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2011 Coding Update

The latest Medicare news for California, Guam, Hawaii, Nevada, American Samoa, & Northern Mariana Islands providers.

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Annual HCPCS/CPT Coding Update

Effective January 1, 2011, providers must use the HCPCS/CPT codes that are valid at the time the service is rendered. If claims are submitted with discontinued codes, they will be rejected.

To ensure prompt and timely payment of claims, use the new HCPCS/CPT codes for 2011 beginning with services rendered on or after January 1, 2011. Each year thereafter, be sure to adopt the new codes.

CMS no longer allows a 90-day grace period for discontinued codes. This also applies to any mid-year HCPCS/CPT deletions.

You Are Responsible. . .

The *Medicare Advisory* contains coverage, billing, and other information for providers in California, Guam, Hawaii, Nevada, American Samoa, & Northern Mariana Islands. This information is not intended to constitute legal advice. It is our official notice to the providers we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA Web site. It is the responsibility of each provider to obtain this information and to follow the guidelines. The *Medicare Advisory* includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time.

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our Web site at: http://www.PalmettoGBA.com/Medicare.

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2011 HCPCS Update
Effective January 1, 2011

Recently, carriers received the year 2011 additions, changes and deletions to the Centers for Medicare and Medicaid Services (CMS) Common Procedure Coding System (HCPCS). The HCPCS codes are effective for dates of service on or after January 1, 2011. CMS no longer allows a 90-day grace period for discontinued codes. This also applies to any mid-year HCPCS/CPT deletions.

HCPCS is a collection of codes and descriptors that represent procedure, supplies, products and services which may be provided to Medicare beneficiaries and individuals enrolled in private health insurance programs. HCPCS also contains modifiers, which are two-position codes and descriptors used to indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. The codes and modifiers are divided into three levels:

LEVEL I – Codes and descriptors copyrighted by the American Medical Association's Current Procedure Terminology (CPT), Standard Edition. These are five-position numeric codes ranging from 00000 to 99999, primarily representing physician services. Level I modifiers are two-position numeric codes.

LEVEL II – Five-position alphanumeric codes, ranging from A0000 to V9999, representing primarily items and nonphysician services that are not represented in the Level I category. These codes and descriptors, with the exception of the D series, are approved and maintained by the Alphanumeric Editorial Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association) and are listed in the HCPCS Level II code book. The D series includes codes copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). Level II modifiers are two-position alphanumeric codes.

LEVEL III – Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are five-position alphanumeric codes in the W, X, Y or Z series (ranging from W0000 to Z9999) representing physician and nonphysician services that are not represented in the Level I or Level II codes. Level III modifiers are two-position alphanumeric codes in the W, X, Y or Z series.

The year 2010 additions, changes and deletions for the HCPCS codes are listed on the following pages. Please use this information to supplement your current materials. Note that the codes listed as changes previously may have had different descriptions of service. **It is important that the most current HCPCS codes are submitted on all claims, so please be sure to use the year 2011 versions of the respective code books.**

Special Instructions

- The additions and deletions for the 2011 HCPCS Update are effective by date of service instead of implementation date.
- The procedure codes listed as additions are valid for services performed on or after January 1, 2011. If these procedure codes are used for dates of service prior to January 1, 2011, the services will be rejected.
- The procedure codes listed as deletions are valid for dates of service up to and including December 31, 2010.

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Additions: 2011 HCPCS Modifiers

HCPCS Modifier	Description
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD
AZ	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
CS	Item or service related, in whole or in part, to an illness, injury, of condition that was caused by or exacerbated by the effective, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities
DA	Oral health assessment by a licensed health professional other than a dentist
GU	Waiver of liability statement issued as required by payer policy, routine notice
GX	Notice of liability issued, voluntary under payer policy (eff 4/1/2010)
NB	Nebulizer system, any type, FDA-cleared for us with specific drug
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure

Changes: 2011 HCPCS Modifiers

HCPCS Codes	Description
GA	Waiver of liability statement issued as required by payer policy, individual case
RA	Replacement of a DME, Orthotic or Prosthetic item
RB	Replacement of a part of a DME, Orthotic or Prosthetic item furnished as part of a repair
V5	Vascular catheter (alone of with any other vascular access)
V6	Arteriovenous graft (or other vascular access not including a vascular catheter)
V7	Arteriovenous fistula only (in use with two needles)

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Additions: 2011 HCPCS/CDT/CPT Codes

HCPCS Code	Description
A4566	Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment
A7020	Interface for cough stimulating device, includes all components, replacement only
A9273	Hot water bottle, ice cap or collar, heat and/or cold wrap, any type
C9274	Crotalidae polyvalent immune fab (ovine), 1 vial
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose
C9276	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (lumizyme), 1 mg
C9278	Injection, incobotulinumtoxin a, 1 unit
C9279	Injection, ibuprofen, 100 mg
D1352*	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
D3354*	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration
D5992*	Adjust maxillofacial prosthetic appliance
D5993*	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
D6254*	Interin pontic
D6795*	Interim retainer crown
D7251*	Coronectomy - intentional partial tooth removal
D7295*	Harvest of bone for use in autogenous grafting procedure
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories
E1831	Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth

* CDT Codes

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HCPCS Code	Description
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)
G0163	Skilled services by a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0164	Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
G0434	Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

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HCPCS Code	Description
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
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
G8629	Documentation of order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)
G8630	Documentation that administration of prophylactic parenteral antibiotics was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered
G8631	Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral antibiotics to be given within one hour (if fluroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)
G8632	Prophylactic parenteral antibiotics were not ordered to be given or given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified)
G8633	Pharmacologic therapy (other than minierals/vitamins) for osteoporosis prescribed
G8634	Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis
G8635	Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified
G8636	Influenza immunization administered or previously received
G8637	Clinician documented that patient is not eligible to receive the influenza immunization
G8638	Influenza immunization not administered or previously received, reason not otherwise specified
G8639	Influenza immunization was administered or previously received
G8640	Clinician has documented that patient is not eligible to receive the influenza immunization
G8641	Influenza immunization was not administered or previously received, reason not otherwise specified
G8642	The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(a) of the Social Security Act

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HCPCS Code	Description
G8643	The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption for the application of the payment adjustment under section 1848 (A) (5) (A) of the Social Security Act
G8644	Eligible professional does not have prescribing privileges
G8645	I intend to report the asthma measures group
G8646	All quality actions for the applicable measures in the asthma measures group have been performed for this patient
G8647	Risk-adjusted functional status change residual score for the knee successfully calculated and the score was equal to zero (0) or greater than zero (>0)
G8648	Risk-adjusted functional status change residual score for the knee successfully calculated and the score was less than zero (<0)
G8649	Risk-adjusted functional status change residual scores for the knee not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate
G8650	Risk-adjusted functional status change residual scores for the knee not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified
G8651	Risk-adjusted functional status change residual score for the hip successfully calculated and the score was equal to zero (0) or greater than zero (>0)
G8652	Risk-adjusted functional status change residual score for the hip successfully calculated and the score was less than zero (<0)
G8653	Risk-adjusted functional status change residual scores for the hip not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate
G8654	Risk-adjusted functional status change residual scores for the hip not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified
G8655	Risk-adjusted functional status change residual score for the lower leg, foot or ankle successfully calculated and the score was equal to zero (0) or greater than zero (>0)
G8656	Risk-adjusted functional status change residual score for the lower leg, foot or ankle successfully calculated and the score was less than zero (<0)
G8657	Risk-adjusted functional status change residual scores for the lower leg, foot or ankle not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate

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HCPCS Code	Description
G8658	Risk-adjusted functional status change residual scores for the lower leg, foot or ankle not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified
G8659	Risk-adjusted functional status change residual score for the lumbar spine successfully calculated and the score was equal to zero (0) or greater than zero (>0)
G8660	Risk-adjusted functional status change residual score for the lumbar spine successfully calculated and the score was less than zero (<0)
G8661	Risk-adjusted functional status change residual scores for the lumbar spine not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate
G8662	Risk-adjusted functional status change residual scores for the lumbar spine not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified
G8663	Risk-adjusted functional status change residual score for the shoulder successfully calculated and the score was equal to zero (o) or greater than zero (>0)
G8664	Risk-adjusted functional status change residual score for the shoulder successfully calculated and the score was less than zero (<0)
G8665	Risk-adjusted functional status change residual scores for the shoulder not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate
G8666	Risk-adjusted functional status change residual scores for the shoulder not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified
G8667	Risk-adjusted functional status change residual score for the elbow, wrist or hand successfully calculated and the score was equal to zero (0) or greater
G8668	Risk-adjusted functional status change residual score for the elbow, wrist or hand successfully calculated and the score was less than zero (<0)
G8669	Risk-adjusted functional status change residual scores for the elbow, wrist or hand not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate
G8670	Risk-adjusted functional status change residual scores for the elbow, wrist or hand not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified

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HCPCS Code	Description
G8671	Risk-adjusted functional status change residual score for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment successfully calculated and the score was equal to zero (o) or greater than zero (>0)
G8672	Risk-adjusted functional status change residual score for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment successfully calculated and the score was less than zero (<0)
G8673	Risk-adjusted functional status change residual scores for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, patient not eligible/not appropriate
G8674	Risk-adjusted functional status change residual scores for the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment not measured because the patient did not complete foto's functional intake on admission and/or follow up status survey near discharge, reason not specified
G8675	Most recent systolic blood pressure >= 140 mm hg
G8676	Most recent diastolic blood pressure >= 90 mm hg
G8677	Most recent systolic blood pressure < 130 mm hg
G8678	Most recent systolic blood pressure 130 to 139 mm hg
G8679	Most recent diastolic blood pressure < 80 mm hg
G8680	Most recent diastolic blood pressure 80 - 89 mm hg
G8681	Patient hospitalized with principal diagnosis of heart failure during the measurement period
G8682	Left ventricular function testing performed during the measurement period
G8683	Clinician documented that patient is not an eligible candidate for left ventricular function testing during the measurement period
G8684	Patient not hospitalized with principal diagnosis of heart failure during the measurement period
G8685	Left ventricular function testing not performed during the measurement period, reason not specified
G8686	Currently a tobacco smoker or current exposure to secondhand smoke
G8687	Currently a tobacco non-user and no exposure to secondhand smoke
G8688	Currently a smokeless tobacco user (eg, chew, snuff) and no exposure to secondhand smoke

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HCPCS Code	Description
G8689	Tobacco use not assessed, reason not otherwise specified
G8690	Current tobacco smoker or current exposure to secondhand smoke
G8691	Current tobacco non-user and no exposure to secondhand smoke
G8692	Current smokeless tobacco user (eg, chew, snuff) and no exposure to secondhand smoke
G8693	Tobacco use not assessed, reason not specified
J0171	Injection, Adrenalin, Epinephrine, 0.1 mg
J0558	Injection, Penicillin G Benzathine and Penicllin G Procaine, 100,000 units
J0561	Injection, Penicillin G Benzathine, 100,000 units
J0597	Injection, C-1 Esterase inhibitor (human), Berinert, 10 units
J0638	Injection, Canakinumab, 1 mg
J0775	Injection, Collagenase, Clostridium Histolyticum, 0.01 mg
J1290	Injection, Ecallantide, 1 mg
J1559	Injection, Immune Globulin (Hizentra), 100 mg
J1599	Injection, Immune Globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg
J1786	Injection, Imiglucerase, 10 units
J1826	Injection, Interferon Beta-1A, 30 mcg
J2358	Injection, Olanzapine, long-acting, 1 mg
J2426	Injection, Paliperidone Palmitate extended release, 1 mg
J3095	Injection, Televancin, 10 mg
J3262	Injection, Tocilizumab, 1 mg
J3357	Injection, Ustekinumab, 1 mg
J3385	Injection, Velaglucerase alfa, 100 units
J7184	Injection, Von Willebrand Factor Complex (human), Wilate, per 100 IU VWF:RCO
J7196	Injection, Antithrombin Recombinant, 50 I.U.
J7309	Methyl Aminolevulinate (MAL) for topical administration, 16.8%, 1 gram
J7312	Injection, Dexamethasone, intravitreal implant, 0.1 mg
J7335	Capsaicin 8% patch, per 10 square centimeters

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HCPCS Code	Description
J7686	Treprostinil, inhalation solution, FDA-approved final product, non- compounded, administered through DME, unit dose form, 1.74 mg
J8562	Fludarabine Phosphate, oral, 10 mg
J9302	Injection, Ofatumumab, 10 mg
J9307	Injection, Pralatrexate, 1 mg
J9315	Injection, Romidepsin, 1 mg
J9351	Injection, Topotecan, 0.1 mg
L3674	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L4631	Ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated
L5961	Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control
L8693	Auditory osseointegrated device abutment, any length, replacement only
Q0478	Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type
Q0479	Power module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)
Q4117	Hyalomatrix, per square centimeter
Q4118	Matristem micromatrix, 1 mg

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HCPCS Code	Description
Q4119	Matristem wound matrix, per square centimeter
Q4120	Matristem burn matrix, per square centimeter
Q4121	Theraskin, per square centimeter
Q5010	Hospice home care provided in a hospice facility

CPT Codes
11045
11046
11047
22551
22552
29914
29915
29916
31295
31296
31297
31634
33620
33621
33622
37220
37221
37222
37223
37224
37225
37226
37227
37228

CPT Codes
37229
37230
37231
37232
37233
37234
37235
38900
43283
43327
43328
43332
43333
43334
43335
43336
43337
43338
43753
43754
43755
43756
43757
49327

CPT Codes
49412
49418
53860
57156
61781
61782
61783
64566
64568
64569
64570
64611
65778
65779
66174
66175
74176
74177
74178
76881
76882
80104
82930
83861

CPT Codes
84112
85598
86481
86902
87501
87502
87503
87906
88120
88121
88177
88363
88749
90460
90461
90654
90664
90666
90667
90668
90867
90868
91013

CPT Codes
91117
92132
92133
92134
92227
92228
93451
93452
93453
93454
93455
93456
93457
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CPT Codes
93566
93567
93568
95800
95801
96446
99224
99225
99226
1400F
3700F
3720F
4324F
4325F
4326F
4328F
4400F
6080F
6090F
0223T
0224T
0225T
0226T
0227T
0228T
0229T
0230T
0231T
0232T
0233T

CPT Codes
0234T
0235T
0236T
0237T
0238T
0239T
0240T
0241T
0242T
0243T
0244T
0245T
0246T
0247T
0248T
0249T
0250T
0251T
0252T
0253T
0254T
0255T
0256T
0257T
0258T
0259T
0260T
0261T

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Deletions: 2011 HCPCS/CPT Codes

HCPCS Codes	Description
C9255	Injection, paliperidone palmitate, 1 mg
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg
C9258	Injection, telavancin, 10 mg
C9259	Injection, pralatrexate, 1 mg
C9260	Injection, ofatumumab, 10 mg
C9261	Injection, ustekinumab, 1 mg
C9262	Fludarabine phosphate, oral, 1 mg
C9263	Injection, ecallantide, 1 mg
C9264	Injection, tocilizumab, 1 mg
C9265	Injection, romidepsin, 1 mg
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg
C9267	Injection, von willebrand factor complex (human), wilate, per 100 IU VWF; RCO
C9268	Capsaicin, patch, 10CM2
C9269	Injection, C-1 esterase inhibitor (human), berinert, 10 units
C9271	Injection, velaglucerase alfa, 100 units
C9801	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
C9802	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes
E0220	Hot water bottle
E0230	Ice cap or collar
E0238	Non-electric heat pad, moist
G0430	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
G8006	Acute myocardial infarction: patient documented to have received aspirin at arrival
G8007	Acute myocardial infarction: patient not documented to have received aspirin at arrival
G8008	Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure
G8009	Acute myocardial infarction: patient documented to have received beta-blocker at arrival
G8010	Acute myocardial infarction: patient not documented to have received beta-blocker at arrival

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HCPCS Codes	Description
G8011	Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure
G8012	Pneumonia: patient documented to have received antibiotic within 4 hours of presentation
G8013	Pneumonia: patient not documented to have received antibiotic within 4 hours of presentation
G8014	Clinician documented that pneumonia patient was not an eligible candidate for antibiotic within 4 hours of presentation measure
G8015	Diabetic patient with most recent hemoglobin A1C level (within the last 6 months) documented as greater than 9%
G8016	Diabetic patient with most recent hemoglobin A1C level (within the last 6 months) documented as less than or equal to 9%
G8017	Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1C measure
G8018	Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1C measure (6 months)
G8019	Diabetic patient with most recent low-density lipoprotein (within the last 2 months) documented as greater than or equal to 100 mg/dl
G8020	Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl
G8021	Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure
G8022	Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)
G8023	Diabetic patient with most recent blood pressure (within the last 6 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 MMHG diastolic
G8024	Diabetic patient with most recent blood pressure (within the last 6 months) documented as less than 140 systolic and less than 80 diastolic
G8025	Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure
G8026	Clinician has not provided care for the diabetic patient for the required time for blood pressure measure (within the last 6 months)
G8027	Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

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HCPCS Codes	Description
G8028	Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy
G8029	Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure
G8030	Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on beta-blocker therapy
G8031	Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on beta-blocker therapy
G8032	Clinician documented that heart failure patient was not eligible candidate for beta-blocker therapy measure
G8033	Prior myocardial infarction-coronary artery disease patient documented to be on beta-blocker therapy
G8034	Prior myocardial infarction-coronary artery disease patient not documented to be on beta-blocker therapy
G8035	Clinician documented that prior myocardial infarction-coronary artery disease patient was not eligible candidate for beta-blocker therapy measure
G8036	Coronary artery disease patient documented to be on antiplatelet therapy
G8037	Coronary artery disease patient not documented to be on antiplatelet therapy
G8038	Clinician documented that coronary artery diosease patient was not eligible candidate for antiplatelet therapy measure
G8039	Coronary artery disease – patient with low-density lipoprotein documented to be greater than 100 mg/dl
G8040	Coronary artery disease – patient with low-density lipoprotein documented to be less than or equal to 100 mg/dl
G8041	Clinician documented that coronary artery disease patient was not eligible candidate for low-density lipoprotein measure
G8051	Patient (female) documented to have been assessed for osteoporosis
G8052	Patient (female) not documented to have been assessed for osteoporosis
G8053	Clinician documented that (female) patient was not an eligible candidate for osteoporosis assessment measure
G8054	Patient not documented for the assessment for falls within last 12 months

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HCPCS Codes	Description
G8055	Patient documented for the assessment for falls within last 12 months
G8056	Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months
G8057	Patient documented to have received hearing assessment
G8058	Patient not documented to have received hearing assessment
G8059	Clinician documented that patient was not an eligible candidate for hearing assessment measure
G8060	Patient documented for the assessment of urinary incontinence
G8061	Patient not documented for the assessment of urinary incontinence
G8062	Clinician documented that patient was not an eligible candidate for urinary incontinence assessment measure
G8075	End stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or KT/V greater than or equal to 1.2)
G8076	End stage renal disease patient with documented dialysis dose of URR less than 65% (or KT/V less than 1.2)
G8077	Clinician documented that end stage renal disease patient was not an eligible candidate for URR or KT/V measure
G8078	End stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)
G8079	End stage renal diseade patient with documented hematocrit less than 33 (or hemoglobin less than 11)
G8080	Clinician documented that end stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure
G8081	End stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula
G8082	End stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula
G8085	End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula
G8093	Newly diagnosed chronic obstructive pulmonary disease (COPD) patient documented to have received smoking cessation intervention, within 3 months of diagnosis
G8094	Newly diagnosed chronic obstructive pulmonary disease (COPD) patient not documented to have received smoking cessation intervention, within 3 months of diagnosis

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HCPCS Codes	Description
G8099	Osteoporosis patient documented to have been prescribed calcium and vitamin D supplements
G8100	Clinician documented that osteoporosis patient was not an eligible candidate for calcium and vitamin D supplement measure
G8103	Newly diagnosed osteoporosis patients documented to have been treated with antiresorptive therapy and/or PTH within 3 months of diagnosis
G8103	Newly diagnosed osteoporosis patients documented to have been treated with antiresorptive therapy and/or PTH within 3 months of diagnosis
G8104	Clinician documented that newly diagnosed osteoporosis patient was not an eligible candidate for antiresorptive therapy and/or PTH treatment measure within 3 months of diagnosis
G8106	Within 6 months of suffering a nontraumatic fracture, female patient 65 years of age or older documented to have undergone bone mineral density testing or to have been prescribed a drug to treat or prevent osteoporosis
G8107	Clinician documented that female patient 65 years of age or older who suffered a nontraumatic fracture within the last 6 months was not an eligible candidate for measure to test bone mineral density or drug to treat or prevent osteoporosis
G8108	Patient documented to have received influenza vaccination during influenza season
G8109	Patient not documented to have received influenza vaccination during influenza season
G8110	Clinician documented that patient was not an eligible candidate for influenza vaccination measure
G8111	Patient (female) documented to have received a mammogram during the measurement year or prior year to the measurement year
G8112	Patient (female) not documented to have received a mammogram during the measurement year or prior year to the measurement year
G8113	Clinician documented that female patient was not an eligible candidate for mammography measure
G8114	Clinician did not provide care to patient for the required time of mammography measure (i.e., measurement year or prior year)
G8115	Patient documented to have received pneumococcal vaccination
G8116	Patient not documented to have received pneumococcal vaccination
G8117	Clinician documented that patient was not an eligible candidate for pneumococcal vaccination measure
G8129	Patient documented as being treated with antidepressant medication for at lease 6 months continuous treatment phase

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HCPCS Codes	Description
G8130	Patient not documented as being treated with antidepressant medication for at least 6 months continuous treatment phase
G8131	Clinician documented that patient was not an eligible candidate for antidepressant medication for continuous treatment phase
G8152	Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
G8153	Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
G8154	Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure
G8155	Patient with documented receipt of thromboembolism prophylaxis
G8156	Patient without documented receipt of thromboembolism prophylaxis
G8157	Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure
G8159	Patient documented to have received coronary artery bypass graft without use of internal mammary artery
G8162	Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade
G8164	Patient with isolated coronary artery bypass graft documented to have prolonged intubation
G8165	Patient with isolated coronary artery bypass graft not documented to have prolonged intubation
G8166	Patient with isolated coronary artery bypass graft documented to have required surgical re-exploration
G8167	Patient with isolated coronary artery bypass graft did not require surgical re-exploration
G8170	Patient with isolated coronary artery bypass graft documented to have been discharged on aspirin or clopidogrel
G8171	Patient with isolated coronary artery bypass graft not documented to have been discharged on aspirin or clopidogrel
G8172	Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for antiplatelet therapy at discharge measure
G8182	Clinician has not provided care for the cardiac patient for the required time for low-density lipoprotein measure (6 months)
G8183	Patient with heart failure and atrial fibrillation documented to be on warfarin therapy

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HCPCS Codes	Description
G8184	Clinician documented that patient with heart failure and atrial fibrillation was not an eligible candidate for warfarin therapy measure
G8185	Patients ediagnosed with symptomatic osteoarthritis with documented annual assessment of function and pain
G8186	Clinician documented that symptomatic osteoarthritis patient was not an eligible candidate for annual assessment of function and pain measure
G8193	Clinician did not document that an order for prophylactic antibiotic to be given within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required) was given
G8196	Clinician did not document a prophylactic antibiotic was administered within one hour (if vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)
G8200	Order for cefazolin or cefuroxime for antimicrobial prophylaxis not documented
G8204	Clinician did not document an order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time
G8209	Clinician did not document an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time
G8214	Clinician did not document an order was given for appropriate venous thromboembolism (VTE) prophylaxis to be given within 24 hrs prior to incision time or 24 hours after surgery end time
G8217	Patient not documented to have received DVT prophylaxis by end of hospital day 2
G8219	Patient documented to have received DVT prophylaxis by end of hospital day 2
G8220	Patient not documented to have received DVT prophylaxis by end of hospital day 2
G8221	Clinician documented that patient was not an eligible candidate for DVT prophylaxis by the end of hospital day 2, including physician documentation that patient is ambulatory
G8223	Patient not documented to have r3eceived prescription for antiplatelet therapy at discharge
G8226	Patient not documented to have received prescription for anticoagulant therapy at discharge
G8231	Patient not documented to have received T-PA or not documented to have been considered a candidate for T-PA administration
G8234	Patient not documented to have received dysphagia screening
G8238	Patient not documented to have received order for or consideration for rehabilitation services
G8240	Internal carotid stenosis patient in the 30-99% range, and no documentation of reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

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HCPCS Codes	Description
G8243	Patient not documented to have received CT or MRI and the presence or absence of hemorrhage, ass lesion and acute infarction not documented in the final report
G8246	Patient was not an eligible candidate for medical history review with assessment of new or changing holes
G8248	Patient with at least one alarm symptom not documented to have had upper endoscopy or referral for upper endoscopy
G8251	Patient not documented to have received an esophageal biopsy when suspicion of Barrett's esophagus is indicated in the endoscopy report
G8254	Patient with no documentation order for barium swallow test
G8257	Clinician has not documented reconciliation of discharge medications with current medication list in medical record
G8260	Patient not documented to have surrogate decision maker or advance care plan in medical record
G8263	Patient not documented to have been assessed for presence or absence of urinary incontinence
G8266	Patient not documented to have received characterization of urinary incontinence
G8268	Patient not documented to have received plan of care for urinary incontinence
G8271	Patient with no documentation of screening for fall risks (2 or more falls in the past year or any fall with injury in the past year)
G8274	Clinician has not documented presence or absence of alarm symptoms
G8276	Patient not documented to have received medical history with assessment of new or changing moles
G8279	Patient not documented to have received a complete physical skin exam
G8282	Patient not documented to have received counseling to perform a self-examination
G8285	Patient not documented to have received pharmacologic therapy
G8289	Patient with no documentation of calcium and vitamin D use or counseling regarding both calcium and vitamin D use, or exercise
G8293	COPD patient without spirometry results documented
G8296	COPD patient not documented to have inhaled bronchodilator therapy prescribed
G8298	Patient documented to have received optic nerve head evaluation
G8299	Patient not documented to have received optic nerve head evaluation
G8302	Patient documented to have a specific target intraocular pressure range goal
G8303	Patient not documented to have a specific target intraocular pressure range goal

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HCPCS Codes	Description
G8304	Clinician documented that patient was not an eligible candidate for a specific target intra-ocular pressure range goal
G8305	Clinician has not provided care for the primary open-angle glaucoma patient for the required time for treatment range goal documentation measurement
G8306	Primary open-angle glaucoma patient with intraocular pressure above the target range goal documented to have received plan of care
G8307	Primary open-angle glaucoma patient with intraocular pressure at or below goal, no plan of care necessary
G8308	Primary open-angle glaucoma patient with intraocular pressure above the target range goal, and not documented to have received plan of care during the reporting year
G8310	Patient not documented to have been prescribed/recommended at least one antioxidant vitamin or mineral supplement during the reporting year
G8314	Patient not documented to have received macular exam with documentation of presence or absence of macular thickening or hemorrhage and no documentation of level of macular degeneration severity
G8318	Patient documented not to have visual functional status assessed
G8322	Patient not documented to have had pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation
G8326	Patient not documented to have received fundus evaluation within six months prior to cataract surgery
G8330	Patient not documented to have received dilated macular or fundus exam with level of severity of retinopathy and the presence or absence of macular edema not documented
G8334	Documentation of findings of macular or fundus exam not communicated to the physician managing the patient's ongoing diabetes care
G8338	Clinician has not documented that communication was sent to the physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
G8341	Patient not documented to have had central dexa measurement or pharmacologic therapy
G8345	Patient not documented to have had central dexa measurement ordered or performed or pharmacologic therapy
G8351	Patient not documented to have had ECG
G8354	Patient not documented to have received or taken aspirin 24 hours before emergency department arrival or during emergency department stay

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HCPCS Codes	Description
G8357	Patient not documented to have had ECG
G8360	Patient not documented to have vital signs recorded and reviewed
G8362	Patient not documented to have oxygen saturation assessed
G8365	Patient not documented to have mental status assessed
G8367	Patient not documented to have appropriate empiric antibiotic prescribed
G8370	Asthma patients with numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire not documented
G8371	Chemotherapy documented as not received or prescribed for stage III colon cancer patients
G8372	Chemotherapy documented as received or prescribed for stage III colon cancer patients
G8373	Chemotherapy plan documented prior to chemotherapy administration
G8374	Chemotherapy plan not documented prior to chemotherapy administration
G8375	Chronic lymphocytic leukemia (CLL) patient with no documentation of baseline flow cytometry performed
C8376	Clinician documentation that breast cancer patient was not eligible for tamoxifen or aromatase inhibitor therapy measure
G8377	Clinician documentation that colon cancer patient is not eligible for chemotherapy measure
G8378	Clinician documentation that patient was not an eligible candidate for radiation therapy measure
G8379	Documentation of radiation therapy recommended within 12 months of first office visit
G8380	For patients with ER or PR positive, stage IC-III breast cancer, clinician did not document that the patient received or was prescribed tamoxifen or aromatase inhibitor
G8381	For patients with ER or PR positive, stage IC-III breast cancer, clinician documented or prescribed that the patient is receiving tamoxifen or aromatase inhibitor
G8382	Multiple myeloma patients with no documentation of prescribed or received intravenous bisphosphonate therapy
G8383	No documentation of radiation therapy recommended within 12 months of first office visit
G8384	Baseline cytogenetic testing not performed in patients with myelodysplastic syndrome (MDS) or acute leukemias
G8385	Diabetic patients with no documentation of hemoglobin A1C level (within the last 12 months)
G8386	Diabetic patients with no documentation of low-density lipoprotein (within the last 12 months)
G8387	End-stage renal disease patient with a hematocrit or hemoglobin not documented

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HCPCS Codes	Description
G8388	End-stage renal disease patient with URR or KT/V value not documented, but otherwise eligible for measure
G8389	Myelodysplastic syndrome (MDS) patients with no documentation of iron stores prior to receiving erythropoietin therapy
G8390	Diabetic patients with no documentation of blood pressure measurement (within the last 12 months)
G8391	Patients with persistent asthma, no documentation of preferred long term control medication or acceptable alternative treatment prescribed
G8402	Tobacco (smoke) use cessation intervention, counseling
G8403	Tobacco (smoke) use cessation intervention not counseled
G8407	ABI measured and documented
G8408	ABI measurement was not obtained
G8409	Clinician documented that patient was not an eligible candidate for ABI measurement measure
G8423	Documented that patient was screened and either influenza vaccination status is current or patient was counseled
G8424	Influenza vaccine status was not screened
G8425	Influenza vaccine status screened, patient not current and counseling was not provided
G8426	Documented that patient was not appropriate for screening and/or counseling about the influenza vaccine (e.g., allergy to eggs)
G8429	Incomplete or no provider documentation that patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary: nutritional# supplements) were assessed
G8434	Documentation of cognitive impairment screening using a standardized tool
G8435	No documentation of cognitive impairment screening using a standardized tool
G8436	Patient not eligible/not appropriate for cognitive impairment screening
G8437	Documentation of clinician and patient involvement with the development of a plan of care including signature by the practitioner/therapist and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative
G8438	No documentation of clinician and patient involvement with the development of a plan of care including signature by the practitioner/therapist and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

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HCPCS Codes	Description
G8439	Documentation that patient is not eligible for co-developing a plan of care including signature by the practitioner/therapist and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative
G8443	All prescriptions created during the encounter were generated using a qualified e-prescribing system
G8445	No prescriptions were generated during the encounter, provider does have access to a qualified e-prescribing system
G8446	Provider does have access to a qualified e-prescribing system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by state or federal law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances
G8449	Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit; use of this code implies that an EMR is in place and generally available
G8453	Tobacco use cessation intervention, counseling
G8454	Tobacco use cessation intervention not counseled, reason not specified
G8455	Current tobacco smoker
G8456	Current smokeless tobacco user
G8457	Current tobacco non-user
G8466	Clinician documented that patient is not an eligible candidate for suicide risk assessment; major depressive disorder, in remission
G8467	Documentation of new diagnosis of initial or recurrent episode of major depressive disorder
G8479	Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy
G8480	Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy
G8481	Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not specified
G8488	Clinician intends to report the end stage renal disease (ESRD) measure group
G8507	Provider documentation that patient is not eligible for patient verification of current medications
G8518	Clinical stage prior to surgery for lung cancer and esophageal cancer resection was recorded

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HCPCS Codes	Description
G8519	Clinician documented that patient was not eligible for clinical stage prior to surgery for lung cancer and esophageal cancer resection measure
G8520	Clinician stage prior to surgery for lung cancer and esophageal cancer resection was not recorded, reason not specified
J0128	Injection, abarelix, 10 mg
J0170	Injection, adrenalin, epinephrine, up to 1 ml ampule
J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0560	Injection, penicillin G benzathine, up to 600,000 units
J0570	Injection, penicillin G benzathine, up to 1,200,000 units
J0580	Injection, penicillin G benzathine, up to 2,400,000 units
J0704	Injection, betamethasone sodium phosphate, per 4 mg
J0970	Injection, estradiol valerate, up to 40 mg
J1390	Injection, estradiol valerate, up to 20 mg
J1470	Injection, gamma globulin, intramuscular, 2 cc
J1480	Injection, gamma globulin, intramuscular, 3 cc
J1490	Injection, gamma globulin, intramuscular, 4 cc
J1500	Injection, gamma globulin, intramuscular, 5 cc
J1510	Injection, gamma globulin, intramuscular, 6 cc
J1520	Injection, gamma globulin, intramuscular, 7 cc
J1530	Injection, gamma globulin, intramuscular, 8 cc
J1540	Injection, gamma globulin, intramuscular, 9 cc
J1550	Injection, gamma globulin, intramuscular, 10 cc
J1785	Injection, imiglucerase, per unit
J1825	Injection, interferon beta-1A, 33 mcg
J2321	Injection, nandrolone decanoate, up to 100 mg
J2322	Injection, nandrolone decanoate, up to 200 mg
J9062	Cisplatin, 50 mg
J9080	Cyclophosphamide, 200 mg
J9090	Cyclophosphamide, 500 mg
J9091	Cyclophosphamide, 1.0 gram

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HCPCS Codes	Description
J9092	Cyclophosphamide, 2.0 gram
J9093	Cyclophosphamide, lyophilized, 100 mg
J9094	Cyclophosphamide, lyophilized, 200 mg
J9095	Cyclophosphamide, lyophilized, 500 mg
J9096	Cyclophosphamide, lyophilized, 1.0 gram
J9097	Cyclophosphamide, lyophilized, 2.0 gram
J9110	Injection, cytarabine, 500 mg
J9140	Dacarbazine, 200 mg
J9290	Mitomycin, 20 mg
J9291	Mitomycin, 40 mg
J9350	Injection, topotecan, 4 mg
J9375	Vincristine sulfate, 2 mg
J9380	Vincristine sulfate, 5 mg
L3660	Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment
L3670	Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment
L3672	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3673	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3675	Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment
Q2025	Fludarabine phosphate, oral, 1 mg
Q4109	Skin substitute, tissuemend, per square centimeter

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CPT Codes
11040
11041
20000
33861
35454
35456
35459
35470
35473
35474
35480
35481
35482
35483
35484
35485
35490
35491
35492
35493
35494
35495
39502
39520
39530
39531
43324
43326
43600
49420

CPT Codes
61795
64573
75992
75993
75994
75995
75996
76150
76350
76880
82926
82928
86903
89100
89105
89130
89132
89135
89136
89140
89141
89225
89235
90465
90466
90467
90468
91000
91011
91012

CPT Codes
91052
91055
91105
91123
92135
93012
93014
93230
93231
93232
93233
93235
93236
93237
93501
93508
93510
93511
93514
93524
93526
93527
93528
93529
93539
93540
93541
93542
93543
93544

CPT Codes
93545
93555
93556
96445
0016T
0017T
0104T
0105T
0130T
0140T
0160T
0161T
0176T
0177T
0187T
0193T
0203T
0204T

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Changes: 2011 HCPCS/CDT/CPT Codes

HCPCS Code	Description
A4399	Ostomy irrigation supply; cone/catheter, with or without brush
A5112	Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each
A6011	Collagen based wound filler, gel/paste, per gram of collagen
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce
A6260	Wound cleansers, any type, any size
A6261	Wound filler, gel/paste, per fluid ounce, not otherwise specified
A6262	Wound filler, dry form, per gram, not otherwise specified
A7013	Filter, disposable, used with aerosol compressor or ultrasonic generator
D0486*	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report
D2940*	Protective restoration
D3351*	Apexification/recalcification/pulpal regeneration-initial visit (apicalclosure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3352*	Apexification/recalcification/pulpal regeneration-interim medication replacement (apical closure/calcific repair of perforation, root resorption, pulp space disinfection, etc.)
D6055*	Connecting bar – implant supported or abutment supported
D7210*	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7960*	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure
D9215*	Local anesthesia in conjunction with operative or surgical procedures
D9230*	Inhalation of nitrous oxide/anxiolysis, analgesia
D9420*	Hospital or ambulatory surgical center call
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0154	Direct skilled nursing services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes

* CDT Codes

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HCPCS Code	Description
G0431	Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
G8427	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional # supplements) documented by the provider, including drug name, dosage, frequency and route
G8428	Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional # supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified
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
G8441	No documentation of pain assessment (including location, intensity and description) prior to initiation of therapy
G8447	Patient encounter was documented using an EHR system that has been certified by an authorized testing and certification body (ATCB)
G8448	Patient encounter was documented using a PQRI qualified EHR or other acceptable systems
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
G8509	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, reason not specified
J0598	Injection, c-1 esterase inhibitor (human), cinryze, 10 units
J9060	Injection, cisplatin, powder or s0lution, 10 mg
L3671	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3677	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment
Q0499	Belt/vest/bag for use to carry external peripheral components of any type ventricular assist device, replacement only
Q4101	Apligraf, per square centimeter

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HCPCS Code	Description
Q4102	Oasis wound matrix, per square centimeter
Q4103	Oasis burn matrix, per square centimeter
Q4104	Integra bilayer matrix wound dressing (BMWD), per square centimeter
Q4105	Integra dermal regeneration template (DRT), per square centimeter
Q4106	Dermagraft, per square centimeter
Q4107	Graftjacket, per square centimeter
Q4108	Integra matrix, per square centimeter
Q4110	Primatrix, per square centimeter
Q4111	Gammagraft, per square centimeter
Q4112	Cymetra, injectable, 1 cc
Q4113	Graftjacket xpress, injectable, 1 cc
Q4115	Alloskin, per square centimeter
Q4116	Alloderm, per square centimeter

CPT Codes	CPT Codes	CPT Codes	CPT Codes	CPT Codes
11011	27070	43605	64483	75964
11012	27071	47480	64484	77003
11042	33411	47490	64575	82952
11043	33860	49324	64708	85597
11044	33863	49419	64712	86480
20005	33864	49421	64713	87901
20664	34900	49422	64714	88172
20930	35471	50250	65780	88332
20931	35526	50542	66761	88334
22315	35626	55866	69801	90470
22851	37205	55876	69802	90644
27065	37206	57155	75954	90650
27066	37207	64479	75960	90662
27067	37208	64480	75962	90663

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CPT Codes
90670
91010
93224
93225
93226
93227
93228
93229
93268
93270
93271
93272
93922
93923
93924
95857
95953
95956
97597
97598
0545F
1200F
1205F
2060F
3008F
3015F
3038F
3110F
3111F
3112F

CPT Codes
3293F
3294F
3323F
3324F
3328F
3650F
4004F
4047F
4048F
4063F
4255F
4256F
4330F
4340F
5200F
6070F
7010F
0184T
0191T
0208T
0209T
0210T
0211T
0212T
0213T
0214T
0215T
0216T
0217T
0218T

CPT Codes
0219T
0220T
0221T
0222T

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Bilateral Modifiers: Use of CPT Modifier 50 & HCPCS Modifiers RT & LT

Effective for claims processed on or after January 1, 2011, **the codes listed in this article cannot be submitted with CPT modifier 50 (Bilateral Procedure) or HCPCS modifiers RT (Right Side) or LT (Left Side), or the services will be rejected**. These codes are considered bilateral and /or the code descriptions include possible multiple services.

HCPCS Codes
G0202
G0204
G0268

CPT Codes
0201T
11010
11011
11012
21194
21195
21196
27158
27392
27395
30801
30802
30905
30906
31231
32853
32854
33880
33881

CPT Codes
33978
34803
35549
37185
37186
38562
38571
38572
40701
40702
40843
42507
42508
42509
42510
50540
51575
51585
51595
51820
52290
52300
52301
54130

CPT Codes
54135
54430
54901
55041
55200
55250
55300
55450
55815
55845
55865
56632
57109
57111
57112
57531
58210
58548
58565
58600
58605
58700
58720
58800

CPT Codes
58805
58900
58920
58925
58940
58950
58951
58952
58953
58954
58956
58957
58958
61000
61001
61253
63045
63046
63047
63295
64600
64611
69210
70330

CPT Codes
71060
71110
71111
73050
73520
73565
75662
75671
75680
75716
75724
75733
75743
75803
75807
75822
75833
75842
76102
76514
76516
76519*
76645
77057

*= Indicates Global & Technical Component (TC) Only

** = Indicates Professional Component (26) Only

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CPT Codes
77059
78458
92002
92004
92012
92014
92020
92025
92060
92065
92081
92082
92083
92100
92120
92130
92132
92133
92134
92136*
92140
92227
92228
92250
92260
92265
92270
92275
92283

CPT Codes
92284
92285
92286
92287
92312
92316
92550
92552
95553
92555
92556
92557
92561
92562
92563
92564
92565
92567
92568
92570
92571
92572
92575
92576
92577
92579
92582
92583
92584

CPT Codes
92585
92586
92587
92588
92596
92620
92625
92626
92640
93875
93880
93922
93923
93924
93925
93930
93965
93970
95865
95868
95925
95926
95930
96000
96001
96002
96003
96004

*= Indicates Global & Technical Component (TC) Only

** = Indicates Professional Component (26) Only

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Bilateral Indicator 3 Procedures
Coding Instructions

The following procedure codes have a Bilateral Indicator “3” on the Medicare Physician Fee Schedule Database (MPFSDB). This means, when performed bilaterally, the full fee schedule amount is payable for “each” side. The 50 percent reduction that occurs with Bilateral Indicator “1” procedure codes is not applicable to Bilateral Indicator “3” procedure codes.

In order to receive the full fee schedule amount for Bilateral Indicator “3” procedure codes performed bilaterally, the days/units (quantity billed) field must reflect “2” even when submitting CPT modifier 50 or when submitting HCPCS modifiers RT and LT on the same detail line.

Example 1:

CPT Code	**CPT Modifier**	**Days/Units**
92235	50	“2”

Example 2:

CPT Code	**HCPCS Modifiers**	**Days/Units**
92235	RT LT	“2”

The global, technical, and professional components of the following procedure codes currently have a Bilateral 3 indicator. (Note: these codes are also applicable when submitted with CPT modifier 26 or HCPCS modifier TC)

CPT Codes
70030
70120
70130
70190
70332
70554
70555
73000
73010
73020
73030
73040
73060

CPT Codes
73070
73080
73085
73090
73092
73100
73110
73115
73120
73130
73140
73200
73201

CPT Codes
73202
73206
73218
73219
73220
73221
73222
73223
73525
73530
73550
73560
73562

CPT Codes
73564
73580
73590
73592
73600
73610
73615
73620
73630
73650
73660
73700

CPT Codes
73701
73702
73706
73718
73719
73720
73721
73722
73723
73725
75685
76510

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Continued from previous page

CPT Codes
76511
76512
76513
76529
92235
92240

The listed components of the following procedure codes currently have a Bilateral 3 indicator: (The 26 modifier is a CPT modifier.)

CPT Codes/Modifier
70336-26
76519-26
77071
92070
92136-26
92225
92226
92230

IMPORTANT: These instructions apply only to Bilateral Indicator "3" procedure codes. When billing Bilateral Indicator "1" services with CPT modifier 50, the days/units must be submitted as "1".

The MPFSDB indicators for procedure codes can be viewed by accessing the following website: http://www.cms.gov/apps/physician-fee-schedule/overview.aspx (then select the Physician Fee Schedule Search tab near the top of the page).

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http://www.cms.hhs.gov/MLNGenInfo

Palmetto GBA Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Contact Center

1-866-931-3901 CSR (Toll-Free)
1-866-931-3903 IVR (Toll-Free)

TTY 1-866-931-3902

Electronic Data Interchange (EDI) Technical Support

1-866-749-4301

Medicare Beneficiary Call Center

1-800-MEDICARE (1-800-633-4227)

TTY 1-877-486-2048

FREE Training Available

To request a Medicare Provider Education meeting/seminar at no cost to you, complete and fax the form located on the http://www.PalmettoGBA.com/j1b/Forms.

http://www.PalmettoGBA.com

Important Sources For You

- http://www.cms.hhs.gov
- http://www.cms.hhs.gov/MLNGenInfo
- http://www.cms.hhs.gov/CMSforms/CMSforms/list.asp
- http://www.cms.hhs.gov/QuarterlyProviderUpdates
- http://www.cms.hhs.gov/MedicareProviderSupEnroll/