PROJECTIONS	78579, 78582-78598
78591	PULMONARY VENTILATION IMAGING, GASEOUS, SINGLE BREATH, SINGLE PROJECTION	78579, 78582-78598
78593	PULMONARY VENTILATION IMAGING, GASEOUS, WITH REBREATHING AND WASHOUT WITH OR WITHOUT SINGLE BREATH; SINGLE PROJECTION	78579, 78582-78598
78594	PULMONARY VENTILATION IMAGING, GASEOUS, WITH REBREATHING AND WASHOUT WITH OR WITHOUT SINGLE BREATH; MULTIPLE PROJECTIONS (EG, ANTERIOR, POSTERIOR, LATERAL VIEWS)	78579, 78582-78598
78596	PULMONARY QUANTITATIVE DIFFERENTIAL FUNCTION (VENTILATION/ PERFUSION) STUDY	78579, 78582-78598
88107	CYTOPATHOLOGY, FLUIDS, WASHINGS OR BRUSHINGS, EXCEPT CERVICAL OR VAGINAL; SMEARS AND SIMPLE FILTER PREPARATION WITH INTERPRETATION	88104, 88106, 88112
88318	DETERMINATIVE HISTOCHEMISTRY TO IDENTIFY CHEMICAL COMPONENTS (EG, COPPER, ZINC)	88313
90470	H1N1 IMMUNIZATION ADMINISTRATION (INTRAMUSCULAR, INTRANASAL), INCLUDING COUNSELING WHEN PERFORMED	NA
90663	INFLUENZA VIRUS VACCINE, PANDEMIC FORMULATION, H1N1	NA
92070	FITTING OF CONTACT LENS FOR TREATMENT OF DISEASE, INCLUDING SUPPLY OF LENS	92071, 92072
92120	TONOGRAPHY WITH INTERPRETATION AND REPORT, RECORDING INDENTATION TONOMETER METHOD OR PERILIMBAL SUCTION METHOD	0198T
92130	TONOGRAPHY WITH WATER PROVOCATION	0198T
93720	PLETHYSMOGRAPHY, TOTAL BODY; WITH INTERPRETATION AND REPORT	94726
93721	PLETHYSMOGRAPHY, TOTAL BODY; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT	94726
93722	PLETHYSMOGRAPHY, TOTAL BODY; INTERPRETATION AND REPORT ONLY	94726

Procedure Code	Description	Alternate Codes for Consideration
93875	NONINVASIVE PHYSIOLOGIC STUDIES OF EXTRACRANIAL ARTERIES, COMPLETE BILATERAL STUDY (EG, PERIORBITAL FLOW DIRECTION WITH ARTERIAL COMPRESSION, OCULAR PNEUMOPLETHYSMOGRAPHY, DOPPLER ULTRASOUND SPECTRAL ANALYSIS)	NA
94240	FUNCTIONAL RESIDUAL CAPACITY OR RESIDUAL VOLUME: HELIUM METHOD, NITROGEN OPEN CIRCUIT METHOD, OR OTHER METHOD	94726, 94727
94260	THORACIC GAS VOLUME	94726, 94727
94350	DETERMINATION OF MALDISTRIBUTION OF INSPIRED GAS: MULTIPLE BREATH NITROGEN WASHOUT CURVE INCLUDING ALVEOLAR NITROGEN OR HELIUM EQUILIBRATION TIME	94726, 94727
94360	DETERMINATION OF RESISTANCE TO AIRFLOW, OSCILLATORY OR PLETHYSMOGRAPHIC METHODS	94726, 94728
94370	DETERMINATION OF AIRWAY CLOSING VOLUME, SINGLE BREATH TESTS	94726, 94727
94720	CARBON MONOXIDE DIFFUSING CAPACITY (EG, SINGLE BREATH, STEADY STATE)	94729
94725	MEMBRANE DIFFUSION CAPACITY	94729
C9270	INJECTION, IMMUNE GLOBULIN (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	J1557
C9272	INJECTION, DENOSUMAB, 1 MG	J0897
C9273	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION	Q2043
C9274	CROTALIDAE POLYVALENT IMMUNE FAB (OVINE), 1 VIAL	J0840
C9276	INJECTION, CABAZITAXEL, 1 MG	J9043
C9277	INJECTION, ALGLUCOSIDASE ALFA (LUMIZYME), 1 MG	J0221
C9278	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	J0588
C9280	INJECTION, ERIBULIN MESYLATE, 1 MG	J9179
C9281	INJECTION, PEGLOTICASE, 1 MG	J2507
C9282	INJECTION, CEFTAROLINE FOSAMIL, 10 MG	J0712
C9283	INJECTION, ACETAMINOPHEN, 10 MG	J0131
C9284	INJECTION, IPILIMUMAB, 1 MG	J9228
C9365	OASIS ULTRA TRI-LAYER MATRIX, PER SQUARE CENTIMETER	Q4124
C9406	IODINE I-123 IOFLUPANE, DIAGNOSTIC, PER STUDY DOSE, UP TO 5 MILLICURIES	A9584
C9729	PERCUTANEOUS LAMINOTOMY/LAMINECTOMY (INTRALAMINAR APPROACH) FOR DECOMPRESSION OF NEURAL ELEMENTS, (WITH LIGAMENTOUS RESECTION, DISCECTOMY, FACETECTOMY AND/OR FORAMINOTOMY, WHEN PERFORMED) ANY METHOD UNDER INDIRECT IMAGE GUIDANCE, WITH THE USE OF AN ENDOSCOPE WHEN PERFORMED, SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; LUMBAR	NA
C9730	BRONCHOSCOPIC BRONCHIAL THERMOPLASTY WITH IMAGING GUIDANCE (IF PERFORMED), RADIOFREQUENCY ABLATION OF AIRWAY SMOOTH MUSCLE, 1 LOBE	0276T
C9731	BRONCHOSCOPIC BRONCHIAL THERMOPLASTY WITH IMAGING GUIDANCE (IF PERFORMED), RADIOFREQUENCY ABLATION OF AIRWAY SMOOTH MUSCLE, 2 OR MORE LOBES	0277T

Procedure Code	Description	Alternate Codes for Consideration
E0571	AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER	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
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
G8440	DOCUMENTATION OF PAIN ASSESSMENT (INCLUDING LOCATION, INTENSITY AND DESCRIPTION) PRIOR TO INITIATION OF THERAPY OR DOCUMENTATION OF THE ABSENCE OF PAIN AS A RESULT OF ASSESSMENT THROUGH DISCUSSION WITH THE PATIENT INCLUDING THE USE OF A STANDARDIZED TOOL AND A FOLLOW-UP PLAN IS DOCUMENTED	NA
G8441	NO DOCUMENTATION OF PAIN ASSESSMENT (INCLUDING LOCATION, INTENSITY AND DESCRIPTION) PRIOR TO INITIATION OF THERAPY	NA
G8508	DOCUMENTATION OF PAIN ASSESSMENT (INCLUDING LOCATION, INTENSITY AND DESCRIPTION) PRIOR TO INITIATION OF THERAPY OR DOCUMENTATION OF THE ABSENCE OF PAIN AS A RESULT OF ASSESSMENT THROUGH DISCUSSION WITH THE PATIENT INCLUDING THE USE OF A STANDARDIZED TOOL; NO DOCUMENTATION OF A FOLLOW-UP PLAN, PATIENT NOT ELIGIBLE	NA
G8534	DOCUMENTATION OF AN ELDER MALTREATMENT SCREEN AND FOLLOW-UP PLAN	NA
G8537	ELDER MALTREATMENT SCREEN DOCUMENTED, FOLLOW-UP PLAN NOT DOCUMENTED, PATIENT NOT ELIGIBLE	NA
G8538	ELDER MALTREATMENT SCREEN DOCUMENTED, FOLLOW-UP PLAN NOT DOCUMENTED, REASON NOT SPECIFIED	NA
G8636	INFLUENZA IMMUNIZATION ADMINISTERED OR PREVIOUSLY RECEIVED	NA
G8637	CLINICIAN DOCUMENTED THAT PATIENT IS NOT ELIGIBLE TO RECEIVE THE INFLUENZA IMMUNIZATION	NA
G8638	INFLUENZA IMMUNIZATION NOT ADMINISTERED OR PREVIOUSLY RECEIVED, REASON NOT OTHERWISE SPECIFIED	NA
G8639	INFLUENZA IMMUNIZATION WAS ADMINISTERED OR PREVIOUSLY RECEIVED	NA
G8640	CLINICIAN HAS DOCUMENTED THAT PATIENT IS NOT ELIGIBLE TO RECEIVE THE INFLUENZA IMMUNIZATION	NA
G8641	INFLUENZA IMMUNIZATION WAS NOT ADMINISTERED OR PREVIOUSLY RECEIVED, REASON NOT OTHERWISE SPECIFIED	NA
G8675	MOST RECENT SYSTOLIC BLOOD PRESSURE >= 140 MM HG	NA
G8676	MOST RECENT DIASTOLIC BLOOD PRESSURE >= 90 MM HG	NA
G8677	MOST RECENT SYSTOLIC BLOOD PRESSURE < 130 MM HG	NA
G8678	MOST RECENT SYSTOLIC BLOOD PRESSURE 130 TO 139 MM HG	NA
G8679	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG	NA
G8680	MOST RECENT DIASTOLIC BLOOD PRESSURE 80 - 89 MM HG	NA
G8681	PATIENT HOSPITALIZED WITH PRINCIPAL DIAGNOSIS OF HEART FAILURE DURING THE MEASUREMENT PERIOD	NA
G8684	PATIENT NOT HOSPITALIZED WITH PRINCIPAL DIAGNOSIS OF HEART FAILURE DURING THE MEASUREMENT PERIOD	NA
G8686	CURRENTLY A TOBACCO SMOKER OR CURRENT EXPOSURE TO SECONDHAND SMOKE	NA
G8687	CURRENTLY A TOBACCO NON-USER AND NO EXPOSURE TO SECONDHAND SMOKE	NA
G8688	CURRENTLY A SMOKELESS TOBACCO USER (EG, CHEW, SNUFF)	NA

Procedure Code	Description	Alternate Codes for Consideration
	AND NO EXPOSURE TO SECONDHAND SMOKE	
G8689	TOBACCO USE NOT ASSESSED, REASON NOT OTHERWISE SPECIFIED	NA
G8690	CURRENT TOBACCO SMOKER OR CURRENT EXPOSURE TO SECONDHAND SMOKE	NA
G8691	CURRENT TOBACCO NON-USER AND NO EXPOSURE TO SECONDHAND SMOKE	NA
G8692	CURRENT SMOKELESS TOBACCO USER (EG, CHEW, SNUFF) AND NO EXPOSURE TO SECONDHAND SMOKE	NA
G8693	TOBACCO USE NOT ASSESSED, REASON NOT SPECIFIED	NA
G9041	REHABILITATION SERVICES FOR LOW VISION BY QUALIFIED OCCUPATIONAL THERAPIST, DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES	NA
G9042	REHABILITATION SERVICES FOR LOW VISION BY CERTIFIED ORIENTATION AND MOBILITY SPECIALISTS, DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES	NA
G9043	REHABILITATION SERVICES FOR LOW VISION BY CERTIFIED LOW VISION REHABILITATION THERAPIST, DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES	NA
G9044	REHABILITATION SERVICES FOR LOW VISION BY CERTIFIED LOW VISION REHABILITATION TEACHER, DIRECT ONE-ON-ONE CONTACT, EACH 15 MINUTES	NA
J7130	HYPERTONIC SALINE SOLUTION, 50 OR 100 MEQ, 20 CC VIAL	J7131
J7184	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, PER 100 IU VWF:RCO	J7183
L1500	THORACIC-HIP-KNEE-ANKLE ORTHOSIS (THKAO), MOBILITY FRAME (NEWINGTON, PARAPODIUM TYPES)	NA
L1510	THKAO, STANDING FRAME, WITH OR WITHOUT TRAY AND ACCESSORIES	NA
L1520	THKAO, SWIVEL WALKER	NA
L3964	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2626
L3965	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, ADJUSTABLE RANCHO TYPE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2627
L3966	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2628
L3968	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2629
L3969	SHOULDER ELBOW ORTHOSIS, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	E2630
L3970	SEO, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROXIMAL ARM	E2631
L3972	SEO, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL	E2632
L3974	SEO, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR	E2633
L4380	PNEUMATIC KNEE SPLINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	NA
L5311	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT, ENDOSKELETAL SYSTEM	NA

Procedure Code	Description	Alternate Codes for Consideration
L7266	SERVO CONTROL, STEEPER OR EQUAL	NA
L7272	ANALOGUE CONTROL, UNB OR EQUAL	NA
L7274	PROPORTIONAL CONTROL, 6-12 VOLT, LIBERTY, UTAH OR EQUAL	NA
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE (EXCLUDES V5335 REPAIR OF ORAL OR LARYNGEAL PROSTHESIS OR ARTIFICIAL LARYNX)	NA
Q0179	ONDANSETRON HYDROCHLORIDE 8 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	NA
Q1003	NEW TECHNOLOGY INTRAOCULAR LENS CATEGORY 3 (REDUCED SPHERICAL ABERRATION)	NA
Q2040	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT	J0588
Q2041	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF:RCO	J7183
Q2042	INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG	J1725
Q2044	INJECTION, BELIMUMAB, 10 MG	J0490
S0181	ONDANSETRON HYDROCHLORIDE, ORAL, 4MG (FOR CIRCUMSTANCES FALLING UNDER THE MEDICARE STATUTE, USE Q0179)	S0119
S0625	RETINAL TELESCREENING BY DIGITAL IMAGING OF MULTIPLE DIFFERENT FUNDUS AREAS TO SCREEN FOR VISION-THREATENING CONDITIONS, INCLUDING IMAGING, INTERPRETATION AND REPORT	NA
S2270	INSERTION OF VAGINAL CYLINDER FOR APPLICATION OF RADIATION SOURCE OR CLINICAL BRACHYTHERAPY (REPORT SEPARATELY IN ADDITION TO RADIATION SOURCE DELIVERY)	NA
S2344	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ENLARGEMENT OF SINUS OSTIUM OPENING USING INFLATABLE DEVICE (I.E., BALLOON SINUPLASTY)	NA
S3628	PLACENTAL ALPHA MICROGLOBULIN-1 RAPID IMMUNOASSAY FOR DETECTION OF RUPTURE OF FETAL MEMBRANES	NA
S3905	NON-INVASIVE ELECTRODIAGNOSTIC TESTING WITH AUTOMATIC COMPUTERIZED HAND-HELD DEVICE TO STIMULATE AND MEASURE NEUROMUSCULAR SIGNALS IN DIAGNOSING AND EVALUATING SYSTEMIC AND ENTRAPMENT NEUROPATHIES	NA
S9075	SMOKING CESSATION TREATMENT	S2344

Table 4 – New 2012 Annual HCPCS Codes Under Review for Coverage

Procedure Code	Description
81206	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MAJOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE
81207	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MINOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE
81208	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; OTHER BREAKPOINT, QUALITATIVE OR QUANTITATIVE
81250	G6PC (GLUCOSE-6-PHOSPHATASE, CATALYTIC SUBUNIT) (EG, GLYCOGEN STORAGE DISEASE, TYPE 1A, VON GIERKE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, R83C, Q347X)
81261	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIAS AND LYMPHOMAS, B-CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); AMPLIFIED METHODOLOGY (EG, POLYMERASE CHAIN REACTION)
81262	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIAS AND LYMPHOMAS, B-CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL

Procedure Code	Description
	POPULATION(S); DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)
81263	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS) (EG, LEUKEMIA AND LYMPHOMA, B-CELL), VARIABLE REGION SOMATIC MUTATION ANALYSIS
81264	IGK@ (IMMUNOGLOBULIN KAPPA LIGHT CHAIN LOCUS) (EG, LEUKEMIA AND LYMPHOMA, B-CELL), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)
81265	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; PATIENT AND COMPARATIVE SPECIMEN (EG, PRE-TRANSPLANT RECIPIENT AND DONOR GERMLINE TESTING, POST-TRANSPLANT NON-HEMATOPOIETIC RECIPIENT GERMLINE [EG, BUCCAL SWAB OR OTHER GERMLINE TISSUE SAMPLE] AND DONOR TESTING, TWIN ZYGOSITY TESTING, OR MATERNAL CELL CONTAMINATION OF FETAL CELLS)
81266	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; EACH ADDITIONAL SPECIMEN (EG, ADDITIONAL CORD BLOOD DONOR, ADDITIONAL FETAL SAMPLES FROM DIFFERENT CULTURES, OR ADDITIONAL ZYGOSITY IN MULTIPLE BIRTH PREGNANCIES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
81267	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITHOUT CELL SELECTION
81268	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITH CELL SELECTION (EG, CD3, CD33), EACH CELL TYPE
81340	TRB@ (T CELL ANTIGEN RECEPTOR, BETA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING AMPLIFICATION METHODOLOGY (EG, POLYMERASE CHAIN REACTION)
81341	TRB@ (T CELL ANTIGEN RECEPTOR, BETA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)
81342	TRG@ (T CELL ANTIGEN RECEPTOR, GAMMA) (EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)
81370	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-A, -B, -C, -DRB1/3/4/5, AND -DQB1
81371	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-A, -B, AND -DRB1/3/4/5 (EG, VERIFICATION TYPING)
81372	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); COMPLETE (IE, HLA-A, -B, AND -C)
81373	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA-A, -B, OR -C), EACH
81374	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT (EG, B*27), EACH
81375	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA-DRB1/3/4/5 AND -DQB1
81376	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, OR -DPA1), EACH
81377	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT, EACH
81378	HLA CLASS I AND II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS), HLA-A, -B, -C, AND -DRB1
81379	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); COMPLETE (IE, HLA-A, -B, AND -C)
81380	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA-A, -B, OR -C), EACH
81381	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE ALLELE OR ALLELE GROUP (EG, B*57:01P), EACH
81382	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, OR -DPA1), EACH
81383	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE ALLELE OR ALLELE GROUP (EG, HLA-DQB1*06:02P), EACH

Procedure Code	Description
81400	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 1 (EG, IDENTIFICATION OF SINGLE GERMLINE VARIANT [EG, SNP] BY TECHNIQUES SUCH AS RESTRICTION ENZYME DIGESTION OR MELT CURVE ANALYSIS)
81401	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 2 (EG, 2-10 SNPS, 1 METHYLATED VARIANT, OR 1 SOMATIC VARIANT [TYPICALLY USING NONSEQUENCING TARGET VARIANT ANALYSIS], OR DETECTION OF A DYNAMIC MUTATION DISORDER/TRIPLET REPEAT)
81402	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 3 (EG, >10 SNPS, 2-10 METHYLATED VARIANTS, OR 2-10 SOMATIC VARIANTS [TYPICALLY USING NON-SEQUENCING TARGET VARIANT ANALYSIS], IMMUNOGLOBULIN AND T-CELL RECEPTOR GENE REARRANGEMENTS, DUPLICATION/DELETION VARIANTS 1 EXON)
81403	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 4 (EG, ANALYSIS OF SINGLE EXON BY DNA SEQUENCE ANALYSIS, ANALYSIS OF >10 AMPLICONS USING MULTIPLEX PCR IN 2 OR MORE INDEPENDENT REACTIONS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 2-5 EXONS)
81404	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 5 (EG, ANALYSIS OF 2-5 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/ DELETION VARIANTS OF 6-10 EXONS, OR CHARACTERIZATION OF A DYNAMIC MUTATION DISORDER/TRIPLET REPEAT BY SOUTHERN BLOT ANALYSIS)
81405	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 6 (EG, ANALYSIS OF 6-10 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/ DELETION VARIANTS OF 11-25 EXONS)
81406	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 7 (EG, ANALYSIS OF 11-25 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 26-50 EXONS, CYTOGENOMIC ARRAY ANALYSIS FOR NEOPLASIA)
81407	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 8 (EG, ANALYSIS OF 26-50 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF >50 EXONS, SEQUENCE ANALYSIS OF MULTIPLE GENES ON ONE PLATFORM)
81408	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 9 (EG, ANALYSIS OF >50 EXONS IN A SINGLE GENE BY DNA SEQUENCE ANALYSIS)

Table 5 – New 2012 HCPCS Codes, Effective January 1, 2012 Under Review for Pricing

Procedure Code	Description
77424	INTRAOPERATIVE RADIATION TREATMENT DELIVERY, X-RAY, SINGLE TREATMENT SESSION
77425	INTRAOPERATIVE RADIATION TREATMENT DELIVERY, ELECTRONS, SINGLE TREATMENT SESSION
81200	ASPA (ASPARTOACYLASE) (EG, CANAVAN DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, E285A, Y231X)
81211	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS IN BRCA1 (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP,
81212	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; 185DELAG, 5385INSC, 6174DELT VARIANTS
81213	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; UNCOMMON DUPLICATION/DELETION VARIANTS
81214	BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND COMMON DUPLICATION/DELETION VARIANTS (IE, EXON 13 DEL 3.835KB, EXON 13 DUP 6KB, EXON 14-20 DEL 26KB, EXON 22 DEL 510BP, EXON 8-9 DEL 7.1KB)
81215	BRCA1 (BREAST CANCER 1) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT
81216	BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE

Procedure Code	Description
	ANALYSIS; FULL SEQUENCE ANALYSIS
81217	BRCA2 (BREAST CANCER 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT
81228	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) MICROARRAY ANALYSIS; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER VARIANTS (EG, BACTERIAL ARTIFICIAL CHROMOSOME [BAC] OR OLIGO-BASED COMPARATIVE GENOMIC HYBRIDIZATION [CGH] MICROARRAY ANALYSIS)
81229	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) MICROARRAY ANALYSIS; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND SINGLE NUCLEOTIDE POLYMORPHISM (SNP) VARIANTS FOR CHROMOSOMAL ABNORMALITIES
81251	GBA (GLUCOSIDASE, BETA, ACID) (EG, GAUCHER DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, N370S, 84GG, L444P, IVS2+1G>A)
81255	HEXA (HEXOSAMINIDASE A [ALPHA POLYPEPTIDE]) (EG, TAY-SACHS DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, 1278INSTATC, 1421+1G>C, G269S)
81257	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2) (EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS, FOR COMMON DELETIONS OR VARIANT (EG, SOUTHEAST ASIAN, THAI, FILIPINO, MEDITERRANEAN, ALPHA3.7, ALPHA4.2, ALPHA20.5, A
81260	IKBKAP (INHIBITOR OF KAPPA LIGHT POLYPEPTIDE GENE ENHANCER IN B-CELLS, KINASE COMPLEX-ASSOCIATED PROTEIN) (EG, FAMILIAL DYSAUTONOMIA) GENE ANALYSIS, COMMON VARIANTS (EG, 2507+6T>C, R696P)
81280	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); FULL SEQUENCE ANALYSIS
81281	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); KNOWN FAMILIAL SEQUENCE VARIANT
81282	LONG QT SYNDROME GENE ANALYSES (EG, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, AND ANK2); DUPLICATION/DELETION VARIANTS
81290	MCOLN1 (MUCOLIPIN 1) (EG, MUCOLIPIDOSIS, TYPE IV) GENE ANALYSIS, COMMON VARIANTS (EG, IVS3-2A>G, DEL6.4KB)
81330	SMPD1(SPHINGOMYELIN PHOSPHODIESTERASE 1, ACID LYSOSOMAL) (EG, NIEMANN-PICK DISEASE, TYPE A) GENE ANALYSIS, COMMON VARIANTS (EG, R496L, L302P, FSP330)
81331	SNRPN/UBE3A (SMALL NUCLEAR RIBONUCLEOPROTEIN POLYPEPTIDE N AND UBIQUITIN PROTEIN LIGASE E3A) (EG, PRADER-WILLI SYNDROME AND/OR ANGELMAN SYNDROME), METHYLATION ANALYSIS
93998	UNLISTED NONINVASIVE VASCULAR DIAGNOSTIC STUDY
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH
L6715	TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER
Q4129	UNITE BIOMATRIX, PER SQUARE CENTIMETER

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

Procedure Code	Description	Outpatient Rate for UB-04 Claims Only	Effective Date of Rate
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	$347.10	1/1/2012

78226	HEPATOBILIARY SYSTEM IMAGING, INCLUDING GALLBLADDER WHEN PRESENT;	$222.86	1/1/2012
78227	HEPATOBILIARY SYSTEM IMAGING, INCLUDING GALLBLADDER WHEN PRESENT; WITH PHARMACOLOGIC INTERVENTION, INCLUDING QUANTITATIVE MEASUREMENT(S) WHEN PERFORMED	$309.48	1/1/2012
78579	PULMONARY VENTILATION IMAGING (EG, AEROSOL OR GAS)	$115.00	1/1/2012
78582	PULMONARY VENTILATION (EG, AEROSOL OR GAS) AND PERFUSION IMAGING	$206.28	1/1/2012
78597	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION, INCLUDING IMAGING WHEN PERFORMED	$123.28	1/1/2012
78598	QUANTITATIVE DIFFERENTIAL PULMONARY PERFUSION AND VENTILATION (EG, AEROSOL OR GAS), INCLUDING IMAGING WHEN PERFORMED	$199.81	1/1/2012