

HCPCS Level II Expert

Service/Supply Codes
for Caregivers & Suppliers

2025

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Introduction

This Healthcare Common Procedure Coding System (HCPCS) Level II code book goes beyond the basics to help you to code accurately and efficiently. In addition to including a customized Alphabetic Index and Tabular List for services, supplies, durable medical equipment, and drugs which the Centers for Medicare and Medicaid Services (CMS) developed, we include the following features:

Features

We've crafted a select set of bonus features based on requests from coders in the field as well as the recommendations of our core group of veteran coding educators. Features that you'll benefit from page after page include:

- HCPCS Level II Coding Procedures guide from CMS to help you to better understand HCPCS Level II codes
- Comprehensive list of new/revised/deleted codes for 2025
- CPT® crosswalk codes for select HCPCS Level II G codes
- Deleted codes crosswalk for 2025
- Symbols showing which codes have restrictions based on age or sex of the patient
- Medicare coverage and reimbursement alerts
- APC status indicators and ASC payment indicators
- HCPCS Level II modifiers with lay descriptions and coding tips
- Updated and enhanced illustrations of body systems at the front of the book so you don't have to search the code book for these large color images of body systems
- Highlighted coding instructional and informational notes help you recognize important code usage guidance for specific sections
- Intuitive color-coded symbols and alerts identify new and revised codes and critical coding and reimbursement issues quickly
- Symbols in Index showing each new code
- A user-friendly page design, including dictionary-style headers, color bleed tabs, and legend keys

Additionally, our dedicated team drew on their years of experience using code books to develop this book's user friendly symbols, highlighting, color coding, and tabs, all designed to help you find the information you need quickly.

Let Us Know What You Think

Our goal for this code book is to support those involved in the business side of healthcare, helping them to do their jobs and do them well. We'd appreciate your feedback, including your suggestions for what you'll need in a HCPCS Level II resource, so we can be sure our code books serve your needs.

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Symbols and Conventions

Citations to AHA's Coding Clinic® for HCPCS Level II

AHA's *Coding Clinic*®, a quarterly newsletter, is the official publication for coding guidelines and advice as designated by the four Cooperating Parties (American Hospital Association, American Health Information Management Association, Centers for Medicare and Medicaid Services (CMS), and National Center for Health Statistics) and the Editorial Advisory Board.

We've marked codes with related *Coding Clinic*® articles with a citation that includes the year and quarter of the issue.

Symbols and Conventions Used in this Code Book Include:

2025 HCPCS Level II Code Updates

●	New code
▲	Revised Code
N	2025 New Index Entries

Symbols and Alerts Related to Medicare or Carrier Coverage and Reimbursement

When relevant, you'll see the following symbols and alerts to the left of a code or beside or under the code descriptor:

C	Carrier judgment
D	Special coverage instructions apply
I	Not payable by Medicare
M	Non-covered by Medicare
S	Non-covered by Medicare statute
A2 - Z3	ASC Payment Indicator
A - Y	APC Status Indicator
ASC	ASC Approved Procedure

Service not separately priced by Part B

Other carrier priced

Reasonable charge

Price established using national RVUs

Price subject to national limitation amount

Price established by carriers

Statute references

BETOS code and descriptor

References to Pub 100 (non-dental codes) – Alert appears under the code descriptor.

Modifier Alerts Showing Applicable Modifiers for a HCPCS Level II Code

DME Modifier - Alert appears under the code descriptor

Symbols for Age and Sex Codes

When relevant, you'll see the following symbols to the right of a code descriptor. We based symbol use on Medicare's Integrated Outpatient Code Editor (I/OCE).

♀	Female code symbol
♂	Male code symbol
A	Age

Symbols and Alerts Related to Services, Supplies, or Equipment

When relevant, you'll see the following symbols to the right of code descriptors:

DME	Paid under the DME fee schedule
MIPS	Merit-based Incentive Payment System (MIPS) quality measure code

MIPS data in this code book is from the latest update from CMS at the time this book went to print. Refer to the CMS website for the latest updates on MIPS reporting.

Understand Code Structure to Choose the Most Specific Code

HCPCS Level II codes are made up of five alphanumeric characters, starting with a letter that represents a category of similar codes, followed by four numbers.

The Tabular List arranges codes in alphanumeric order, starting with codes beginning with the letter A.

Code descriptors identify a category of like items or services and typically do not identify specific products or brand/trade names.

Code Services, Supplies, Equipment, and Drugs With Confidence Following This Approach

- The first step in choosing the proper HCPCS Level II code is reading the medical documentation to identify the service, supply, equipment, or drug that the provider documents and confirms.
  - Be sure to check online or hard copy references, such as medical dictionaries and anatomy resources, to look up unfamiliar terms.
- Next, decide which main term you will search in the Index based on the patient's specific case. You can look under the name of the service (magnetic resonance angiography, EMG), supply (dialysis drain bag, filler), equipment (bathtub, cane), drug (hydrocortisone, ipratropium bromide), the body site involved (hip, knee), or the type of service (laboratory tests, oncology).
- Once you find the term in the Index, note the recommended code. Start with the main term and review any available subterms. Cross-reference all codes listed, whether it is one code, a series of codes separated by commas, or a code range separated by a hyphen. Pay attention to the Index "*see*" convention that directs you to look elsewhere in the Index to find the code or the "*see also*" convention that directs you to look in an additional place to find the code.
- Turn to that code in the Tabular List, and read the full code descriptor for correct code assignment.
- Before making your final code decision, review the surrounding codes to be sure there isn't a more appropriate code available. Pay attention to the "*see*" convention in the Tabular List that directs you to look elsewhere to find the code or the "*see also*" convention that directs you to look in an additional place to find the code.
- Finally, take a moment to confirm that your code choice complies with the philosophy of ethical coding. Never report a HCPCS Level II code simply because it will support reimbursement from a payer. Report only those codes the documentation supports.
- When searching the Table of Drugs and Biologicals, search for the name of the drug, then the unit and route to find the drug code to cross-reference to the Tabular List.

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HCPCS Level II Coding Procedures

HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) LEVEL II CODING PROCEDURES

This information provides a description of the procedures the Centers for Medicare & Medicaid Services (CMS) follows in processing HCPCS Level II applications and making coding decisions.

FOR FURTHER INFORMATION CONTACT:

Please submit an inquiry to the HCPCS mailbox at HCPCS@cms.hhs.gov.

HCPCS BACKGROUND INFORMATION

Each year, in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS Level II Code Set is one of the standard code sets used for this purpose. The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT® (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT® is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT® to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or revision of CPT® codes are made by the AMA. The CPT® codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT® codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT® codes, the level II HCPCS codes were established for submitting claims for these items. The development and use of level II of the HCPCS began in the 1980's. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT® codes are identified using 5 numeric digits.

A. HISTORY

The development and use of Level II of the HCPCS began in the 1980s. Concurrent to the use of Level II codes, there were also Level III codes. HCPCS Level III were developed and used by Medicaid State agencies, Medicare contractors, and private insurers in their specific programs or local areas of jurisdiction. For purposes of Medicare, Level III codes were also referred to as local codes. Local codes were established when an insurer preferred that suppliers use a local code to identify a service, for which there is no Level I or Level II code, rather than using a "miscellaneous or not otherwise classified code."

HIPAA required the Secretary to adopt standards for coding systems that are used for reporting health care transactions. Thus, regulations were published in the Federal Register on

August 17, 2000 (65 FR 50312), to implement standardized coding systems under HIPAA. These regulations provided for the elimination of Level III local codes by October 2002, at which time, the Level I and Level II code sets could be used. The elimination of local codes was postponed, as a result of section 532(a) of BIPA, which continued the use of local codes through December 31, 2003.

The regulation that was published on August 17, 2000 (45 CFR 162.1002), to implement the HIPAA requirement for standardized coding systems established the HCPCS Level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not within the CPT® code set jurisdiction. The HCPCS Level II coding system was selected as the standardized coding system because of its wide acceptance among both public and private insurers.

B. AUTHORITY

The Secretary of the Department of Health and Human Services has delegated authority under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the AMA and CMS to maintain and distribute HCPCS Level I and Level II codes, respectively.

C. HCPCS LEVEL II CODES

The HCPCS Level II coding system is a comprehensive, standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing. For each alpha-numeric HCPCS code, there is descriptive terminology that identifies a category of like items. These codes are used primarily for billing purposes. For example, suppliers use HCPCS Level II codes to identify items on claim forms that are being billed to a private or public health insurer. Currently, there are national HCPCS codes representing almost 8,000 separate categories of like items or services that encompass products from different manufacturers. When submitting claims, suppliers are required to use one of these codes to identify the items they are billing.

HCPCS is a system for identifying items and certain services. It is not a methodology or system for making coverage or payment determinations, and the existence of a code does not, of itself, determine coverage or non-coverage for an item or service. While these codes are used for billing purposes, decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for making determinations regarding coverage and payment.

With regard to the Medicare program, if specific Medicare coverage or payment indicators or values have not been established for any new HCPCS codes, this may be because a national Medicare coverage determination and/or fee schedule amounts have not yet been established for these items. This is neither an indicator of Medicare coverage or non-coverage. In these cases, until national Medicare coverage and payment guidelines have been established for these codes, the Medicare coverage and payment determinations for these items may be made based on the discretion of the Medicare contractors processing claims for these items.

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D. TYPES OF HCPCS LEVEL II CODES

There are several types of HCPCS Level II codes depending on the purpose for the codes and the entity with responsibility for establishing and maintaining them.

HCPCS National Codes

National HCPCS Level II codes are maintained by CMS. CMS is responsible for making decisions about additions, revisions, and deletions to the national alpha-numeric codes. These codes are for the use of all private and public health insurers.

HCPCS Level II applications are reviewed by a group comprised of Federal government employees who represent the major components of CMS, as well as other pertinent Federal agencies such as the Department of Veterans Affairs and the Department of Defense at regularly scheduled meetings to determine whether coding requests warrant a change to the HCPCS Level II national code set. This group of reviewers informs CMS' decisions.

The application and instructions for requesting that CMS add, revise, or discontinue a HCPCS Level II code can be accessed at: https://mearis.cms.gov/public/home. CMS may also issue codes based on the needs of its programs or other federal programs.

Dental Codes

Dental codes, or D codes, are a separate category of national codes. The Current Dental Terminology (CDT) is published, copyrighted, and licensed by the American Dental Association (ADA). The CDT lists codes for billing for dental procedures and supplies. While the CDT codes are considered HCPCS Level II codes, decisions regarding the revision, deletion, or addition of CDT codes are made by the ADA, not CMS.

Miscellaneous Codes

National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. The importance of miscellaneous codes is that they allow suppliers to begin billing immediately for a service or item as soon as it is allowed to be marketed by the Food and Drug Administration (FDA), even though there is no distinct code that describes the service or item. A miscellaneous code may be assigned by insurers for use during the period of time a request for a new code is being considered under the HCPCS review process. The use of miscellaneous codes also helps avoid the inefficiency and administrative burden of assigning distinct codes for items or services that are rarely furnished or for which few claims are expected to be filed. Because of miscellaneous codes, the absence of a specific code for a distinct category of products does not affect the ability of a supplier to submit claims to private or public insurers.

In those cases, in which a supplier or manufacturer has been advised to use a miscellaneous code because there is no existing code that describes a given product, and the supplier or manufacturer believes that a new code is needed, the supplier or manufacturer may submit a request to modify the HCPCS in accordance with the established process. The standard process for requesting a revision to the HCPCS Level II codes is explained later in this document.

Other Notable Codes

- The C codes (pass-through) were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. HCPCS C codes are utilized to report drugs, biologicals, magnetic resonance angiography (MRA), and devices used for CMS' Medicare Hospital Outpatient Prospective Payment System (HOPPS). HCPCS C codes are reported for device categories, new technology procedures, and drugs, biologicals, and radiopharmaceuticals that do not have other HCPCS code assignments. Non-OPPS hospitals, Critical Access Hospitals (CAHs), Indian Health Service (IHS) hospitals, and hospitals located in American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands, as well as Maryland waiver hospitals, may report these codes at their discretion.

  For information about the HOPPS pass-through process, please visit the HOPPS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/HospitalOutpatientPPS/index
- The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT®-4 (the current version of CPT® codes) but for which there are no CPT®-4 codes. CMS does not have an application process for G codes, as they are established internally by CMS to support Medicare claims processing needs. As G codes are part of the national HCPCS Level II code set, they may also be used by non-Medicare insurers.
- The G codes and C codes are considered HCPCS Level II codes and as such, these codes, and changes to them, are included in CMS' HCPCS Level II Updates published by CMS. The code application procedures described in this document are not for use to apply for changes to HCPCS C codes and G codes.
- The Q codes are established to identify drugs, biologicals, and medical equipment or services not identified by national HCPCS Level II codes, but for which codes are needed for Medicare claims processing.
- The K codes are established for use by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) when current national codes do not include the codes needed to implement a DME MAC medical review policy. For example, codes other than the current, existing national codes may be needed by the DME MACs to identify certain product categories and supplies necessary for establishing appropriate regional medical review coverage policies.

Code Modifiers

HCPCS code modifiers are established internally by CMS to facilitate accurate Medicare claims processing. Modifiers are assigned for use when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, the UE modifier is used when the item identified by a HCPCS code is "used equipment," and the NU modifier is used for "new equipment." The HCPCS Level II modifiers are either alpha-numeric or two letters. HCPCS code modifiers are published as part of the HCPCS code set at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric- HCPCS. The modifiers appear at the beginning of the file, before alpha-numeric codes.

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HCPCS Code Assignment Following Medicare National Coverage Determination (NCD)

Pursuant to section 1862(l)(3)(C)(iv) of the Social Security Act (added by section 731(a) of the Medicare Modernization Act), CMS identifies an appropriate existing code category and/or establishes a new code category to describe the item that is the subject of a National Coverage Determination (NCD).

Effective July 1, 2004, CMS' procedures are as follows:

1. Assignment of an existing code: When CMS determines that an item is already identified by an existing HCPCS code category, but was previously not covered, CMS will assign the item to the existing code category and ensure that the coverage indicator assigned to the code category accurately reflects Medicare policy regarding coverage for the item. Section 731 of the MMA does not require that a new code category or a product specific code be created for an item simply because a new coverage determination was made, without regard to codes available in the existing code set.
2. Assignment of a New Code: When CMS determines that a new code category is appropriate, CMS will make every effort to establish, publish, and implement the new code at the time the final coverage determination is made.
3. Assignment of a Miscellaneous Code: Under certain circumstances, the assignment of an Item to a miscellaneous code may be necessary. A number of miscellaneous codes already exist under various headings throughout the HCPCS Level II code set. When a new code is appropriate, but the change cannot be implemented and incorporated into billing and claims processing systems at the time the final NCD decision memorandum is released, an unclassified code may be assigned in the interim, until a new code can be implemented, in order to ensure that claims can be processed for the item. The timing of implementation of new codes relative to the date of the coverage determination depends on a variety of factors, some of which are not within the control of the code set maintainers. One such example is when the timing of the coverage determination is such that the publication deadline for the next update is missed.

E. REQUESTING A REVISION TO THE HCPCS LEVEL II CODES

Anyone may submit a request for modifying the HCPCS Level II national code set. CMS' HCPCS Level II application instructions can be accessed at: https://mearis.cms.gov/public/home.

As part of the application, the applicant should also submit any descriptive material, including the manufacturer's product literature and information that the applicant thinks would be helpful in furthering CMS' understanding of the medical features of the item for which a coding revision is requested.

Applications that are received and determined by CMS to be complete by the deadline will be considered for inclusion in that cycle. Applications received after the deadline will be considered for the subsequent coding cycle. Applications received by the deadline that are determined to be incomplete will also be declined and the applicant should submit a completed application in a subsequent coding cycle. CMS will make every effort to complete the review within the applicable coding cycle for all timely and complete code applications. However, it should be understood that on the rare occasion a particularly complex or multi-faceted decision requires additional evaluation beyond the timeframe of the coding cycle, CMS maintains the flexibility at its discretion to continue consideration of that application into the next coding cycle. Examples of circumstances under which application consideration may be extended to the next coding cycle may include, but are not limited to, coding considerations that require in-depth clinical or other research and complicated claims adjudication scenarios.

There are three types of coding revisions to the HCPCS that can be requested:

1. That a new code be added. This could include requests to split an existing code category into its components or into subcategories;
2. That the language used to describe an existing code be changed:

   When there is an existing code, a request can be made when a stakeholder believes that the descriptor for the code needs to be revised to provide a better description of the category of products represented by the code.
3. That an existing code be discontinued.

When an existing code becomes obsolete or is duplicative of another code, a request can be made to discontinue the code. This could include requests to combine existing codes.

The electronic application intake system, Medicare Electronic Application Request Information System (MEARIS™), is available for HCPCS Level II Q4 2021 and B1 2022 application submissions, with application submissions due no later than September 20, 2021 and January 4, 2022, respectively. The HCPCS Level II Application form designed for MEARIS™ is similar to the current OMB-approved paper application (CMS-10224, OMB-0938-1042). The CMS HCPCS Level II Modification to Code Set Form can be accessed at: https://mearis.cms.gov/public/home.

Moving forward, CMS will only accept HCPCS Level II applications submitted via MEARIS™. Applications submitted through the HCPCS application mailbox will no longer be considered. Within MEARIS™, we have built in several resources to support applicants:

- Please refer to the "Resources" section for guidance regarding the application submission process at: https://mearis.cms.gov/public/resources.
- Technical support is available under "Useful Links" at the bottom of the MEARIS™
- Application related questions can be submitted to CMS using the form available under "Contact" at: https://mearis.cms.gov/public/resources?app=HCPCS.
- The time required for application submission, including the time needed to gather relevant information as well as to complete the form, is estimated to be roughly around 10 hours per submission. Applicants are, therefore, encouraged to start in advance of the due date to ensure adequate time for submission.

Application submission through MEARIS™ will not only help CMS track applications and streamline the review process, but it will also create efficiencies for applicants when compared to the previous paper submission process.

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Evaluating HCPCS Level II Coding Applications

CMS applies the following criteria to determine when there is no demonstrated need for a new or modified code or the need to remove a code:

1. When an existing code adequately describes the item in a coding request, no new or modified code is established. An existing code adequately describes an item in a coding request when the existing code describes items with the following:
   - Functions similar to the item in the coding request.
   - No significant therapeutic distinctions from the item in the coding request.
2. When an existing code describes items that provide almost the same functionality with only minor distinctions from the item in the coding request, the item in the coding request may be grouped with that code and the code descriptor modified to reflect the distinctions.
3. A code is not established for an item that is used only in the inpatient setting or for an item that is not diagnostic or therapeutic in nature.
4. A new or modified code is not established for an item that is regulated by the FDA, unless the FDA allows the item to be marketed. Documentation of FDA approval is required to be submitted with the coding request application.
5. Applications for non-drug items that are not regulated by the FDA and also not yet available in the U.S. market will be considered incomplete and will not be processed.
6. The determination to remove a code is based on CMS' consideration of whether a code is obsolete (for example, items no longer are used, other more specific codes have been added) or duplicative and no longer useful (for example, new codes are established that better describe items identified by existing codes).

In developing its decisions, CMS uses the criteria mentioned above. Cost or pricing is not a factor.

HCPCS Level II Submission Deadlines

Beginning in 2023, HCPCS Level II application submission deadlines will align with the first business day of each quarter (January, April, July and October) for drugs and biological product applications and the first business day of January and July for non drug and non-biological items and services applications. Please visit the MEARIS™ homepage at https://mearis.cms.gov/public/home or the MEARIS™ HCPCS Level II Resources page for specific HCPCS Level II application deadlines at https://mearis.cms.gov/public/ resources.

To be considered in the applicable cycle, applications must be submitted by the deadlines provided below.

Quarterly Coding Cycles for Drugs or Biologicals:

First quarterly cycle	January 2, 2024 11:59 PM EST
Second quarterly cycle	April 1, 2024 11:59 PM EST
Third quarterly cycle	July 1, 2024 11:59 PM EST
Fourth quarterly cycle	October 1, 2024 11:59 PM EST

Bi-annual Coding Cycles for Non-drug, Non-Biological Items or Services:

First bi-annual cycle	January 2, 2024 11:59 PM EST
Second bi-annual cycle	July 1, 2024 11:59 PM EST

Requirements

Applicants may submit an application to establish, revise, or discontinue a HCPCS code using the online electronic application form. In addition to providing the required information in the application, please attach descriptive material that you think would be helpful in furthering CMS' understanding of the medical benefits of the product for which a coding modification is being requested.

Applications claiming a 'significant therapeutic distinction' must include relevant substantiating clinical information that distinguishes the product from other, similar products (refer to 'Significant Therapeutic Distinction' on the application). The clinical information must be attached to the application.

Applicants may submit more than one HCPCS application, but a separate application is required for each coding action, even if they are related. Only one coding request per application will be accepted.

Final Decisions for All HCPCS Level II Applications:

CMS is responsible for making the final decisions pertaining to requests for additions, deletions, and revisions to the HCPCS Level II codes. These decisions may include:

1. The request to establish a new national code has been approved.
2. The request to revise an existing national code has been approved.
3. The request to discontinue an existing national code has been approved.
4. A change to the national codes has been approved that reflects, completely or in part, the coding request. Examples of circumstances under which a change to coding might reflect, in part, the coding request include the addition of a single new code when the incoming request was to establish a series of related codes (e.g., for different package sizes); or addition of a new code that includes a dose descriptor reflecting the lowest common denominator that could be billed in multiples, as per CMS' longstanding coding convention, when the incoming request specified a different dose descriptor.
5. The request for a new code has not been approved because the scope of the request necessitates that additional consideration be given to the request before CMS reaches a final decision.
6. The request for a new national code has not been approved because there already is an existing code that describes the product.
7. The request for a code has not been approved because the product is not used by health care providers for diagnostic or therapeutic purposes.
8. The request for a code has not been approved because the code requested is for capital equipment.
9. The request for a code has not been approved because the product is an integral part of another service and the code for that service includes the product.

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10. The request for a revision to the language that describes the current code has not been approved because it does not improve the code descriptor.
11. The request for a new code has not been approved because the product is not primarily medical in nature.
12. The request for a code has not been approved because the product is used exclusively in the inpatient hospital setting.
13. The request for a code has not been approved because it is inappropriate for inclusion in the HCPCS Level II code set and a request should be submitted independently to another coding authority (e.g., AMA for CPT® coding, ADA for CDT coding)

CMS will include the reasoning for reaching its decision, along with the decision.

Any applicant who disagrees with CMS' final HCPCS coding decision may submit a new request in a subsequent coding cycle. Applicants are encouraged to provide any new information that may be helpful in explaining why CMS' prior decision should be changed.

F. AVAILABILITY OF HCPCS LEVEL II UPDATES

As of April 2020, the Alpha-Numeric HCPCS File is a quarterly file. Please see the HCPCS Quarterly Update webpage for those updates. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update.

HCPCS Webpage Updates

As all HCPCS Level II updates are now fully searchable and sortable electronic files, CMS will no longer publish the Table of Drugs and HCPCS Index as part of the HCPCS quarterly updates.

Additionally, due to the establishment of complete HCPCS quarterly files beginning in 2020, CMS is removing the "Other Codes (other than C and G HCPCS codes)" section from the HCPCS Quarterly Update page. The information contained in this section has been incorporated into the annual HCPCS file for the appropriate year. For more information go to https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/alpha-numeric.

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NEW CODES

Code	Code Descriptor
A2026	Restrata minimatrix, 5 mg
A2027	Matriderm, per square centimeter
A2028	Micromatrix flex, per mg
A2029	Mirotract wound matrix sheet, per cubic centimeter
A4438	Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month
A4544	Electrode for external lower extremity nerve stimulator for restless legs syndrome
A4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month
A4564	Pessary, disposable, any type
A4593	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controller
A4594	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)
A9293	Fertility cycle (contraception & conception) tracking software application, fda cleared, per month, includes accessories (e.g., thermometer)
A9506	Graphite crucible for preparation of technetium tc 99m-labeled carbon aerosol, one crucible
A9610	Xenon xe-129 hyperpolarized gas, diagnostic, per study dose
A9615	Injection, pegulicianine, 1 mg
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation
C1606	Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)
C1738	Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device
C1739	Tissue marker, imaging and non-imaging device (implantable)

Code	Code Descriptor
C7562	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed with intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7563	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, initial artery and all additional arteries
C7564	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance with intravascular ultrasound (noncoronary vessel(s)) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation
C7565	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s) less than 3 cm, reducible with removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair
C8000	Support device, extravascular, for arteriovenous fistula (implantable)
C8001	3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy
C8002	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)
C8003	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (eg, fluoroscopy)
C9173	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram
C9610	Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis])

Code	Code Descriptor
C9797	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
C9804	Elastomeric infusion pump (e.g., on-q* pump with bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9806	Rotary peristaltic infusion pump (e.g., ambit pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9807	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9901	Endoscopic defect closure within the entire gastrointestinal tract, including upper endoscopy (including diagnostic, if performed) or colonoscopy (including diagnostic, if performed), with all system and tissue anchoring components
E0152	Walker, battery powered, wheeled, folding, adjustable or fixed height
E0468	Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump
E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises
E0716	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region
E0736	Transcutaneous tibial nerve stimulator
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application
E0738	Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories
E0743	External lower extremity nerve stimulator for restless legs syndrome, each
E0767	Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories
E1803	Dynamic adjustable elbow extension only device, includes soft interface material
E1804	Dynamic adjustable elbow flexion only device, includes soft interface material
E1807	Dynamic adjustable wrist extension only device, includes soft interface material
E1808	Dynamic adjustable wrist flexion only device, includes soft interface material
E1813	Dynamic adjustable knee extension only device, includes soft interface material
E1814	Dynamic adjustable knee flexion only device, includes soft interface material
E1822	Dynamic adjustable ankle extension only device, includes soft interface material
E1823	Dynamic adjustable ankle flexion only device, includes soft interface material
E1826	Dynamic adjustable finger extension only device, includes soft interface material
E1827	Dynamic adjustable finger flexion only device, includes soft interface material
E1828	Dynamic adjustable toe extension only device, includes soft interface material
E1829	Dynamic adjustable toe flexion only device, includes soft interface material
E2104	Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type
E2513	Accessory for speech generating device, electromyographic sensor
E3200	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only
G0138	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga
G0519	Management of new patient-caregiver dyad with dementia, low complexity, for use in cmmi model
G0520	Management of new patient-caregiver dyad with dementia, moderate complexity, for use in cmmi model
G0521	Management of new patient-caregiver dyad with dementia, high complexity, for use in cmmi model
G0522	Management of a new patient with dementia, low complexity, for use in cmmi model
G0523	Management of a new patient with dementia, moderate to high complexity, for use in cmmi model

Code	Code Descriptor
G0524	Management of established patient-caregiver dyad with dementia, low complexity, for use in cmmi model
G0525	Management of established patient-caregiver dyad with dementia, moderate complexity, for use in cmmi model
G0526	Management of established patient-caregiver dyad with dementia, high complexity, for use in cmmi model
G0527	Management of established patient with dementia, low complexity, for use in cmmi model
G0528	Management of established patient with dementia, moderate to high complexity, for use in cmmi model
G0529	In-home respite care, 4-hour unit, for use in cmmi model
G0530	Adult day center, 8-hour unit, for use in cmmi model
G0531	Facility-based respite, 24-hour unit, for use in cmmi model
G0532	Take-home supply of nasal nalmefene hydrochloride; one carton of two, 2.7 mg per 0.1 ml nasal sprays (provision of the services by a medicare-enrolled opioid treatment program);(list separately in addition to each primary code)
G0533	Medication assisted treatment, buprenorphine (injectable) administered on a weekly basis; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G0534	Coordinated care and/or referral services, such as to adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an opioid use disorder; each additional 30 minutes of services (provision of the services by a medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0535	Patient navigational services, provided directly or by referral; including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self-advocacy and communication skills with care providers, and to promote patient-driven action plans and goals; each additional 30 minutes of services (provision of the services by a medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0536	Peer recovery support services, provided directly or by referral; including leveraging knowledge of the condition or lived experience to provide support, mentorship, or inspiration to meet oud treatment and recovery goals; conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes; developing and proposing strategies to help meet person-centered treatment goals; assisting the patient in locating or navigating recovery support services; each additional 30 minutes of services (provision of the services by a medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
G0537	Administration of a standardized, evidence-based atherosclerotic cardiovascular disease (ascvd) risk assessment, 5-15 minutes, not more often than every 12 months
G0538	Atherosclerotic cardiovascular disease (ascvd) risk management services; clinical staff time; per calendar month
G0539	Caregiver training in behavior management/ modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540	Caregiver training in behavior management/ modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use G0542 in conjunction with G0541)
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
G0544	Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month
G0545	Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, subsequent or discharge)
G0546	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review

Code	Code Descriptor
G0547	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review
G0548	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review
G0549	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review
G0550	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time
G0551	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes
G0552	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan
G0553	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month
G0554	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month
G0555	Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring

Code	Code Descriptor
G0556	Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: • Consent; ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ Document in patient's medical record that consent was obtained. • Initiation during a qualifying visit for new patients or patients not seen within 3 years; • Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; • Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; • Overall comprehensive care management; ++ Systematic needs assessment (medical and psychosocial). ++ System-based approaches to ensure receipt of preventive services. ++ Medication reconciliation, management and oversight of self-management. • Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan with typical care plan elements when clinically relevant; ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; • Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

Code	Code Descriptor
G0556 (*cont.*)	• Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; • Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/ practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/ internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). • Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; • Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; • Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology
G0557	Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: • Consent; ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ Document in patient's medical record that consent was obtained. • Initiation during a qualifying visit for new patients or patients not seen within 3 years; • Provide 24/7 access for urgent needs to care team/ practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; • Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; • Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours;

Code	Code Descriptor
G0557 (*cont.*)	• Overall comprehensive care management; ++ Systematic needs assessment (medical and psychosocial). ++ System-based approaches to ensure receipt of preventive services. ++ Medication reconciliation, management and oversight of self-management. • Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; • Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated. • Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; • Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/ practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/ internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). • Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; • Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; • Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

Code	Code Descriptor
G0558	Advanced primary care management services for a patient that is a qualified medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate: • Consent; ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply. ++ Document in patient's medical record that consent was obtained. • Initiation during a qualifying visit for new patients or patients not seen within 3 years; • Provide 24/7 access for urgent needs to care team/ practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; • Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments; • Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours; • Overall comprehensive care management; ++ Systematic needs assessment (medical and psychosocial). ++ System-based approaches to ensure receipt of preventive services. ++ Medication reconciliation, management and oversight of self-management. • Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan; ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver; • Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable; ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

Code	Code Descriptor
G0558 (*cont.*)	• Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record; Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/ practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate; ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits). • Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate; • Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients; • Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology
G0559	Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation. research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. communicate with the practitioner who performed the procedure if any questions or concerns arise. (list separately in addition to office/outpatient evaluation and management visit, new or established)

Code	Code Descriptor
G0560	Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky substance use; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe
G0561	Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583T)
G0562	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)
G0563	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions
G0564	Creation of subcutaneous pocket with insertion of 365 day implantable interstitial glucose sensor, including system activation and patient training
G0565	Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365 day implantable sensor, including system activation
G9037	Interprofessional telephone/internet/electronic health record clinical question/request for specialty recommendations by a treating/requesting physician or other qualified health care professional for the care of the patient (i.e. not for professional education or scheduling) and may include subsequent follow up on the specialist's recommendations; 30 minutes
G9038	Co-management services with the following elements: new diagnosis or acute exacerbation and stabilization of existing condition; condition which may benefit from joint care planning; condition for which specialist is taking a co-management role; condition expected to last at least 3 months; comprehensive care plan established, implemented, revised or monitored in partnership with co-managing clinicians; ongoing communication and care coordination between co-managing clinicians furnishing care
H0051	Traditional healing service
H0052	Missing and murdered indigenous persons (mmip) mental health and clinical care
H0053	Historical trauma (ht) mental health and clinical care for indigenous persons
J0138	Injection, acetaminophen 10 mg and ibuprofen 3 mg
J0139	Injection, adalimumab, 1 mg
J0175	Injection, donanemab-azbt, 2 mg
J0177	Injection, aflibercept hd, 1 mg
J0209	Injection, sodium thiosulfate (hope), 100 mg
J0211	Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg (nithiodote)
J0577	Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy
J0578	Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit
J0601	Sevelamer carbonate (renvela or therapeutically equivalent), oral, 20 mg (for esrd on dialysis)
J0602	Sevelamer carbonate (renvela or therapeutically equivalent), oral, powder, 20 mg (for esrd on dialysis)
J0603	Sevelamer hydrochloride (renagel or therapeutically equivalent), oral, 20 mg (for esrd on dialysis)
J0605	Sucroferric oxyhydroxide, oral, 5 mg (for esrd on dialysis)
J0607	Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)
J0608	Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to J0607 (for esrd on dialysis)
J0609	Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis)
J0615	Calcium acetate, oral, 23 mg (for esrd on dialysis)
J0650	Injection, levothyroxine sodium, not otherwise specified, 10 mcg
J0666	Injection, bupivacaine liposome, 1 mg
J0687	Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to J0690, 500 mg
J0870	Injection, imetelstat, 1 mg
J0872	Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg
J0901	Vadadustat, oral, 1 mg (for esrd on dialysis)
J0911	Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis)
J1010	Injection, methylprednisolone acetate, 1 mg
J1171	Injection, hydromorphone, 0.1 mg
J1202	Miglustat, oral, 65 mg
J1203	Injection, cipaglucosidase alfa-atga, 5 mg
J1307	Injection, crovalimab-akkz, 10 mg
J1323	Injection, elranatamab-bcmm, 1 mg
J1414	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose
J1434	Injection, fosaprepitant (focinvez), 1 mg
J1552	Injection, immune globulin (alyglo), 500 mg
J1597	Injection, glycopyrrolate (glyrx-pf), 0.1 mg
J1598	Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to J1596, 0.1 mg
J1748	Injection, infliximab-dyyb (zymfentra), 10 mg
J1749	Injection, iloprost, 0.1 mcg
J2002	Injection, lidocaine hcl in 5% dextrose, 1 mg
J2003	Injection, lidocaine hydrochloride, 1 mg
J2004	Injection, lidocaine hcl with epinephrine, 1 mg
J2183	Injection, meropenem (wg critical care), not therapeutically equivalent to J2185, 100 mg

Code	Code Descriptor
J2246	Injection, micafungin in sodium (baxter), not therapeutically equivalent to J2248, 1 mg
J2252	Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg
J2253	Injection, midazolam (seizalam), 1 mg
J2267	Injection, mirikizumab-mrkz, 1 mg
J2277	Injection, motixafortide, 0.25 mg
J2290	Injection, nafcillin sodium, 20 mg
J2373	Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms
J2468*	Injection, palonosetron hydrochloride (posfrea), 25 micrograms
J2470	Injection, pantoprazole sodium, 40 mg
J2471	Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg
J2472	Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg
J2601	Injection, vasopressin (baxter), 1 unit
J2782	Injection, avacincaptad pegol, 0.1 mg
J2801	Injection, risperidone (rykindo), 0.5 mg
J2802	Injection, romiplostim, 1 microgram
J2919	Injection, methylprednisolone sodium succinate, 5 mg
J3055	Injection, talquetamab-tgvs, 0.25 mg
J3247	Injection, secukinumab, intravenous, 1 mg
J3263	Injection, toripalimab-tpzi, 1 mg
J3392	Injection, exagamglogene autotemcel, per treatment
J3393	Injection, betibeglogene autotemcel, per treatment
J3394	Injection, lovotibeglogene autotemcel, per treatment
J3424	Injection, hydroxocobalamin, intravenous, 25 mg
J7165	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity
J7171	Injection, adamts13, recombinant-krhn, 10 iu
J7354	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)
J7355	Injection, travoprost, intracameral implant, 1 microgram
J7514	Mycophenolate mofetil (myhibbin), oral suspension, 100 mg
J7601	Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg
J8522	Capecitabine, oral, 50 mg
J8541	Dexamethasone (hemady), oral, 0.25 mg
J8611	Methotrexate (jylamvo), oral, 2.5 mg
J8612	Methotrexate (xatmep), oral, 2.5 mg
J9026	Injection, tarlatamab-dlle, 1 mg
J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram
J9073	Injection, cyclophosphamide (ingenus), 5 mg
J9074	Injection, cyclophosphamide (sandoz), 5 mg
J9075	Injection, cyclophosphamide, not otherwise specified, 5 mg
J9076	Injection, cyclophosphamide (baxter), 5 mg
J9248	Injection, melphalan (hepzato), 1 mg
J9249	Injection, melphalan (apotex), 1 mg
J9292	Injection, pemetrexed (avyxa), not therapeutically equivalent to j9305, 10 mg
J9329	Injection, tislelizumab-jsgr, 1mg
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg
J9376	Injection, pozelimab-bbfg, 1 mg
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility
L1006	Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated
L1653	Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, off the shelf
L1821	Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, off the shelf
L5783	Addition to lower extremity, user adjustable, mechanical, residual limb volume management system
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control
L8720*	External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg
L8721	Receptor sole for use with L8720, replacement, each
M0224	Intravenous infusion, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known sars-cov-2 exposure, who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, includes infusion and post administration monitoring
M1371	Most recent glycemic status assessment (hba1c or gmi) level < 7.0%
M1372	Most recent glycemic status assessment (hba1c or gmi) level >= 7.0% and < 8.0%
M1373	Most recent glycemic status assessment (hba1c or gmi) level >= 8.0% and <= 9.0%
M1374	An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
M1375	An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
M1376	An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
M1377	Recommended follow-up interval for repeat colonoscopy of 10 years documented in colonoscopy report and communicated with patient

* Codes J2468 and L8720 were added by CMS mid-year and revised in the January 2025 code set release. The official descriptors shown here are the most recent revised descriptors.

Code	Code Descriptor
M1378	Documentation of medical reason(s) for not recommending a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, or life expectancy < 10 years, other medical reasons)
M1379	A 10 year follow-up interval for colonoscopy not recommended, reason not otherwise specified
M1380	Filled at least two prescriptions during the performance period for any combination of the qualifying oral antipsychotic medications listed under "denominator note" or the long-acting injectable antipsychotic medications listed under "denominator note"
M1381	Patients with secondary stroke (e.g., a subsequent stroke that may occur with vasospasm in the setting of subarachnoid hemorrhage) within 5 days of the initial procedure
M1382	Patient encounter during the performance period with place of service code 11
M1383	Acute pvd
M1384	Patients who died during the performance period
M1385	Documentation of patient reasons for patients who were not seen for the second pam survey (e.g., less than four months between baseline pam assessment and follow-up
M1386	Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial ajcc staging of 0, i, or ii at the start of the performance period
M1387	Patients who died during the performance period
M1388	Patients with documentation of an exam performed for recurrence of melanoma
M1389	Documentation of patient reasons for no examination i.e., refusal of examination or lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail - at least one method must be documented)
M1390	Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period
M1391	All patients who were diagnosed with recurrent melanoma during the current performance period
M1392	Documentation of patient reasons for no examination, i.e., refusal of examination or lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail - at least one method must be documented)
M1393	Patients who were not diagnosed with recurrent melanoma during the current performance period
M1394	Stages i-iii breast cancer
M1395	Patients receiving an initial chemotherapy regimen with a defined duration with the eligible clinician or group
M1396	Patients on a therapeutic clinical trial
M1397	Patients with recurrence/disease progression
M1398	Patients with baseline and follow-up promis surveys documented in the medical record
M1399	Patients who leave the practice during the follow-up period
M1400	Patients who died during the follow-up period
M1401	Stages i-iii breast cancer
M1402	Patients receiving an initial chemotherapy regimen with a defined duration with the eligible clinician or group
M1403	Patients with baseline and follow-up promis surveys documented in the medical record
M1404	Patients on a therapeutic clinical trial
M1405	Patients with recurrence/disease progression
M1406	Patients who leave the practice during the follow-up period
M1407	Patients who died during the follow-up period
M1408	Patients who have germline brca testing completed before diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer
M1409	Patients who received germline testing for brca1 and brca2 or genetic counseling completed within 6 months of diagnosis
M1410	Patients who did not have germline testing for brca1 and brca2 or genetic counseling completed within 6 months of diagnosis
M1411	Currently on first-line immune checkpoint inhibitors without chemotherapy
M1412	Patients with metastatic nsclc with epidermal growth factor receptor (egfr) mutations, alk genomic tumor aberrations, or other targetable genomic abnormalities with approved first-line targeted therapy, such as nsclc with ros1 rearrangement, braf v600e mutation, ntrk 1/2/3 gene fusion, met ex14 skipping mutation, and ret rearrangement
M1413	Patients who had a positive pd-l1 biomarker expression test result prior to the initiation of first-line immune checkpoint inhibitor therapy
M1414	Documentation of medical reason(s) for not performing the pd-l1 biomarker expression test prior to initiation of first-line immune checkpoint inhibitor therapy (e.g., patient is in an urgent or emergent situation where delay of treatment would jeopardize the patient's health status; other medical reasons/contraindication)
M1415	Patients who did not have a positive pd-l1 biomarker expression test result prior to the initiation of first-line immune checkpoint inhibitor therapy
M1416	Patient received hospice services any time during the performance period
M1417	Patients who are up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination
M1418	Patients who are not up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination because of a medical contraindication documented by clinician
M1419	Patients who are not up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination
M1420	Complete ophthalmologic care mips value pathway

Code	Code Descriptor
M1421	Dermatological care mips value pathway
M1422	Gastroenterology care mips value pathway
M1423	Optimal care for patients with urologic conditions mips value pathway
M1424	Pulmonology care mips value pathway
M1425	Surgical care mips value pathway
P9027	Red blood cells, leukocytes reduced, oxygen/ carbon dioxide reduced, each unit
Q0155	Dronabinol (syndros), 0.1 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
Q0224	Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known sars-cov-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to covid-19 vaccination, 4500 mg
Q0521	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription
Q4305	American amnion ac tri-layer, per square centimeter
Q4306	American amnion ac, per square centimeter
Q4307	American amnion, per square centimeter
Q4308	Sanopellis, per square centimeter
Q4309	Via matrix, per square centimeter
Q4310	Procenta, per 100 mg
Q4311	Acesso, per square centimeter
Q4312	Acesso ac, per square centimeter
Q4313	Dermabind fm, per square centimeter
Q4314	Reeva ft, per square cenitmeter
Q4315	Regenelink amniotic membrane allograft, per square centimeter
Q4316	Amchoplast, per square centimeter
Q4317	Vitograft, per square centimeter
Q4318	E-graft, per square centimeter
Q4319	Sanograft, per square centimeter
Q4320	Pellograft, per square centimeter
Q4321	Renograft, per square centimeter
Q4322	Caregraft, per square centimeter
Q4323	Alloply, per square centimeter
Q4324	Amniotx, per square centimeter
Q4325	Acapatch, per square centimeter
Q4326	Woundplus, per square centimeter
Q4327	Duoamnion, per square centimeter
Q4328	Most, per square centimeter
Q4329	Singlay, per square centimeter
Q4330	Total, per square centimeter
Q4331	Axolotl graft, per square centimeter
Q4332	Axolotl dualgraft, per square centimeter
Q4333	Ardeograft, per square centimeter
Q4334	Amnioplast 1, per square centimeter
Q4335	Amnioplast 2, per square centimeter
Q4336	Artacent c, per square centimeter
Q4337	Artacent trident, per square centimeter
Q4338	Artacent velos, per square centimeter
Q4339	Artacent vericlen, per square centimeter
Q4340	Simpligraft, per square centimeter
Q4341	Simplimax, per square centimeter
Q4342	Theramend, per square centimeter
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter
Q4344	Tri-membrane wrap, per square centimeter
Q4345	Matrix hd allograft dermis, per square centimeter
Q4346	Shelter dm matrix, per square centimeter
Q4347	Rampart dl matrix, per square centimeter
Q4348	Sentry sl matrix, per square centimeter
Q4349	Mantle dl matrix, per square centimeter
Q4350	Palisade dm matrix, per square centimeter
Q4351	Enclose tl matrix, per square centimeter
Q4352	Overlay sl matrix, per square centimeter
Q4353	Xceed tl matrix, per square centimeter
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg
Q5139	Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg
Q5145	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg
Q5146	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (selarsdi), 1 mg
S4988	Penile contracture device, manual, greater than 3 lbs traction force
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device

REVISED CODES

Code	Code Descriptor
A2024	Resolve matrix or xenopatch, per square centimeter
A4271	Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests
A4561	Pessary, reusable, rubber, any type
A4562	Pessary, reusable, non rubber, any type
E0739	Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors
E1800	Dynamic adjustable elbow extension and flexion device, includes soft interface material
E1805	Dynamic adjustable wrist extension and flexion device, includes soft interface material
E1810	Dynamic adjustable knee extension and flexion device, includes soft interface material
E1815	Dynamic adjustable ankle extension and flexion device, includes soft interface material
E1825	Dynamic adjustable finger extension and flexion device, includes soft interface material
E1830	Dynamic adjustable toe extension and flexion device, includes soft interface material
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system
G2069	Medication assisted treatment, buprenorphine (injectable) administered on a monthly basis; bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2076	Intake activities, including initial medical examination that is conducted by an appropriately licensed practitioner and preparation of a care plan, which may be informed by administration of a standardized, evidence-based social determinants of health risk assessment to identify unmet health-related social needs, and that includes the patient's goals and mutually agreed-upon actions for the patient to meet those goals, including harm reduction interventions; the patient's needs and goals in the areas of education, vocational training, and employment; and the medical and psychiatric, psychosocial, economic, legal, housing, and other recovery support services that a patient needs and wishes to pursue, conducted by an appropriately licensed/credentialed personnel (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to each primary code
G2077	Periodic assessment; assessing periodically by an otp practitioner and includes a review of moud dosing, treatment response, other substance use disorder treatment needs, responses and patient-identified goals, and other relevant physical and psychiatric treatment needs and goals; assessment may be informed by administration of a standardized, evidence-based social determinants of health risk assessment to identify unmet health-related social needs, or the need and interest for harm reduction interventions and recovery support services (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to each primary code

Code	Code Descriptor
G2091	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2099	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2101	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2107	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2116	Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G2126	Patients 66-80 years of age with at least one claim/ encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
G8577	Re-exploration required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason
G8578	Re-exploration not required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason
G8694	Current or prior left ventricular ejection fraction (lvef) < = 40% or documentation of moderate or severe lvsd
G8842	Apnea hypopnea index (ahi), respiratory disturbance index (rdi) or respiratory event index (rei) documented or measured within 2 months after initial evaluation for suspected obstructive sleep apnea
G8843	Documentation of reason(s) for not measuring an apnea hypopnea index (ahi), a respiratory disturbance index (rdi), or a respiratory event index (rei) within 2 months after initial evaluation for suspected obstructive sleep apnea (e.g., medical, neurological, or psychiatric disease that prohibits successful completion of a sleep study, patients for whom a sleep study would present a bigger risk than benefit or would pose an undue burden, dementia, patients previously diagnosed with osa and severity assessed by another provider, patients who decline ahi/rdi/rei measurement, patients who had a financial reason for not completing testing, test was ordered but not completed, patients decline because their insurance (payer) does not cover the expense)

Code	Code Descriptor
G8844	Apnea hypopnea index (ahi), respiratory disturbance index (rdi), or respiratory event index (rei) not documented or measured within 2 months after initial evaluation for suspected obstructive sleep apnea, reason not given
G8923	Current or prior left ventricular ejection fraction (lvef) <= 40% or documentation of moderately or severely depressed left ventricular systolic function
G8934	Current or prior left ventricular ejection fraction (lvef) <=40% or documentation of moderately or severely depressed left ventricular systolic function
G9246	Patient did not have two eligible encounters at least 90 days apart or one eligible encounter and one hiv viral load test at least 90 days apart
G9247	Patient had two eligible encounters at least 90 days apart or one eligible encounter and one hiv viral load test at least 90 days apart
G9254	Documentation of patient discharged to home later than post-operative day 2 following cea or cas
G9255	Documentation of patient discharged to home no later than post operative day 2 following cea or cas
G9321	Count of previous ct (any type of ct) and cardiac nuclear medicine (myocardial perfusion or infarct avid imaging) studies documented in the 12-month period prior to the current study
G9322	Count of previous ct and cardiac nuclear medicine (myocardial perfusion or infarct avid imaging) studies not documented in the 12-month period prior to the current study, reason not given
G9659	Patients greater than or equal to 86 years of age who underwent a screening colonoscopy and did not have a history of colorectal cancer or other valid medical reason for the colonoscopy, including: iron deficiency anemia, lower gastrointestinal bleeding, familial adenomatous polyposis, lynch syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease (i.e., crohn's disease or ulcerative colitis), abnormal finding of gastrointestinal tract, weight loss, or changes in bowel habits
G9660	Documentation of medical reason(s) for a colonoscopy performed on a patient greater than or equal to 86 years of age (e.g., iron deficiency anemia, lower gastrointestinal bleeding, familial history of adenomatous polyposis, lynch syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease (i.e., crohn's disease or ulcerative colitis), abnormal finding of gastrointestinal tract, weight loss, or changes in bowel habits)
G9999	Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report, patient cannot provide precise date or details from previous colonoscopy, previous colonoscopy report was incomplete)
J0134	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to J0131, 10 mg
J0136	Injection, acetaminophen (b braun), not therapeutically equivalent to J0131, 10 mg
J0137	Injection, acetaminophen (hikma), not therapeutically equivalent to J0131, 10 mg
J0173	Injection, epinephrine (belcher), not therapeutically equivalent to J0171, 0.1 mg
J0208	Injection, sodium thiosulfate (pedmark), 100 mg
J0401	Injection, aripiprazole (abilify maintena), 1 mg
J0612	Injection, calcium gluconate, not otherwise specified, 10 mg
J0613	Injection, calcium gluconate (wg critical care), not therapeutically equivalent to J0612, 10 mg
J0651	Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to J0650, 10 mcg
J0652	Injection, levothyroxine sodium (hikma), not therapeutically equivalent to J0650, 10 mcg
J0873	Injection, daptomycin (xellia), not therapeutically equivalent to J0878 or J0872, 1 mg
J0893	Injection, decitabine (sun pharma), not therapeutically equivalent to J0894, 1 mg
J1574	Injection, ganciclovir sodium (exela), not therapeutically equivalent to J1570, 500 mg
J1806	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to J1805, 10 mg
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to J1920, 5 mg
J2021	Injection, linezolid (hospira), not therapeutically equivalent to J2020, 200 mg
J2184	Injection, meropenem (b. braun), not therapeutically equivalent to J2185, 100 mg
J2251	Injection, midazolam in 0.9% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg
J2272	Injection, morphine sulfate (fresenius kabi), not therapeutically equivalent to J2270, up to 10 mg
J2281	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to J2280, 100 mg
J2468 *	Injection, palonosetron hydrochloride (posfrea), 25 micrograms
J2599	Injection, vasopressin (american regent), not therapeutically equivalent to J2598, 1 unit
J3244	Injection, tigecycline (accord), not therapeutically equivalent to J3243, 1 mg
J3371	Injection, vancomycin hcl (mylan), not therapeutically equivalent to J3370, 500 mg
J3372	Injection, vancomycin hcl (xellia), not therapeutically equivalent to J3370, 500 mg
J3380	Injection, vedolizumab, intravenous, 1 mg
J3425	Injection, hydroxocobalamin, intramuscular, 10 mcg
J7516	Injection, cyclosporine, 250 mg
J9029	Intravesical Instillation, nadofaragene firadenovec-vncg, per therapeutic dose
J9033	Injection, bendamustine hydrochloride, 1 mg
J9046	Injection, bortezomib (dr. reddy's), not therapeutically equivalent to J9041, 0.1 mg
J9071	Injection, cyclophosphamide (auromedics), 5 mg
J9072	Injection, cyclophosphamide (avyxa), 5 mg
J9172	Injection, docetaxel (docivyx), 1 mg

* Code J2468 was added by CMS mid-year and revised in the January 2025 code set release. The official descriptor shown here is the most recent revised descriptor.

Code	Code Descriptor
J9255	Injection, methotrexate (accord), not therapeutically equivalent to J9260, 50 mg
J9260	Injection, methotrexate sodium, 50 mg
J9294	Injection, pemetrexed (hospira), not therapeutically equivalent to J9305, 10 mg
J9296	Injection, pemetrexed (accord), not therapeutically equivalent to J9305, 10 mg
J9314	Injection, pemetrexed (teva), not therapeutically equivalent to J9305, 10 mg
J9322	Injection, pemetrexed (bluepoint), not therapeutically equivalent to J9305, 10 mg
J9393	Injection, fulvestrant (teva), not therapeutically equivalent to J9395, 25 mg
L1652	Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1820	Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L8720*	External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg
M0004	Quality care for patients with neurological conditions mips value pathway
M1150	Current or prior left ventricular ejection fraction (lvef) less than or equal to 40% or documentation of moderately or severely depressed left ventricular systolic function
M1176	Patient did not receive two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period
M1177	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period
M1179	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine, on or after their 19th birthday and before or during measurement period
M1211	Most recent glycemic status assessment (hba1c or gmi) level > 9.0%
M1212	Glycemic status assessment (hba1c or gmi) level is missing, or was not performed during the measurement period
M1259	Patient status documented within the first year of initiating dialysis
M1260	Patient status not documented within the first year of initiating dialysis
M1267	Patients not observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period
M1268	Patients observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period
M1272	Patients observed on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period
M1292	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period
M1343	Patients who are at pam level 4 at baseline or patients who are flagged with extreme straight line response sets on the pam or with excessive missing responses
M1344	Patients who did not have a baseline pam score and/ or a second score within 4 to 12 months of baseline pam score
M1345	Patients who had a baseline pam score and a second score within 4 to 12 month of baseline pam score
M1346	Patients who did not have a net increase in pam score of at least 6 points within a 4 to 12 month period
M1347	Patients who achieved a net increase in pam score of at least 3 points in a 4 to 12 month period (passing)
M1348	Patients who achieved a net increase in pam score of at least 6-points in a 4 to 12 month period (excellent)
M1349	Patients who did not have a net increase in pam score of at least 3 points within a 4 to 12 month period
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose

* Code L8720 was added by CMS mid-year and revised in the January 2025 code set release. The official descriptor shown here is the most recent revised descriptor.

DELETED CODES

Code	Code Descriptor
C7558	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed
C9113	Injection, pantoprazole sodium, per vial
C9150	Xenon xe-129 hyperpolarized gas, diagnostic, per study dose
C9159	Injection, prothrombin complex concentrate (human), balfaxar, per i.u. of factor ix activity
C9160	Injection, daxibotulinumtoxina-lanm, 1 unit
C9161	Injection, aflibercept hd, 1 mg
C9162	Injection, avacincaptad pegol, 0.1 mg
C9163	Injection, talquetamab-tgvs, 0.25 mg
C9164	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)
C9165	Injection, elranatamab-bcmm, 1 mg
C9166	Injection, secukinumab, intravenous, 1 mg
C9167	Injection, adamts13, recombinant-krhn, 10 iu
C9168	Injection, mirikizumab-mrkz, 1 mg
C9169	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram
C9170	Injection, tarlatamab-dlle, 1 mg
C9171	Injection, pegulicianine, 1 mg
C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose
C9290	Injection, bupivacaine liposome, 1 mg
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance
C9769	Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts
C9786	Echocardiography image post processing for computer aided detection of heart failure with preserved ejection fraction, including interpretation and report
C9787	Gastric electrophysiology mapping with simultaneous patient symptom profiling
C9790	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance

Code	Code Descriptor
C9794	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)
C9795	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions
E2300	Wheelchair accessory, power seat elevation system, any type
G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.
G0122	Colorectal cancer screening; barium enema
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2070	Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)
G8482	Influenza immunization administered or previously received
G8483	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)
G8484	Influenza immunization was not administered, reason not given
G8965	Cardiac stress imaging test primarily performed on low chd risk patient for initial detection and risk assessment

Code	Code Descriptor
G8966	Cardiac stress imaging test performed on symptomatic or higher than low chd risk patient or for any reason other than initial detection and risk assessment
G9402	Patient received follow-up within 30 days after discharge
G9403	Clinician documented reason patient was not able to complete 30 day follow-up from acute inpatient setting discharge (e.g., patient death prior to follow-up visit, patient non-compliant for visit follow-up)
G9404	Patient did not receive follow-up within 30 days after discharge
G9405	Patient received follow-up within 7 days after discharge
G9406	Clinician documented reason patient was not able to complete 7 day follow-up from acute inpatient setting discharge (i.e patient death prior to follow-up visit, patient non-compliance for visit follow-up)
G9407	Patient did not receive follow-up within 7 days after discharge
G9458	Patient documented as tobacco user and received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user
G9459	Currently a tobacco non-user
G9460	Tobacco assessment or tobacco cessation intervention not performed, reason not given
G9707	Patient received hospice services any time during the measurement period
G9751	Patient died at any time during the 24-month measurement period
G9760	Patients who use hospice services any time during the measurement period
G9892	Documentation of patient reason(s) for not performing a dilated macular examination
G9893	Dilated macular exam was not performed, reason not otherwise specified
G9919	Screening performed and positive and provision of recommendations
G9920	Screening performed and negative
G9921	No screening performed, partial screening performed or positive screen without recommendations and reason is not given or otherwise specified
G9974	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity
G9975	Documentation of medical reason(s) for not performing a dilated macular examination
G9990	Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period
G9991	Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period

Code	Code Descriptor
J0135	Injection, adalimumab, 20 mg
J0570	Buprenorphine implant, 74.2 mg
J0576	Injection, buprenorphine extended-release (brixadi), 1 mg
J1020	Injection, methylprednisolone acetate, 20 mg
J1030	Injection, methylprednisolone acetate, 40 mg
J1040	Injection, methylprednisolone acetate, 80 mg
J1170	Injection, hydromorphone, up to 4 mg
J1840	Injection, kanamycin sulfate, up to 500 mg
J1850	Injection, kanamycin sulfate, up to 75 mg
J2001	Injection, lidocaine hcl for intravenous infusion, 10 mg
J2780	Injection, ranitidine hydrochloride, 25 mg
J2796	Injection, romiplostim, 10 micrograms
J2806	Injection, sincalide (maia), not therapeutically equivalent to j2805, 5 micrograms
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg
J8520	Capecitabine, oral, 150 mg
J8521	Capecitabine, oral, 500 mg
J9058	Injection, bendamustine hydrochloride (apotex), 1 mg
J9059	Injection, bendamustine hydrochloride (baxter), 1 mg
J9070	Cyclophosphamide, 100 mg
J9250	Methotrexate sodium, 5 mg
J9258	Injection, paclitaxel protein-bound particles (teva), not therapeutically equivalent to j9264, 1 mg
J9259	Injection, paclitaxel protein-bound particles (american regent), not therapeutically equivalent to j9264, 1 mg
J9371	Injection, vincristine sulfate liposome, 1 mg
M0003	Optimal care for patients with episodic neurological conditions mips value pathways
M1154	Hospice services provided to patient any time during the measurement period
M1155	Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period
M1219	Anaphylaxis due to the vaccine on or before the date of the encounter
M1264	Patients age 75 or older on their initiation of dialysis date
Q0516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days
Q0517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days
Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days

Code	Code Descriptor
Q0519	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days
Q0520	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 60-days
Q4210	Axolotl graft or axolotl dualgraft, per square centimeter
Q4244	Procenta, per 200 mg
Q4277	Woundplus membrane or e-graft, per square centimeter
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg
Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg
S0164	Injection, pantoprazole sodium, 40 mg

Deleted Codes Crosswalk

Deleted Code	Crosswalk Code
C7558	CMS does not provide crosswalk codes for this deleted code.
C9113	CMS does not provide crosswalk codes for this deleted code.
C9150	A9610
C9159	CMS does not provide crosswalk codes for this deleted code.
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C9164	CMS does not provide crosswalk codes for this deleted code.
C9165	CMS does not provide crosswalk codes for this deleted code.
C9166	J3247
C9167	J7171
C9168	CMS does not provide crosswalk codes for this deleted code.
C9169	CMS does not provide crosswalk codes for this deleted code.
C9170	CMS does not provide crosswalk codes for this deleted code.
C9171	CMS does not provide crosswalk codes for this deleted code.
C9172	CMS does not provide crosswalk codes for this deleted code.
C9290	CMS does not provide crosswalk codes for this deleted code.
C9734	55882
C9769	53865
C9786	0932T
C9787	0868T
C9790	0888T
C9794	G0562
C9795	G0563
E2300	CMS does not provide crosswalk codes for this deleted code.
G0106	CMS does not provide crosswalk codes for this deleted code.
G0120	CMS does not provide crosswalk codes for this deleted code.
G0122	CMS does not provide crosswalk codes for this deleted code.
G2012	98016

Deleted Code	Crosswalk Code
G2070	CMS does not provide crosswalk codes for this deleted code.
G2071	CMS does not provide crosswalk codes for this deleted code.
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G8482	CMS does not provide crosswalk codes for this deleted code.
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G8965	CMS does not provide crosswalk codes for this deleted code.
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G9406	CMS does not provide crosswalk codes for this deleted code.
G9407	CMS does not provide crosswalk codes for this deleted code.
G9458	CMS does not provide crosswalk codes for this deleted code.
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G9460	CMS does not provide crosswalk codes for this deleted code.
G9707	CMS does not provide crosswalk codes for this deleted code.
G9751	CMS does not provide crosswalk codes for this deleted code.
G9760	CMS does not provide crosswalk codes for this deleted code.
G9892	CMS does not provide crosswalk codes for this deleted code.
G9893	CMS does not provide crosswalk codes for this deleted code.
G9919	CMS does not provide crosswalk codes for this deleted code.
G9920	CMS does not provide crosswalk codes for this deleted code.
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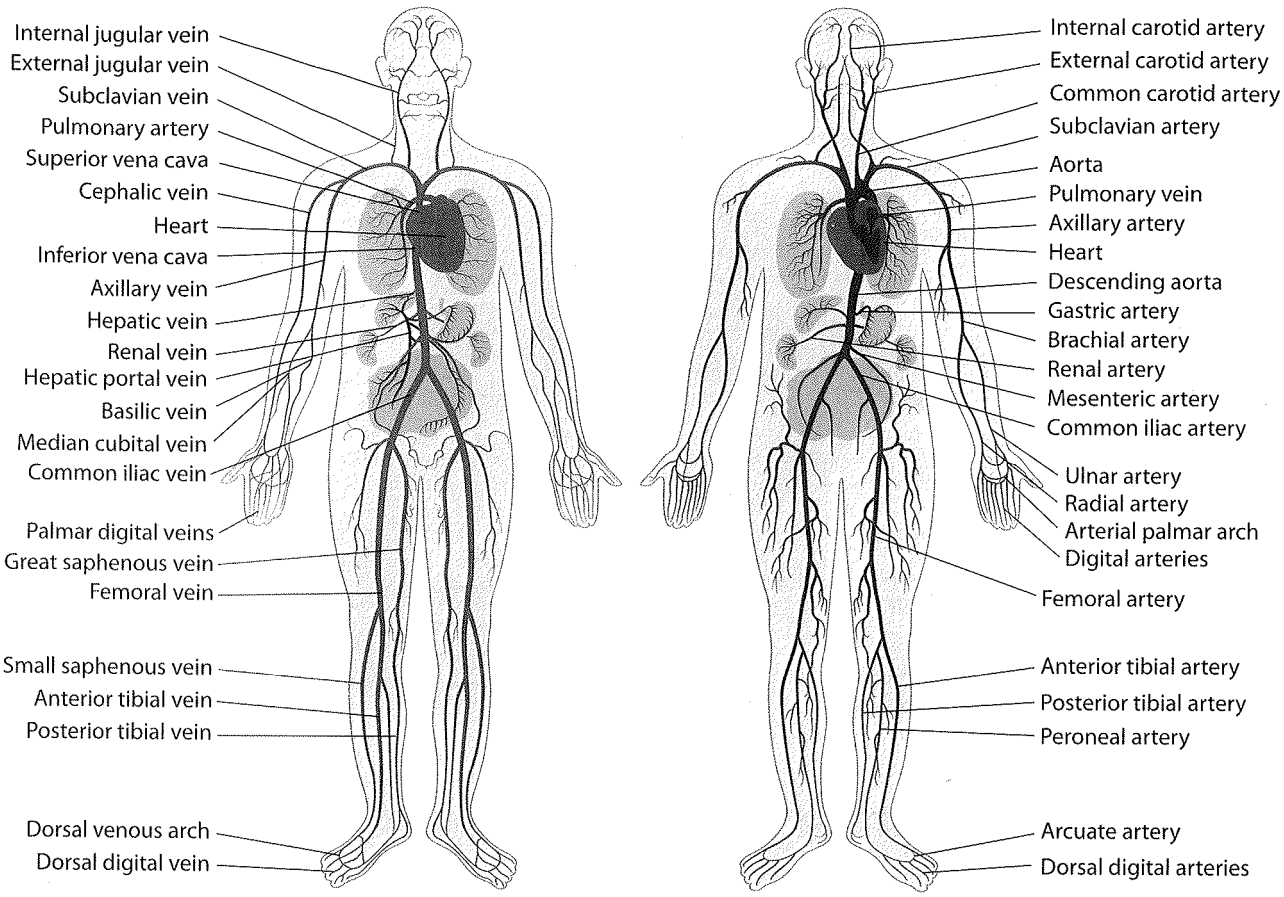
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J1170	CMS does not provide crosswalk codes for this deleted code.
J1840	CMS does not provide crosswalk codes for this deleted code.
J1850	CMS does not provide crosswalk codes for this deleted code.
J2001	CMS does not provide crosswalk codes for this deleted code.
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J9058	CMS does not provide crosswalk codes for this deleted code.
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Deleted Code	Crosswalk Code
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M1154	CMS does not provide crosswalk codes for this deleted code.
M1155	CMS does not provide crosswalk codes for this deleted code.
M1219	CMS does not provide crosswalk codes for this deleted code.
M1264	CMS does not provide crosswalk codes for this deleted code.
Q0516	CMS does not provide crosswalk codes for this deleted code.
Q0517	CMS does not provide crosswalk codes for this deleted code.
Q0518	CMS does not provide crosswalk codes for this deleted code.
Q0519	CMS does not provide crosswalk codes for this deleted code.
Q0520	CMS does not provide crosswalk codes for this deleted code.
Q4210	CMS does not provide crosswalk codes for this deleted code.
Q4244	CMS does not provide crosswalk codes for this deleted code.
Q4277	CMS does not provide crosswalk codes for this deleted code.
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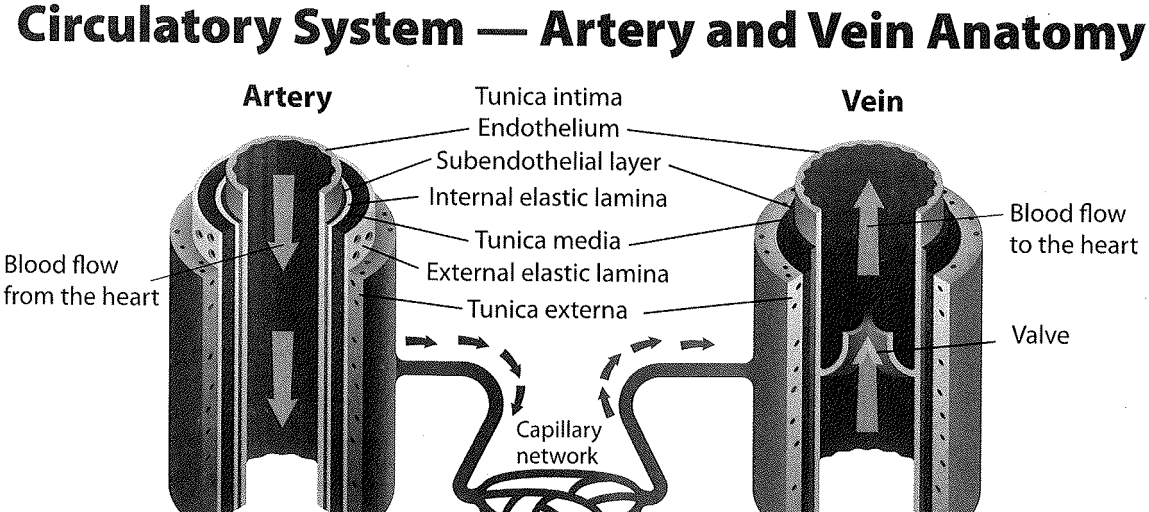
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Anatomical Illustrations

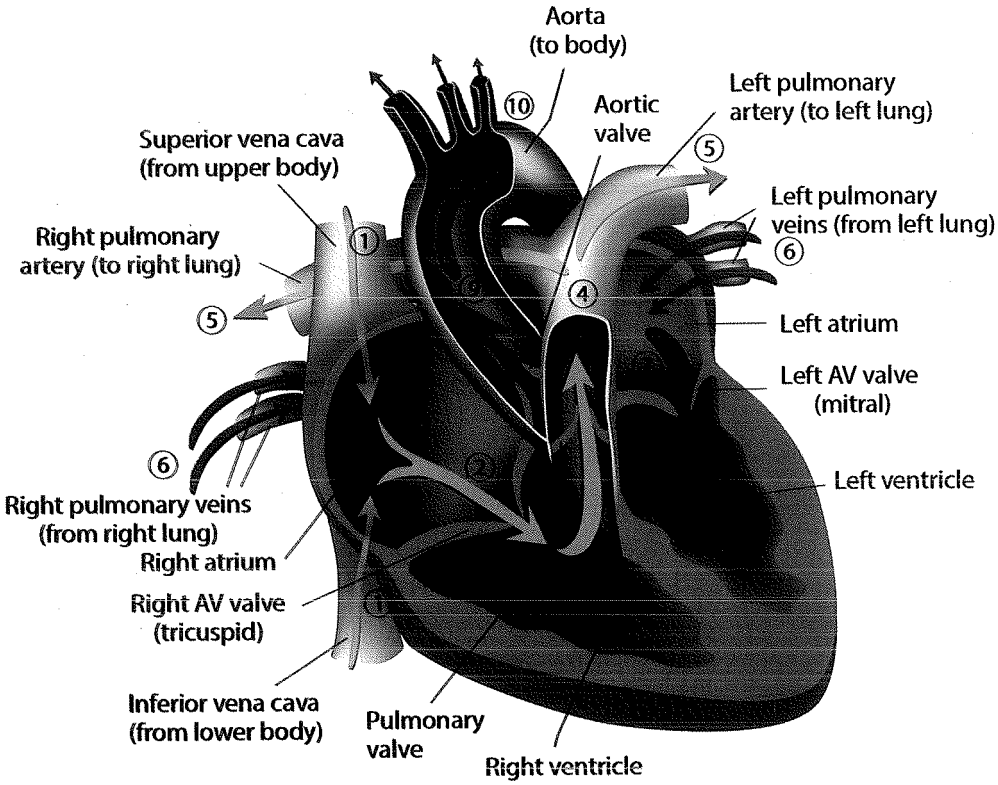
Circulatory System — Arteries and Veins



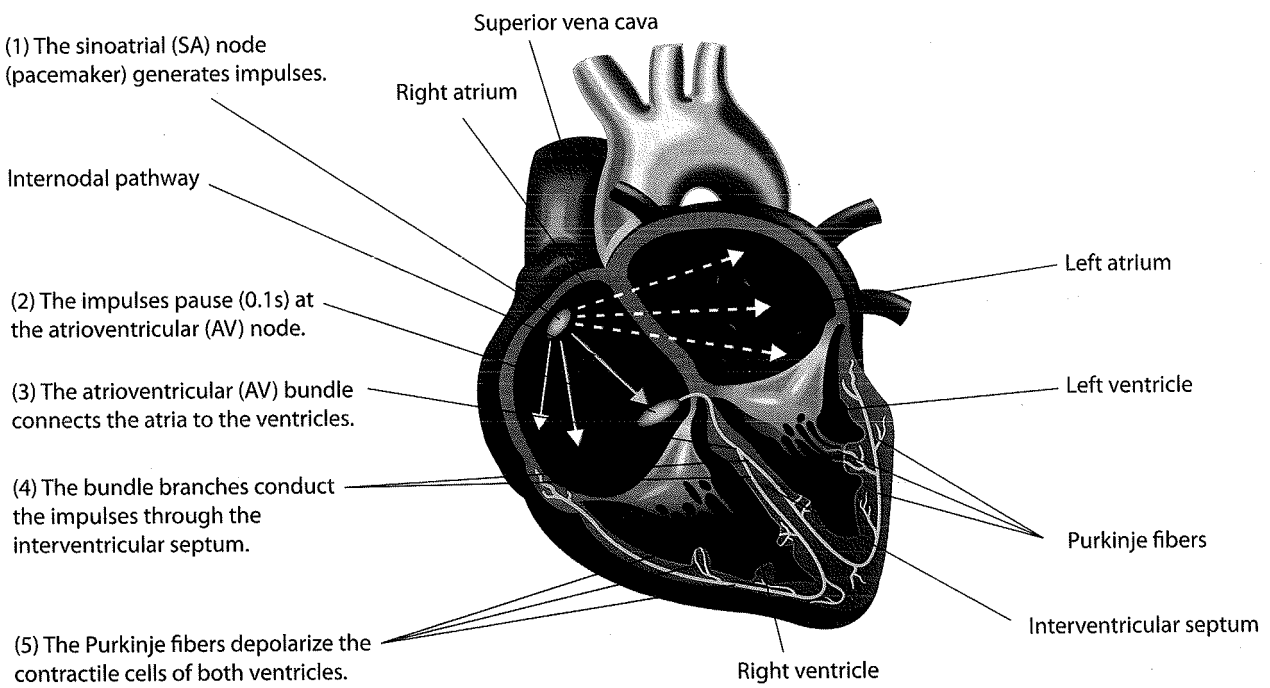
Circulatory System — Artery and Vein Anatomy



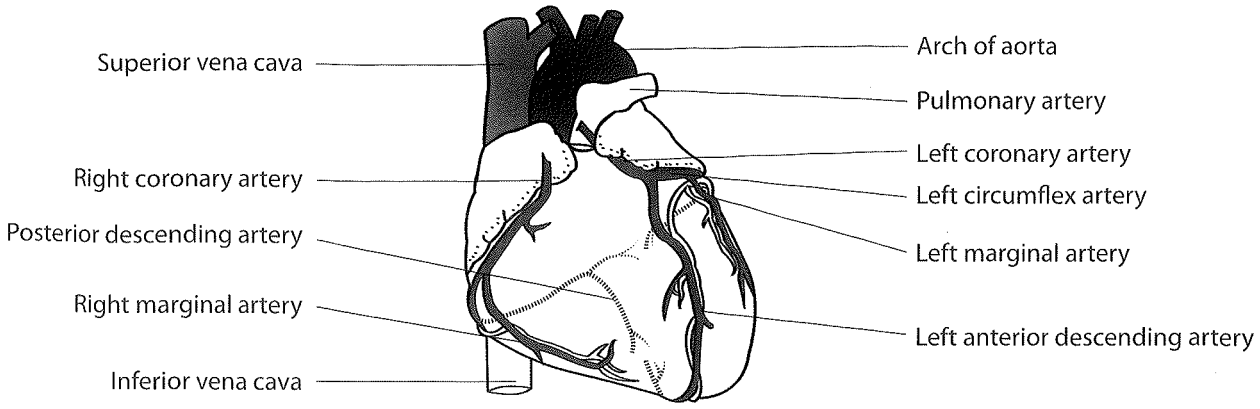
Circulatory System — The Pathway of Blood Flow Through the Heart



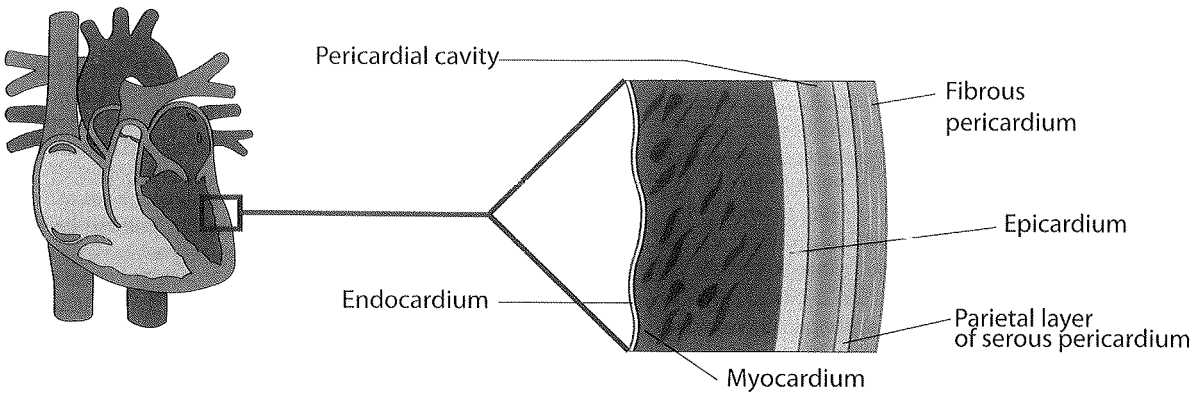
Circulatory System — Electrical Conducting System



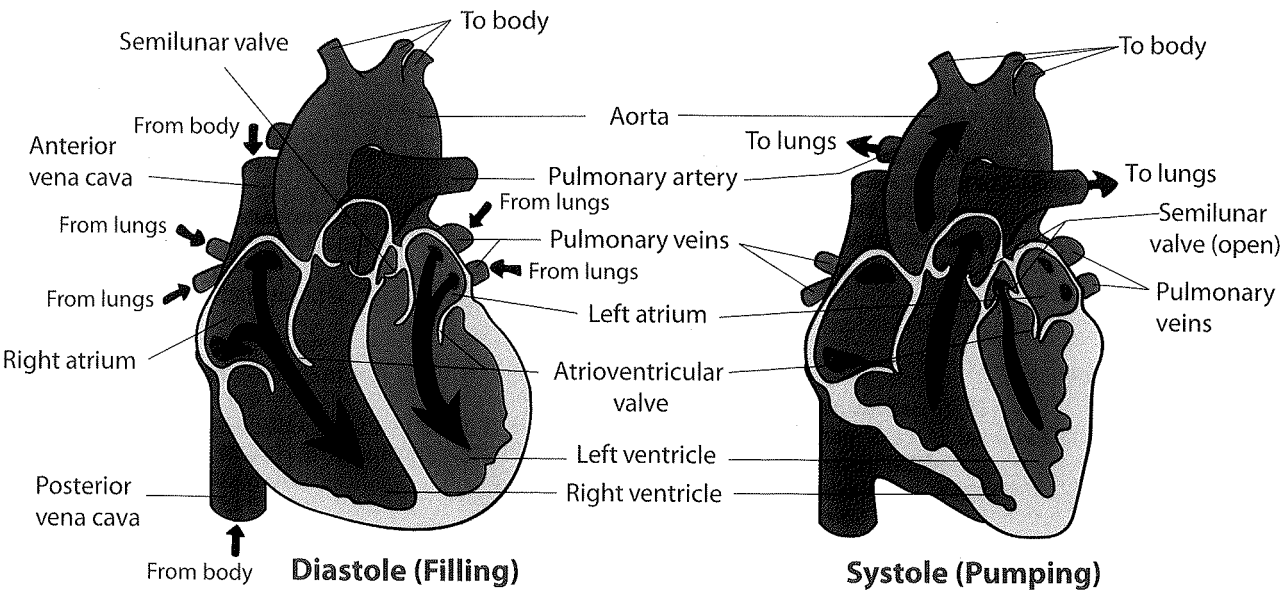
Circulatory System — Coronary Arteries



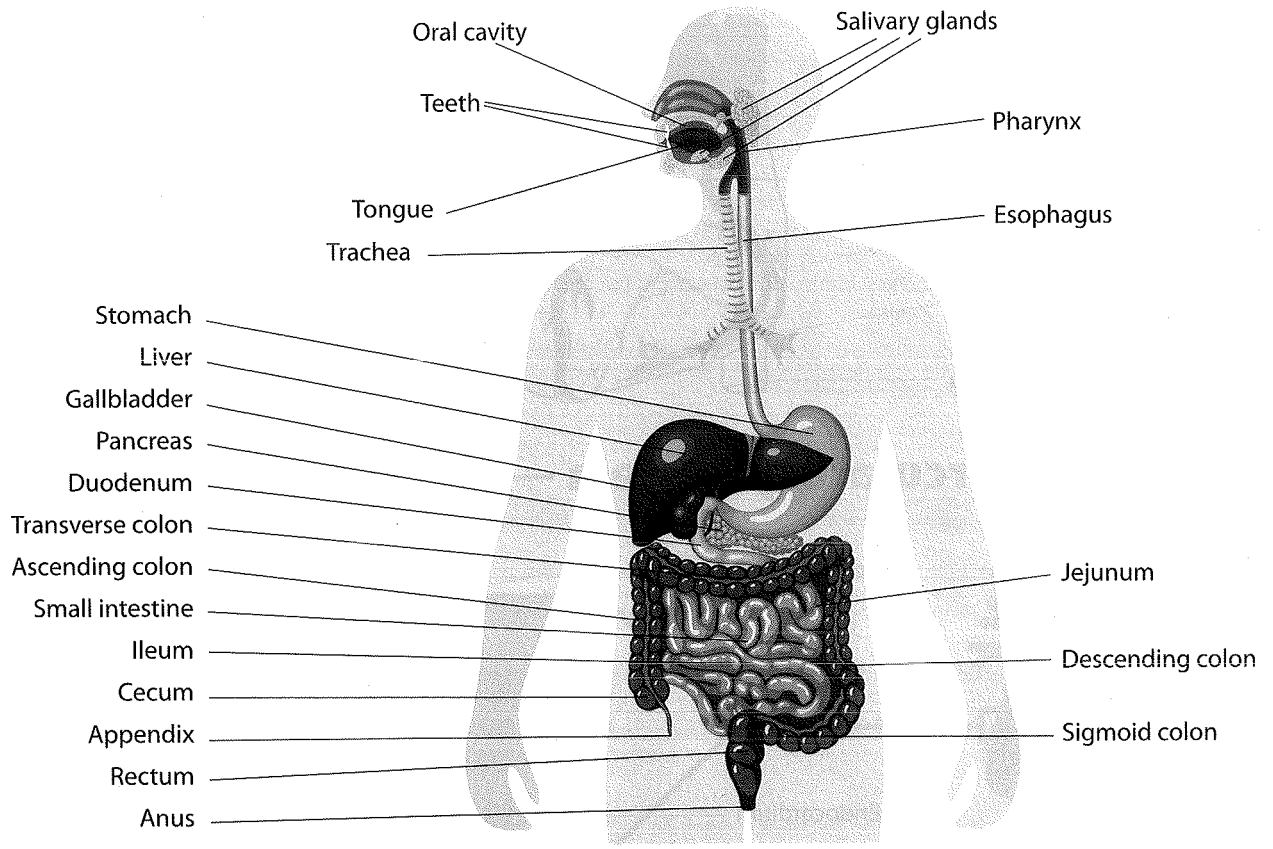
Circulatory System — Heart Wall



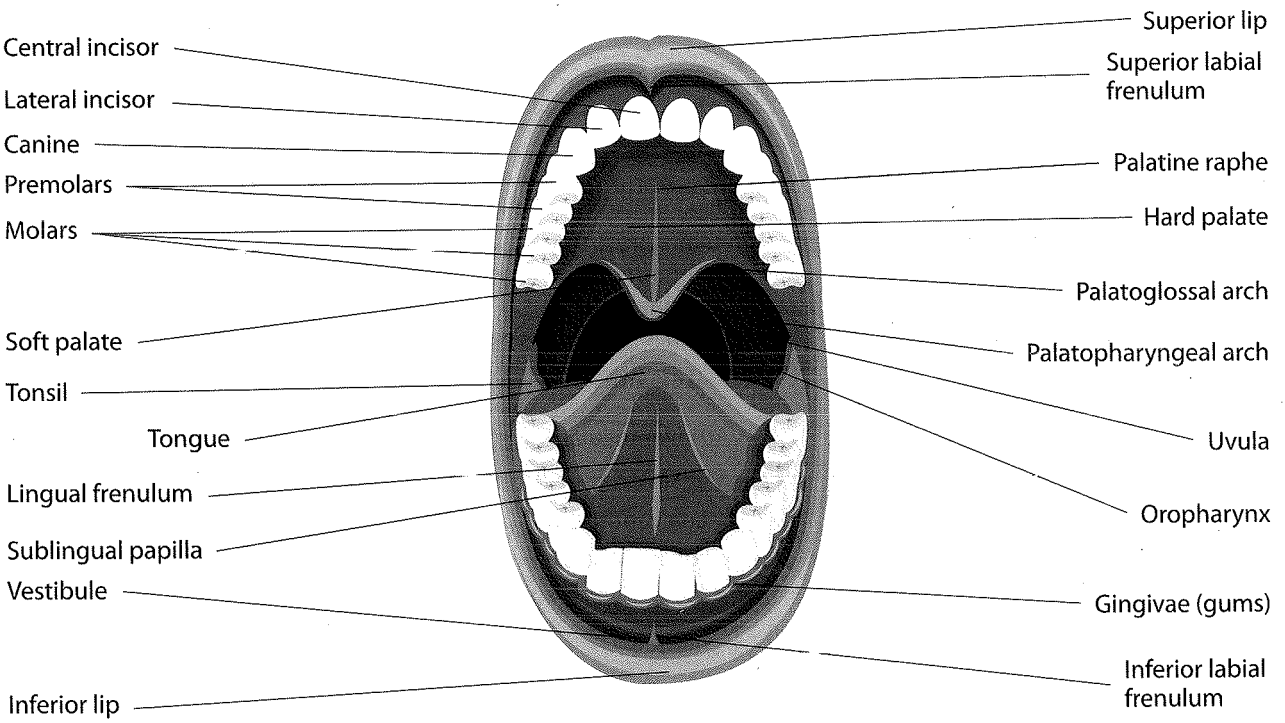
Circulatory System — Cardiac Cycle



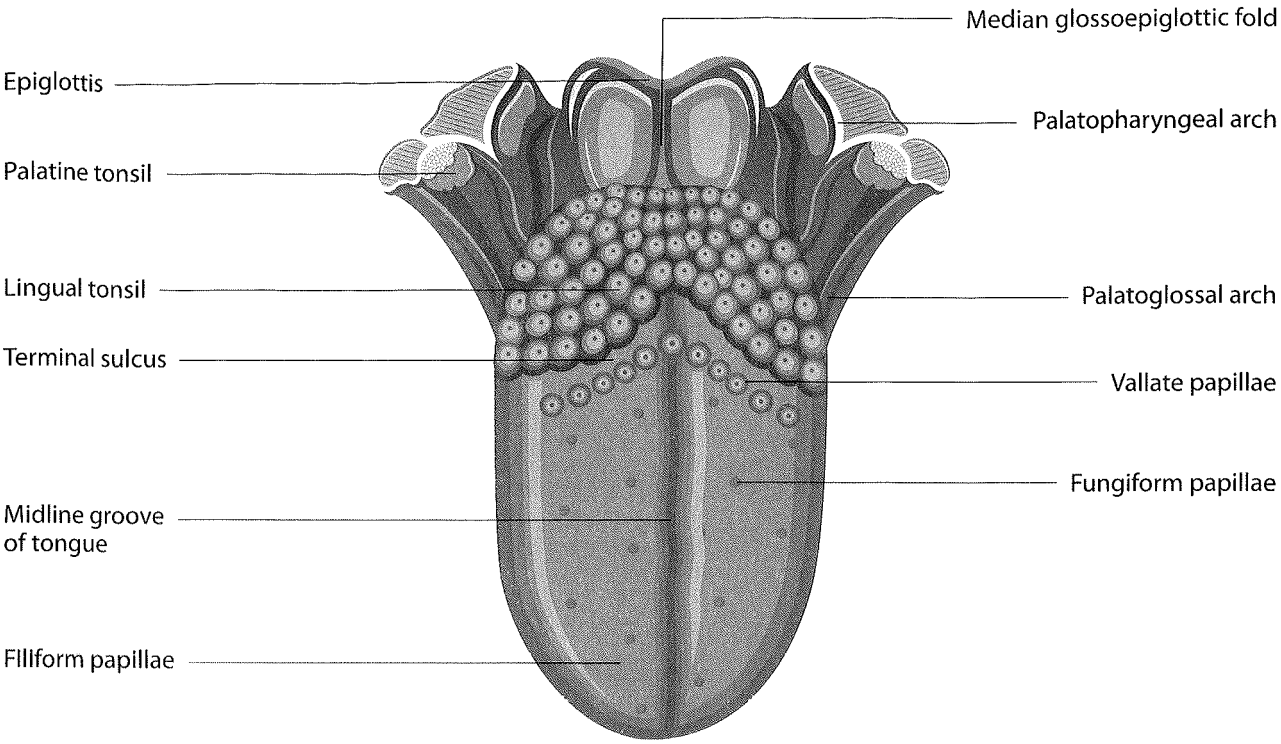
Digestive System Anatomy



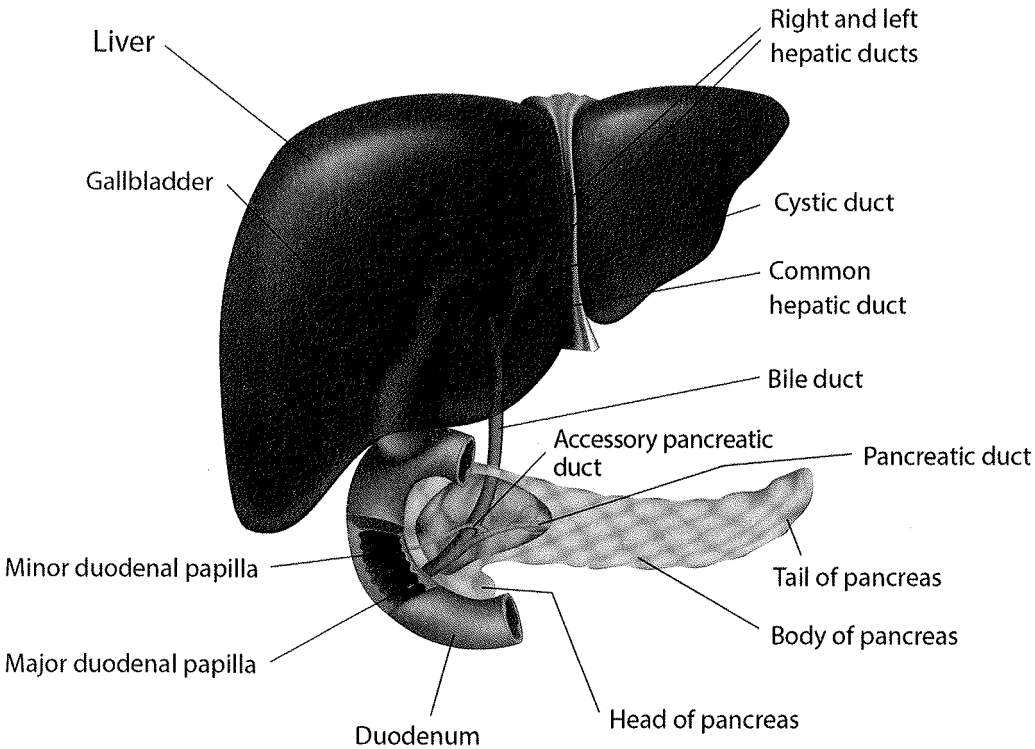
Digestive System — Mouth Anatomy



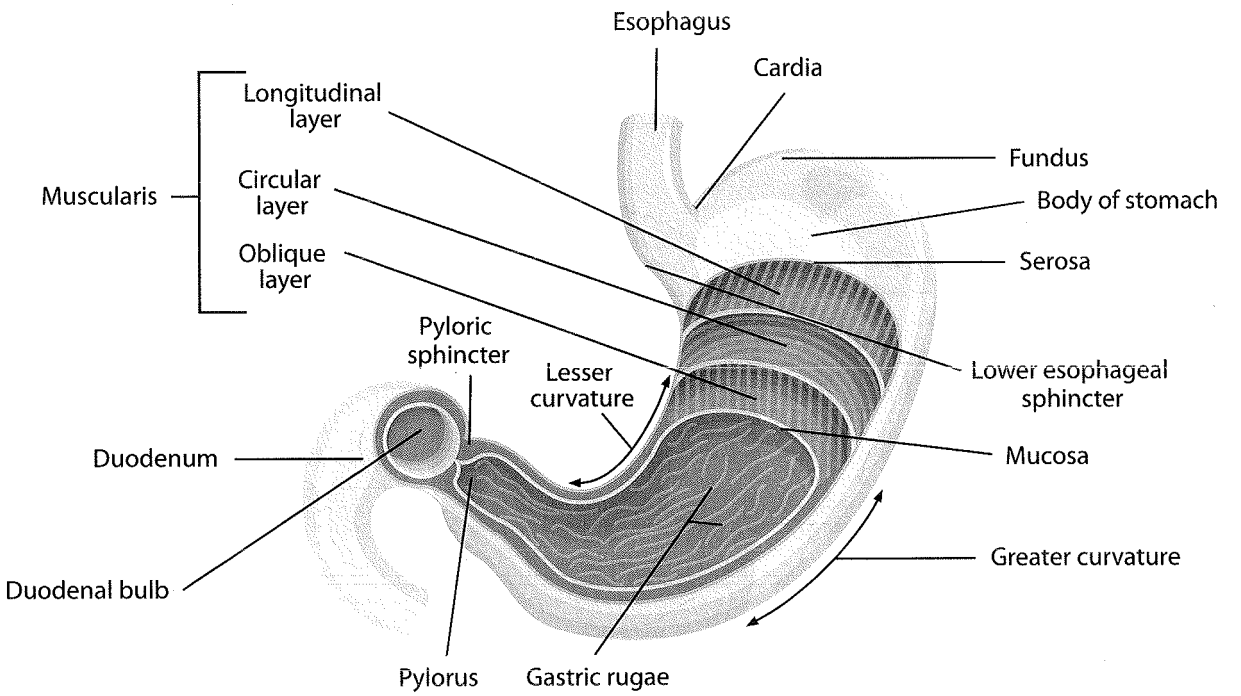
Digestive System — Tongue Anatomy



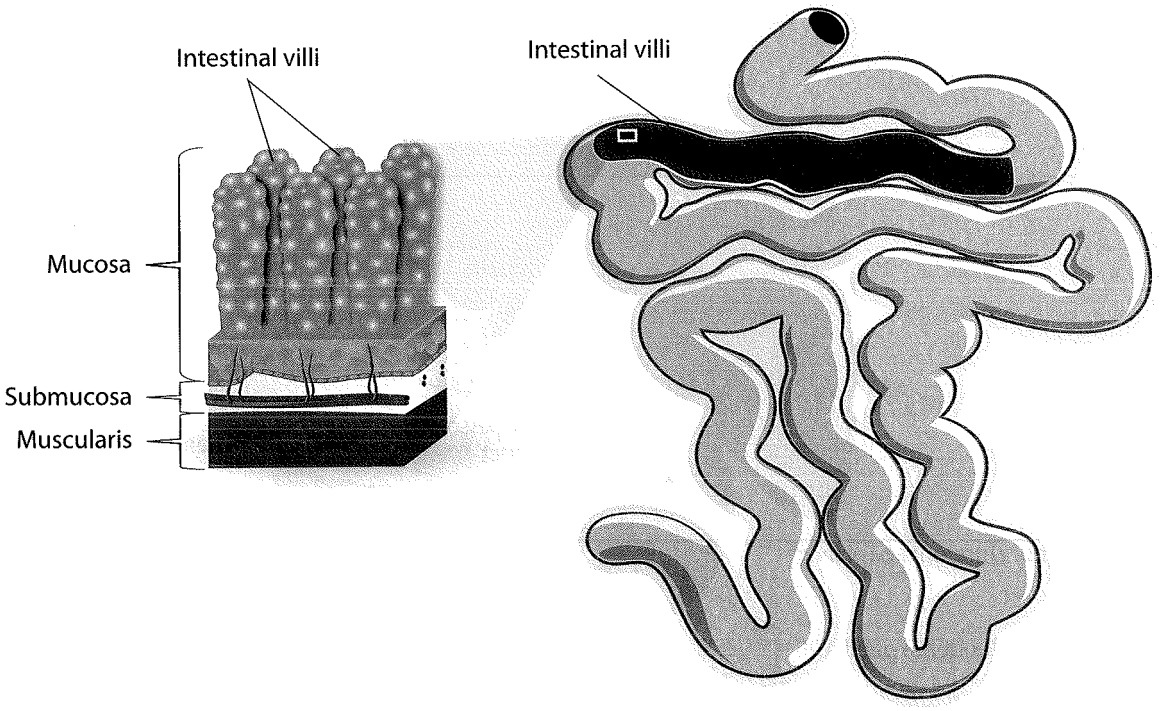
Digestive System — Liver, Gallbladder, Pancreas



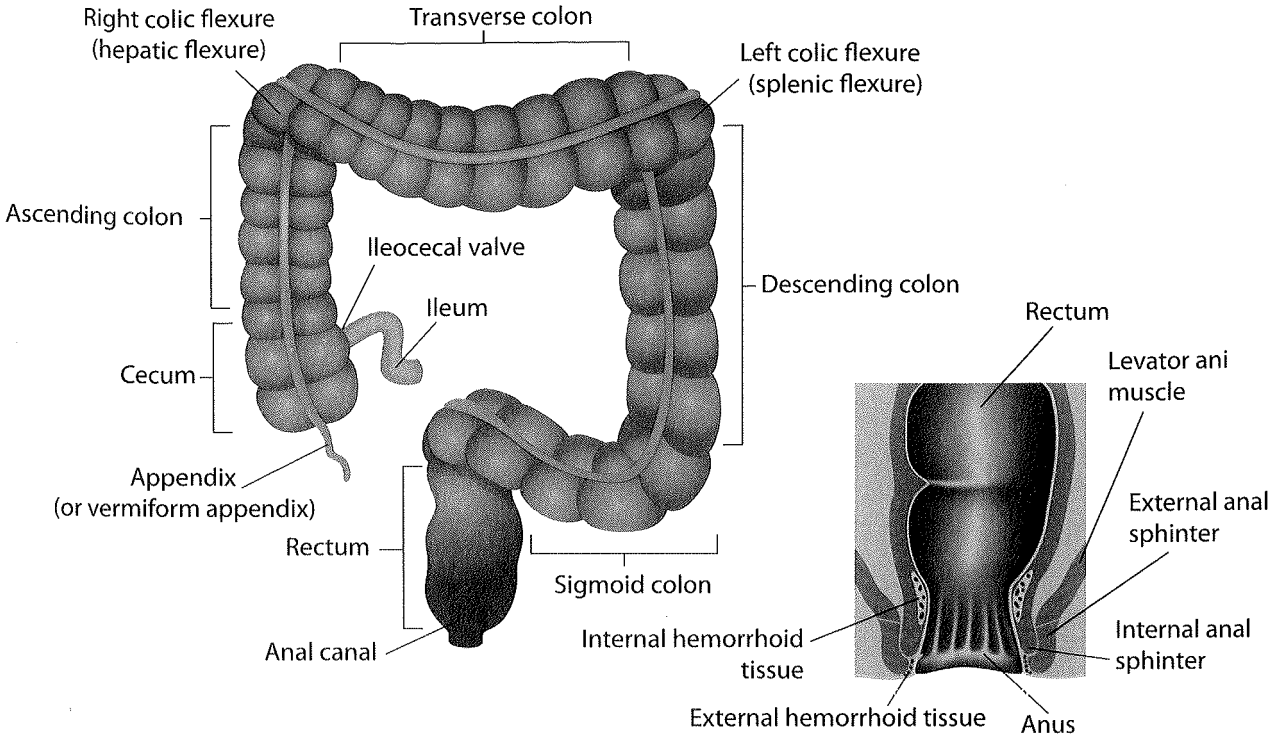
Digestive System — Stomach Anatomy



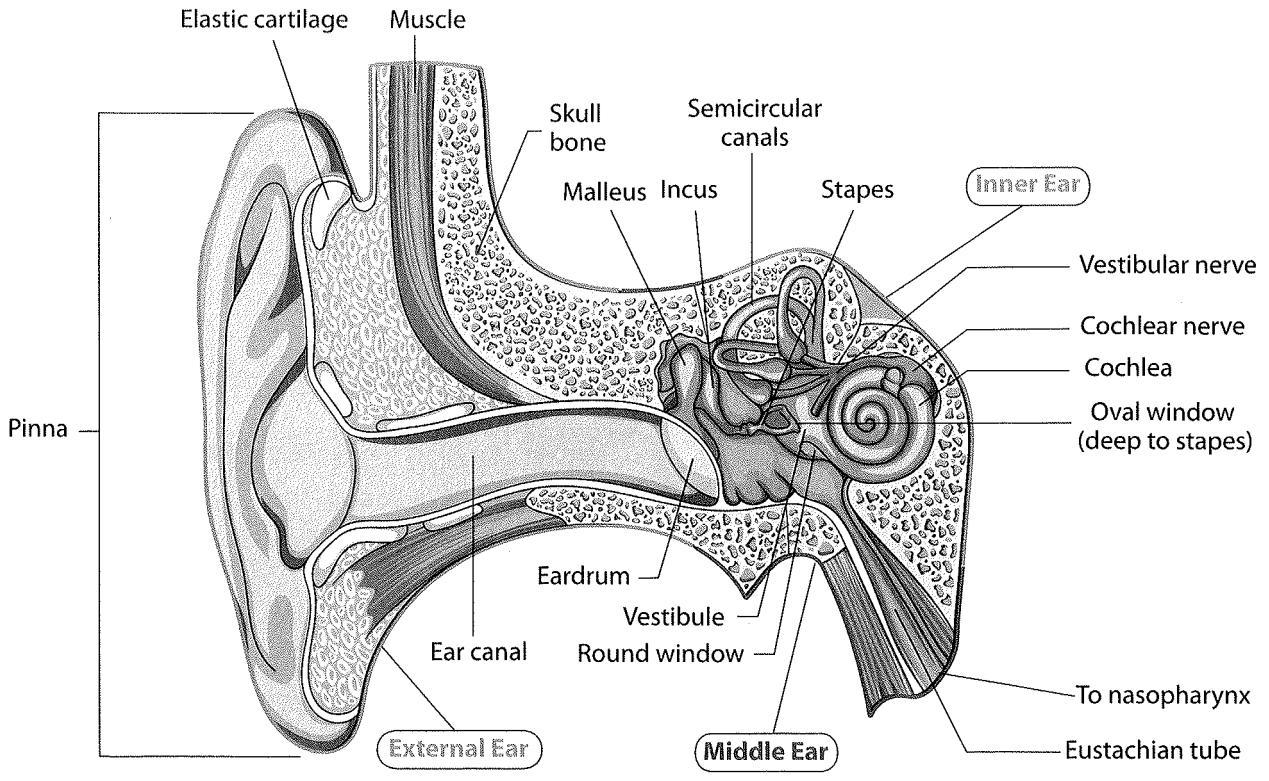
Digestive System — Small Intestine Anatomy



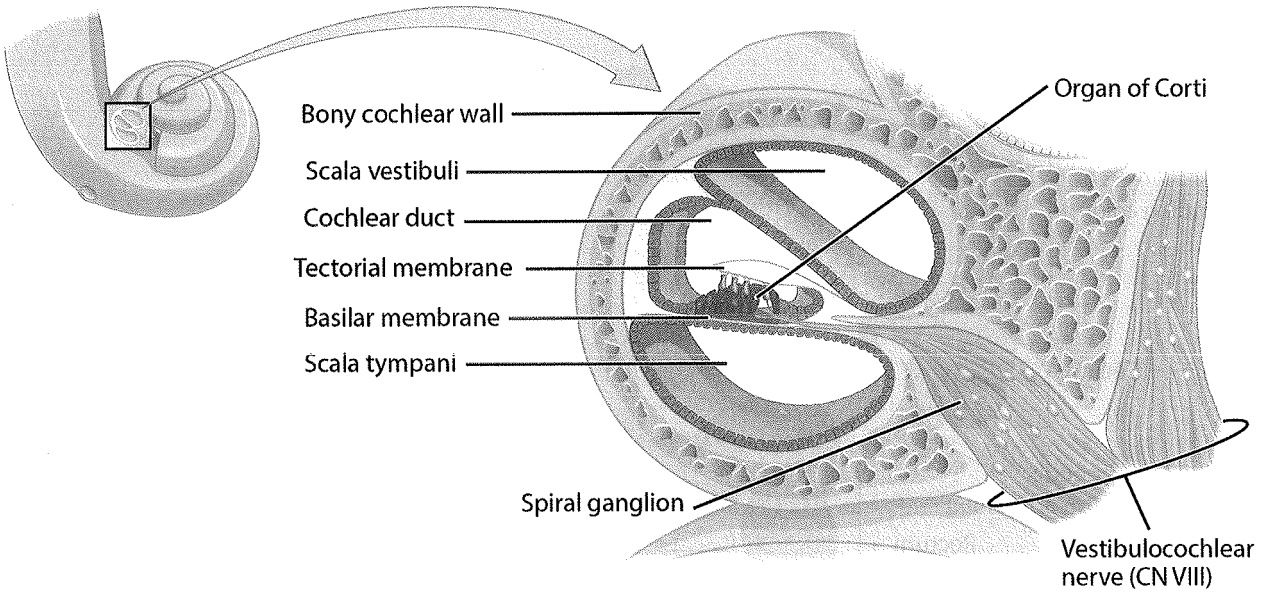
Digestive System — Large Intestine Anatomy



Ear Anatomy

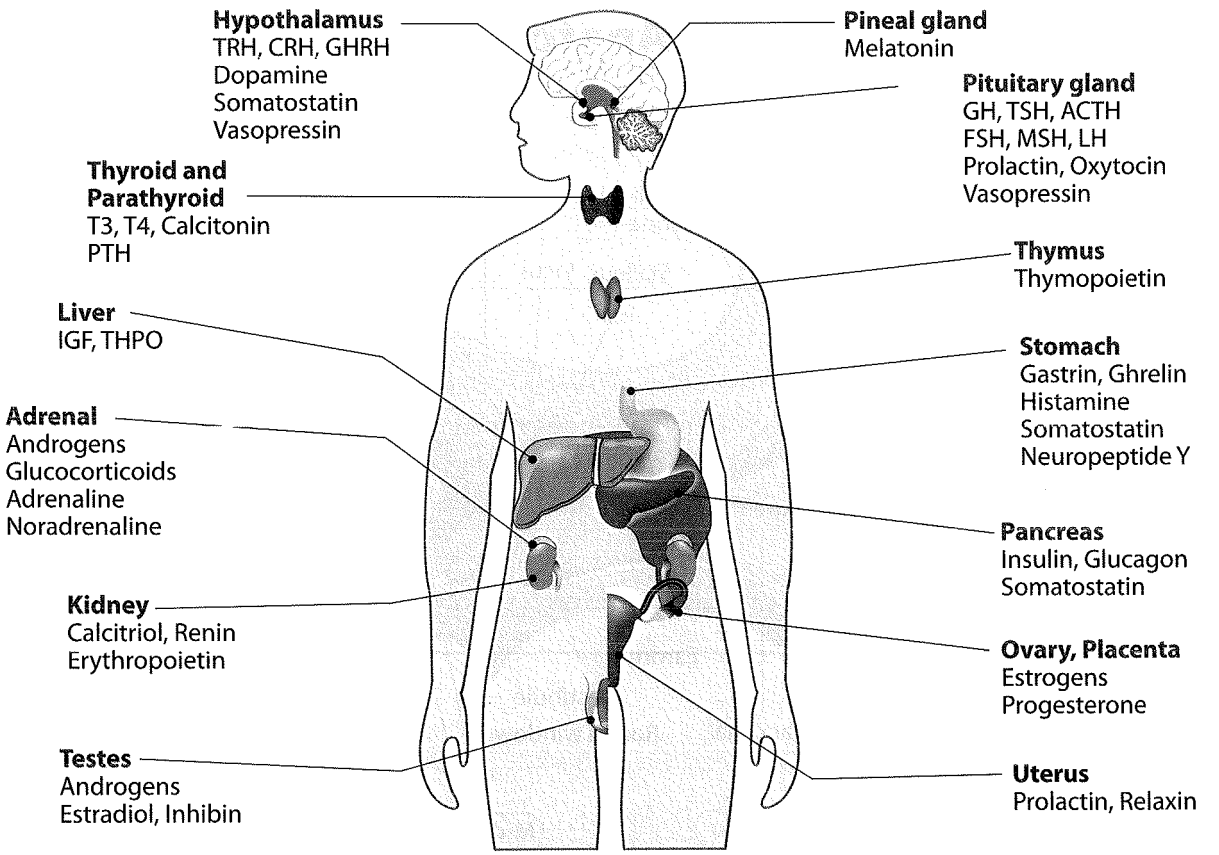


Ear Anatomy — Inner Ear

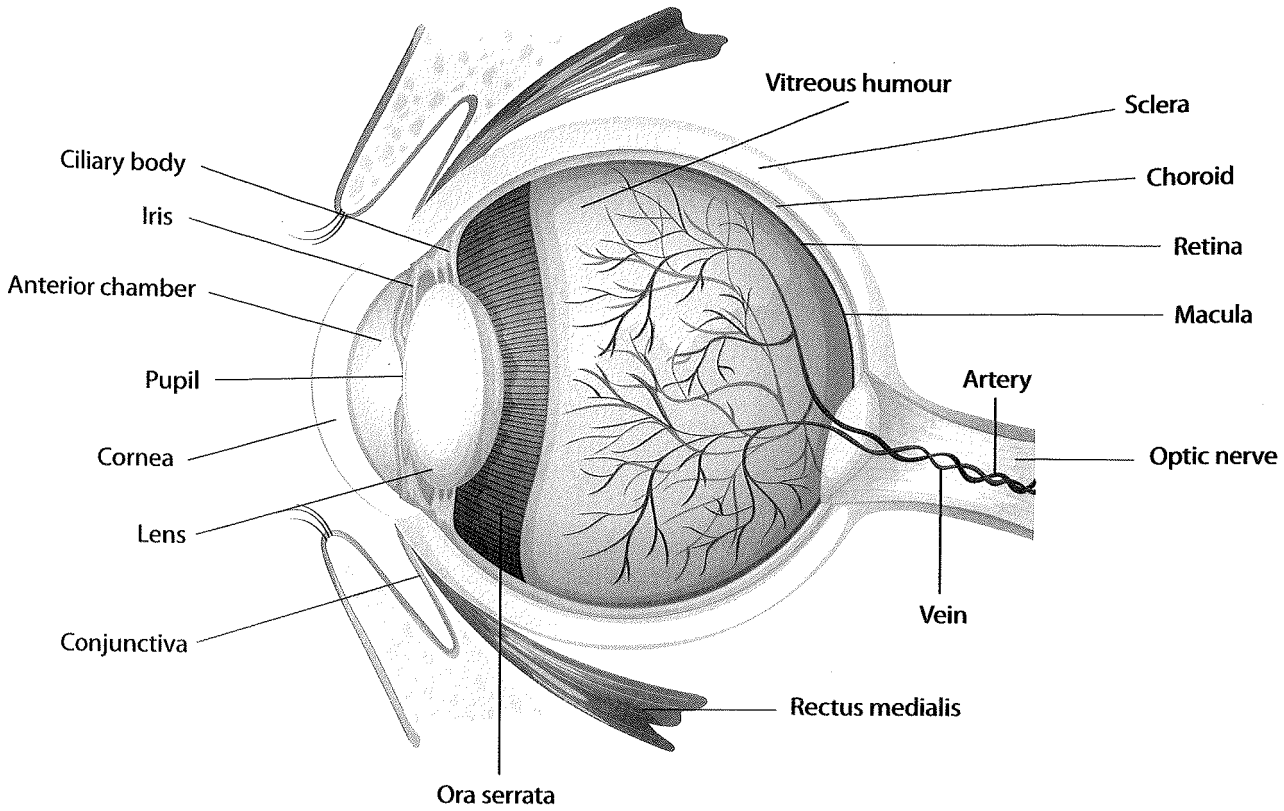


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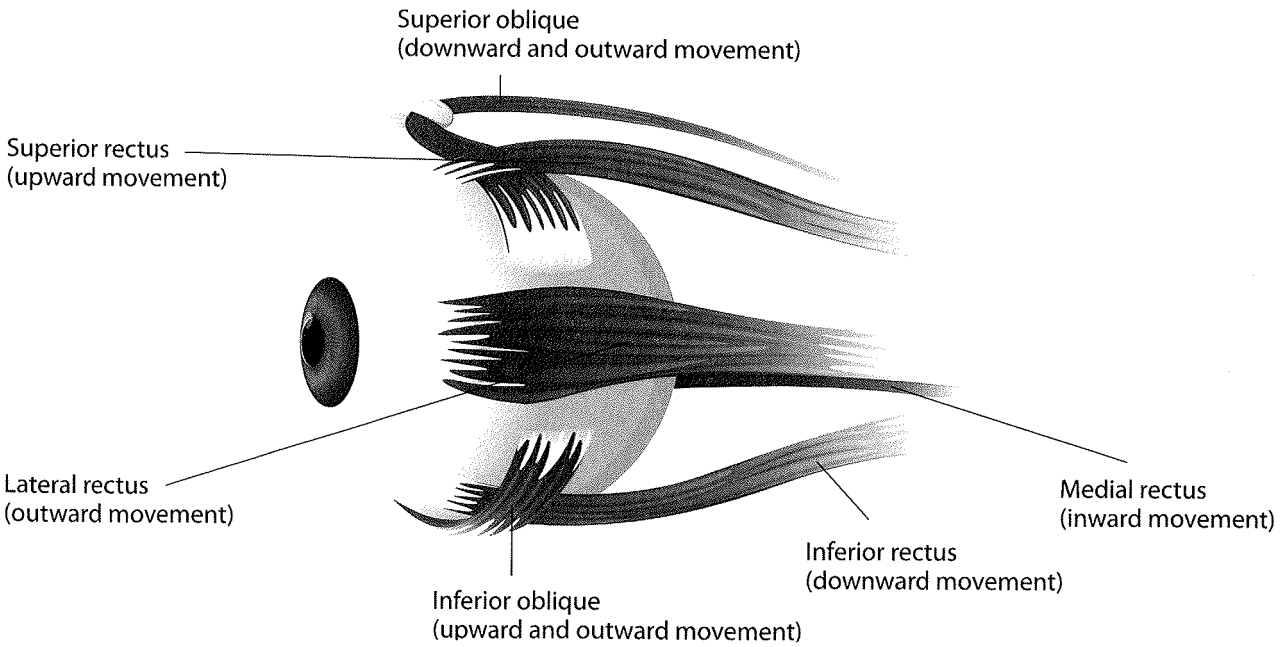
Endocrine System Anatomy and Hormones



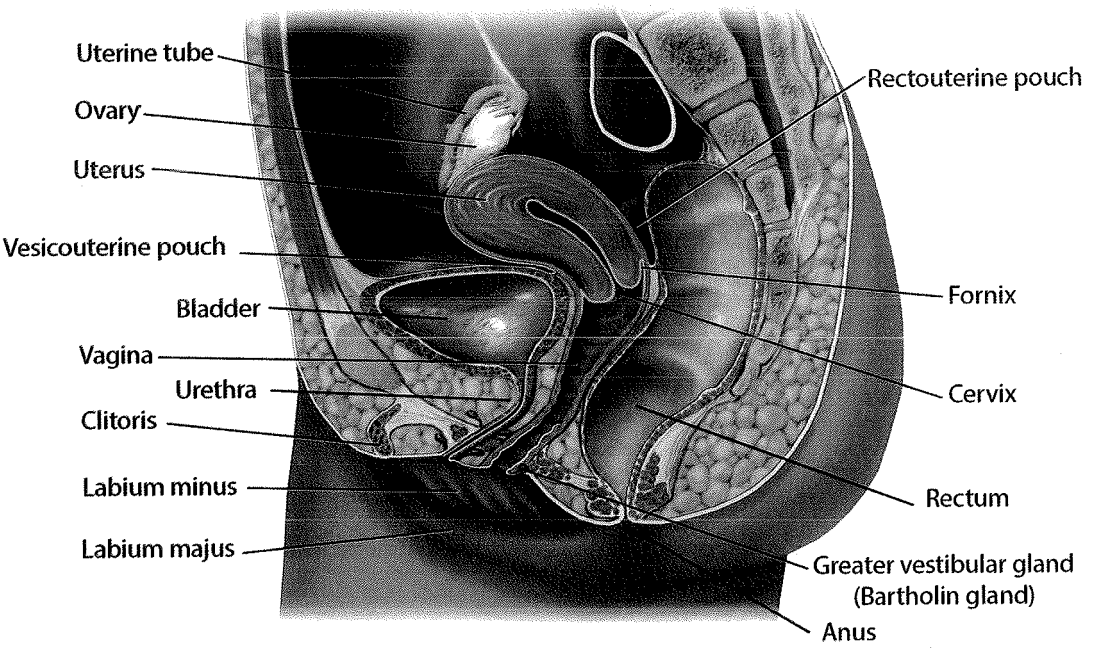
Eye Anatomy



Eye Musculature

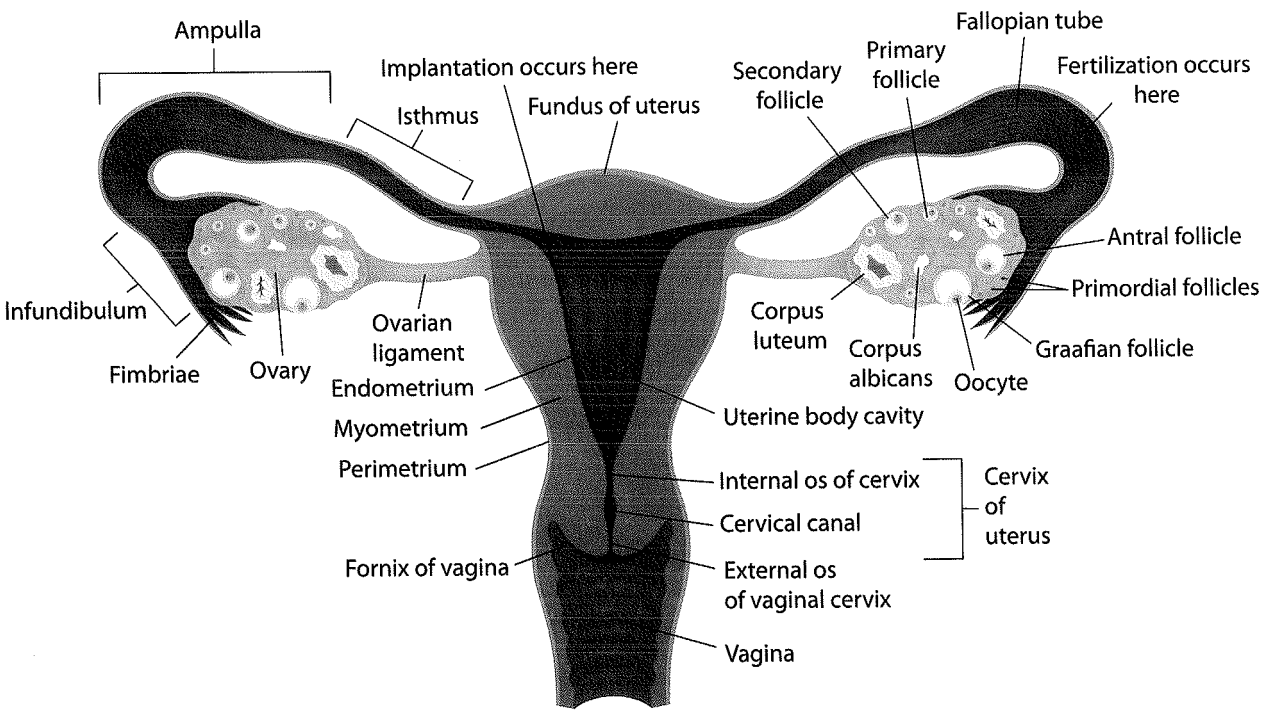


Female Reproductive System Anatomy



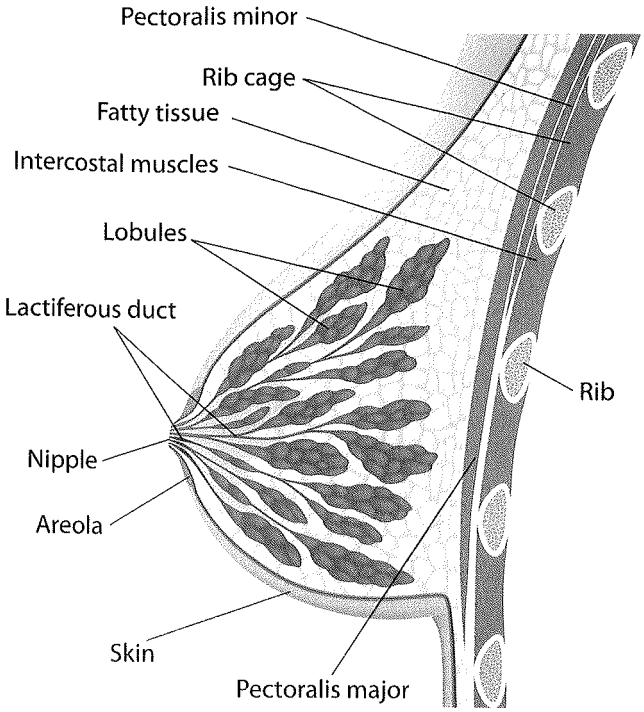
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Female Reproductive System — Uterus and Adnexa Anatomy

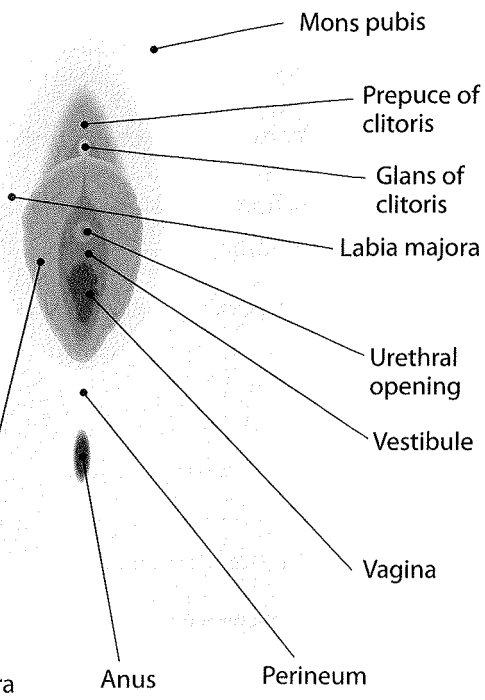


Female Reproductive System

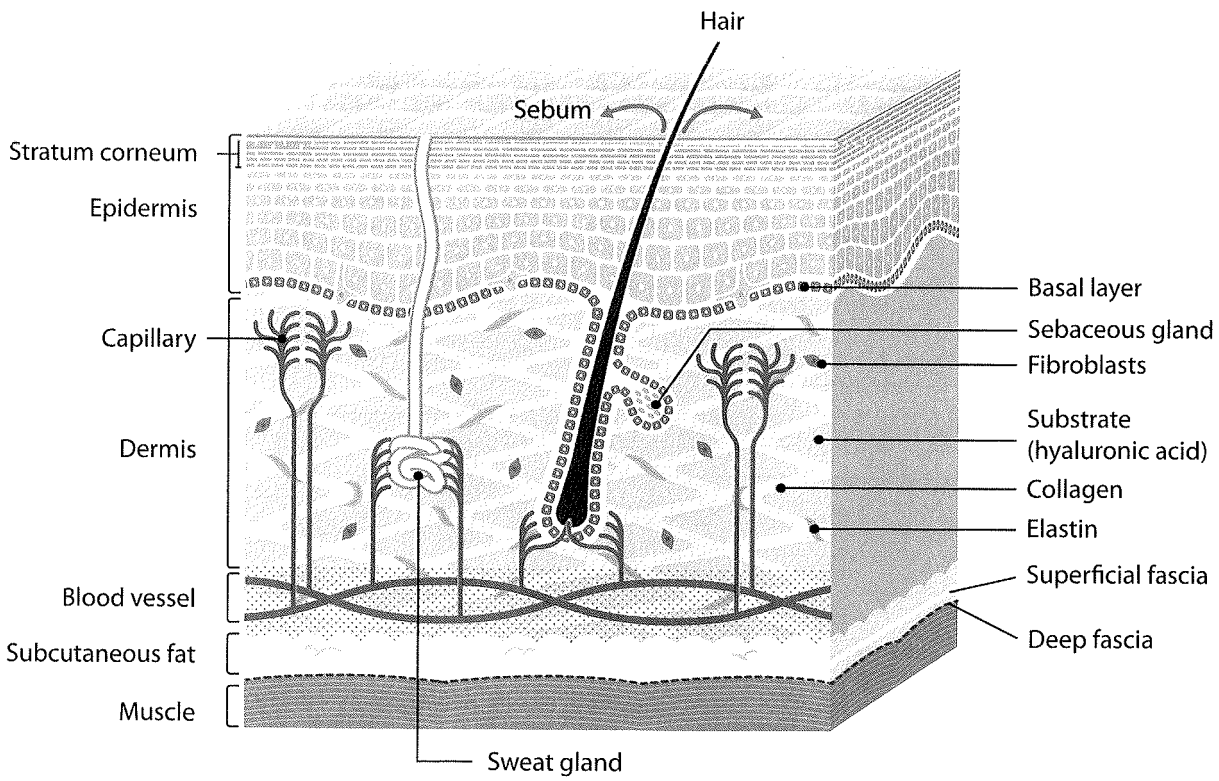
Breast Anatomy



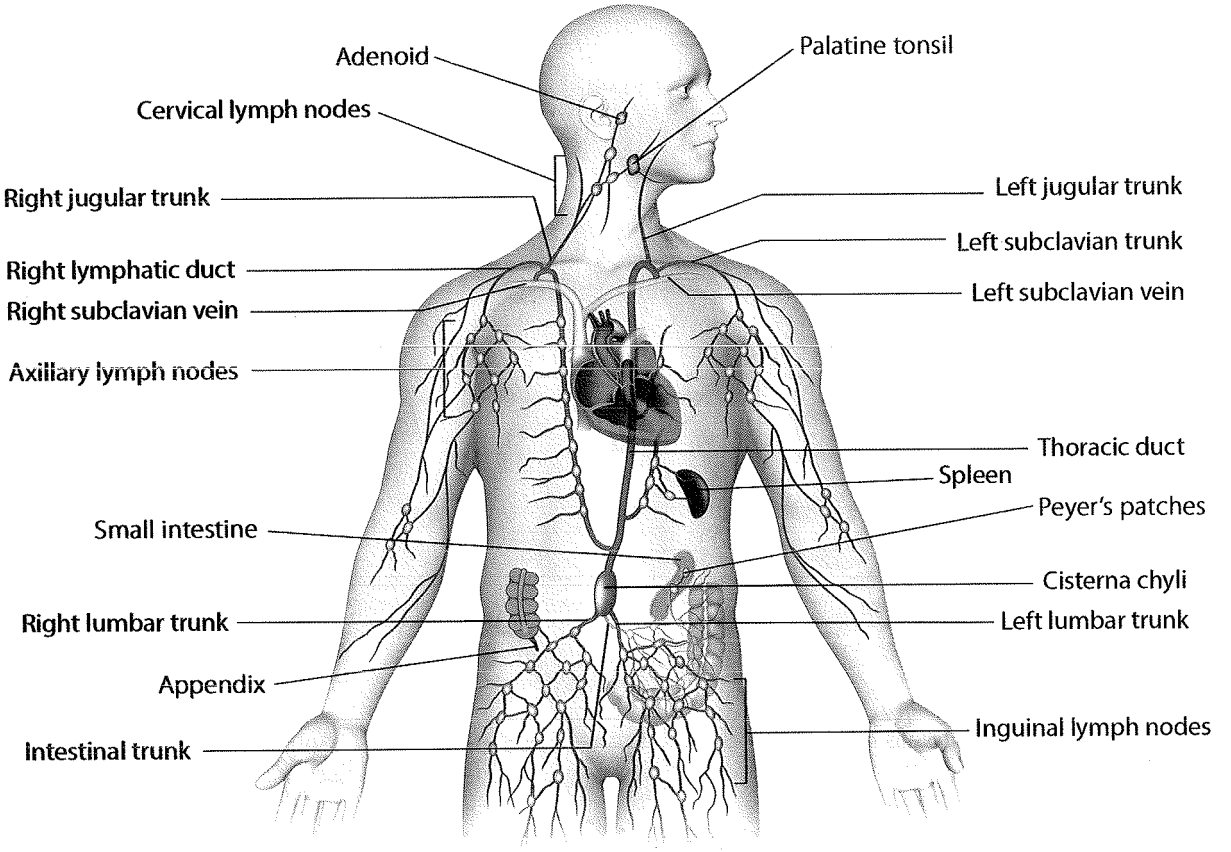
Perineum Anatomy



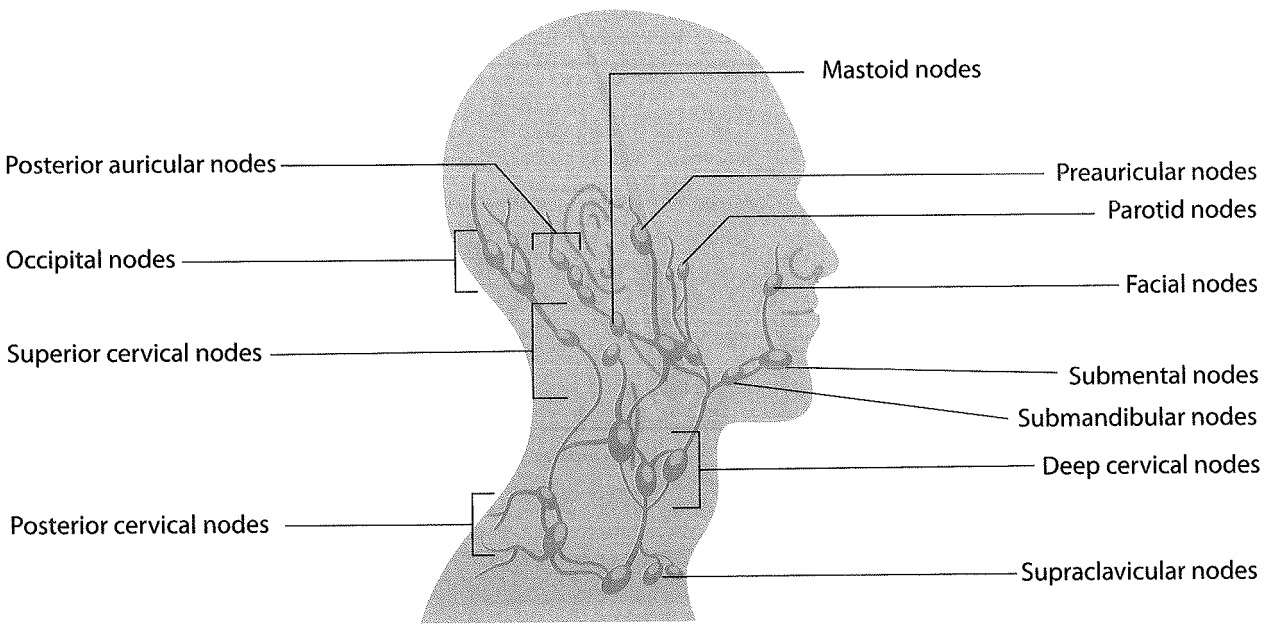
Integumentary System Anatomy



Lymphatic System Anatomy

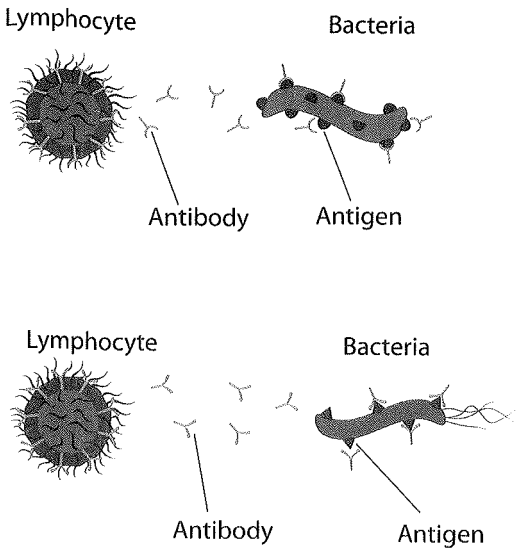


Lymphatic System — Lymph Nodes of the Head and Neck

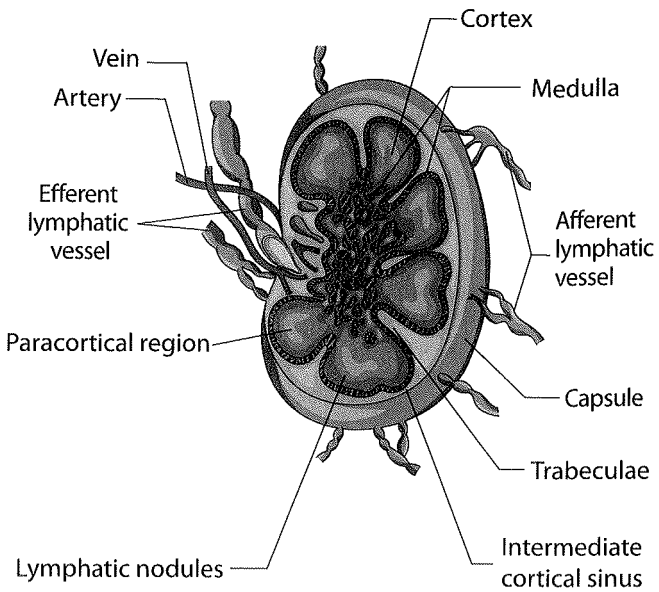


Lymphatic System

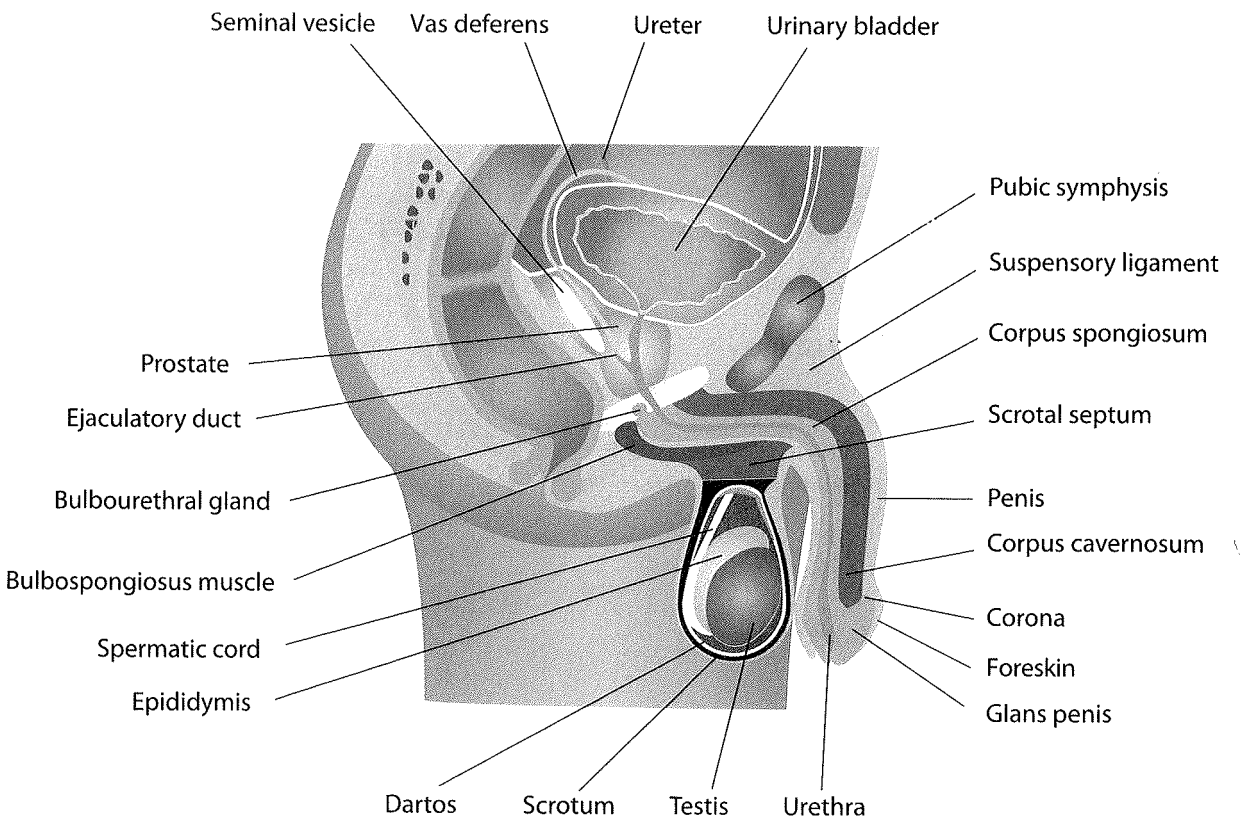
Humoral Immunity



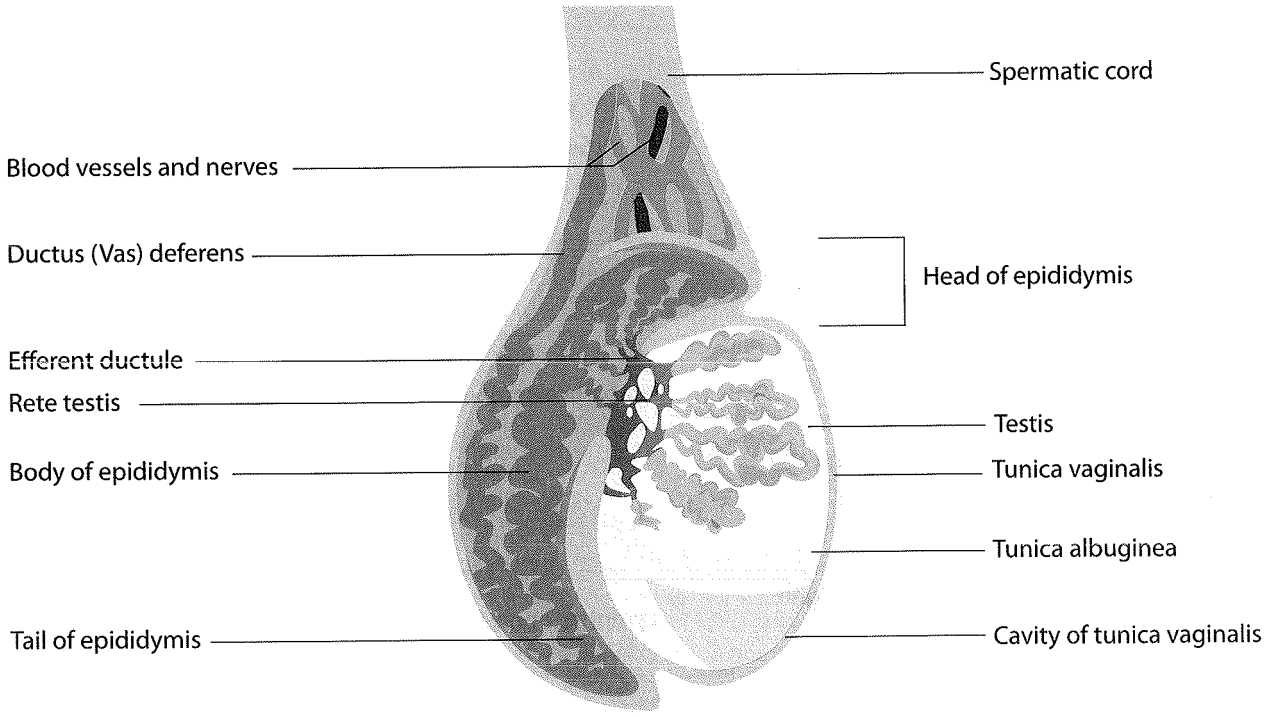
Lymph Node Anatomy



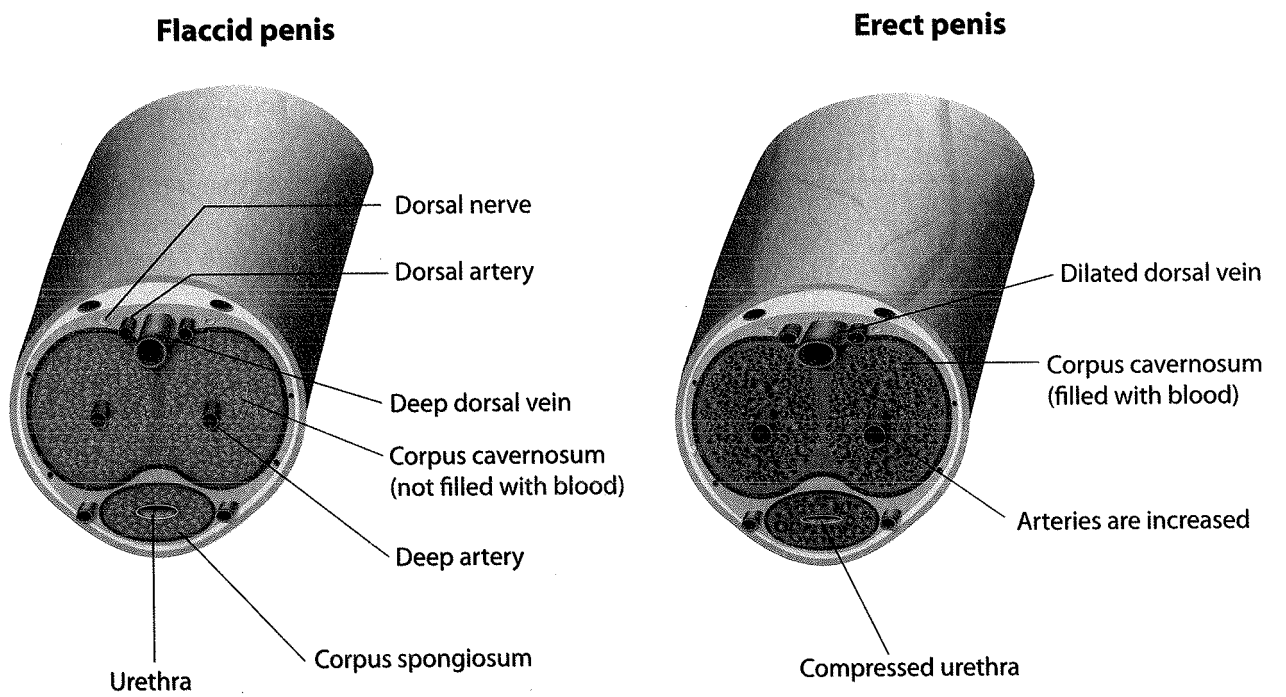
Male Reproductive System Anatomy



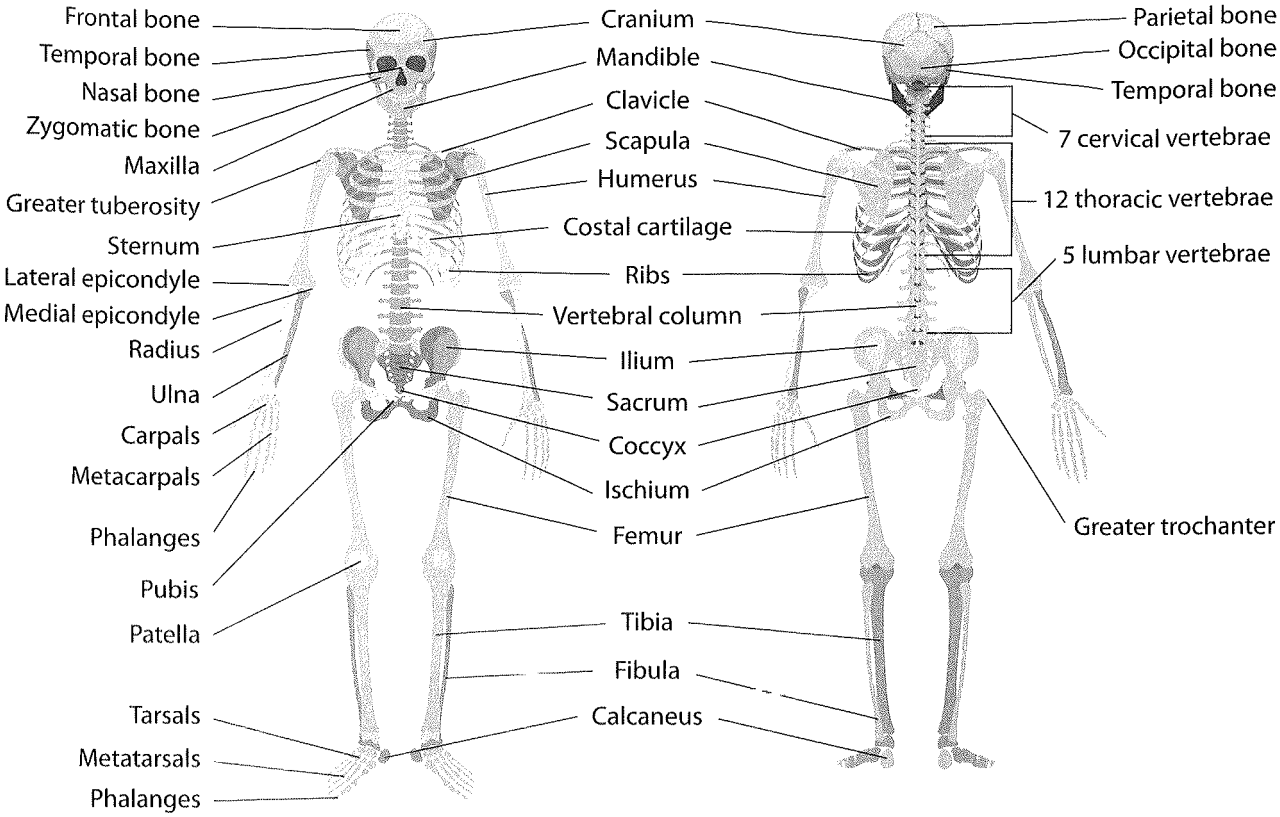
Male Reproductive System — Testicle Anatomy



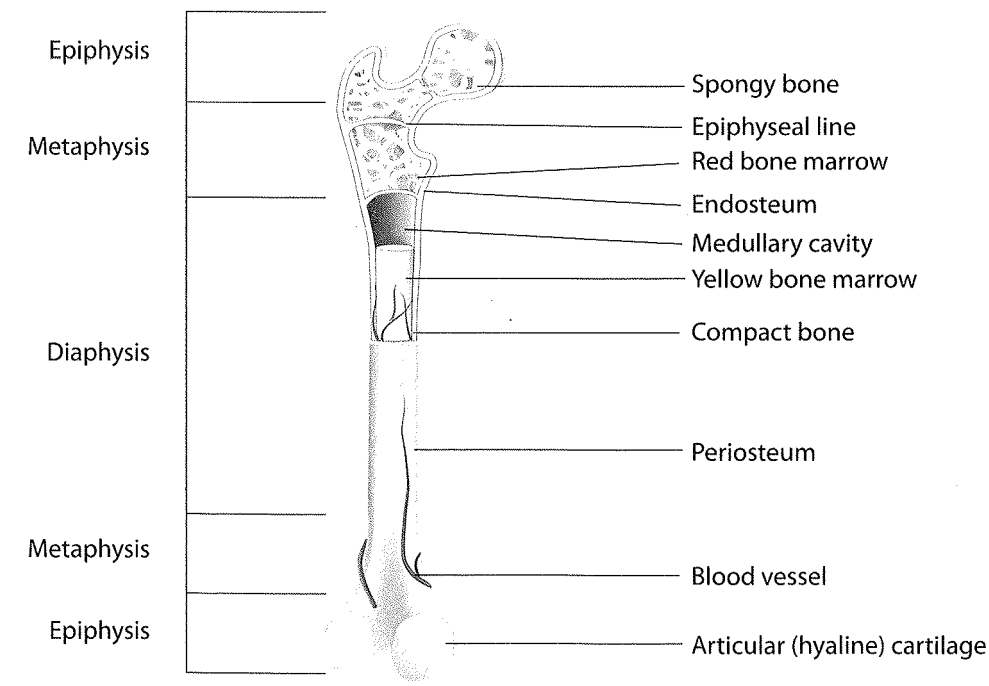
Male Reproductive System — Penis Anatomy



Musculoskeletal System — Skeletal Anatomy

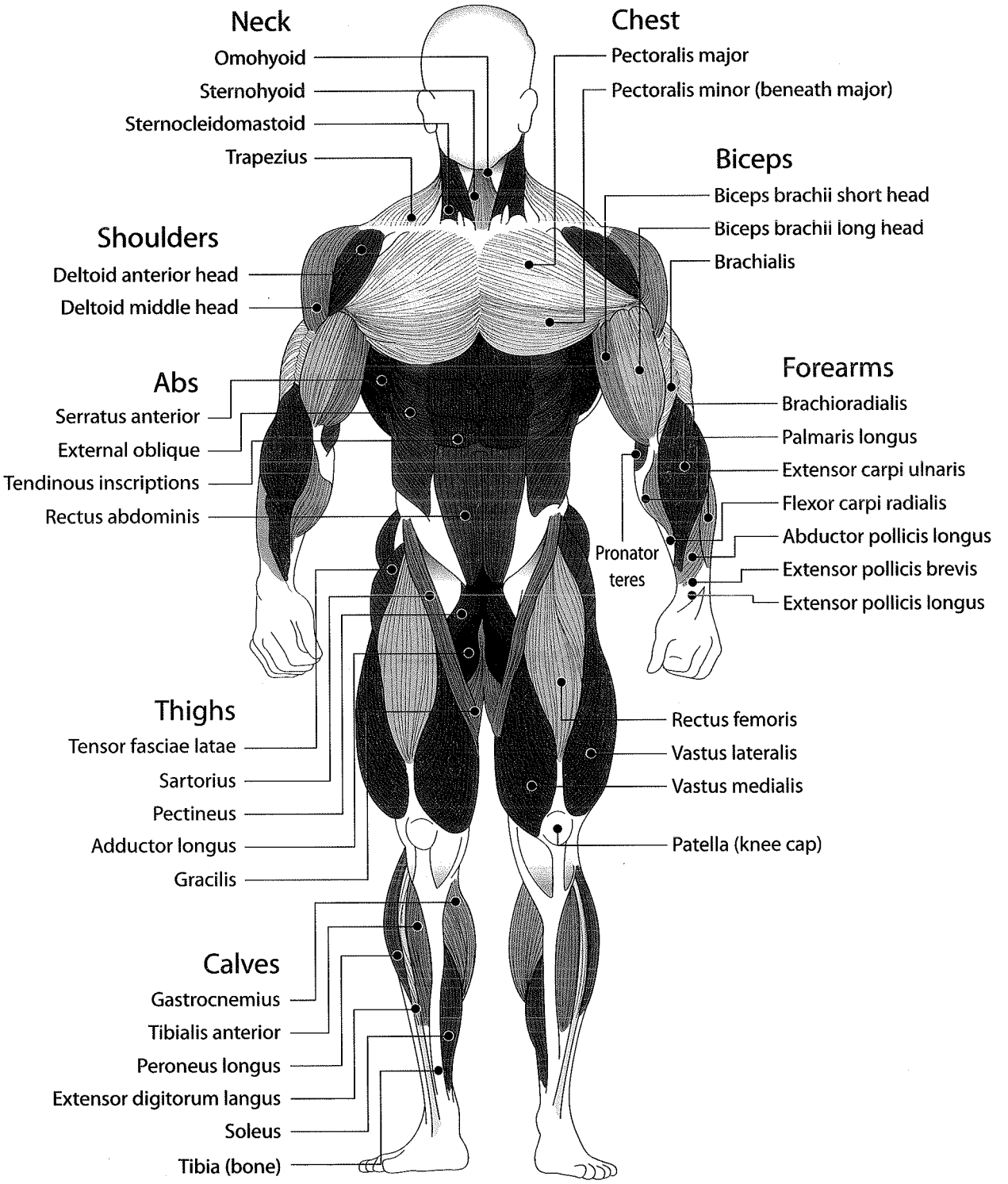


Musculoskeletal System — Bone Structure



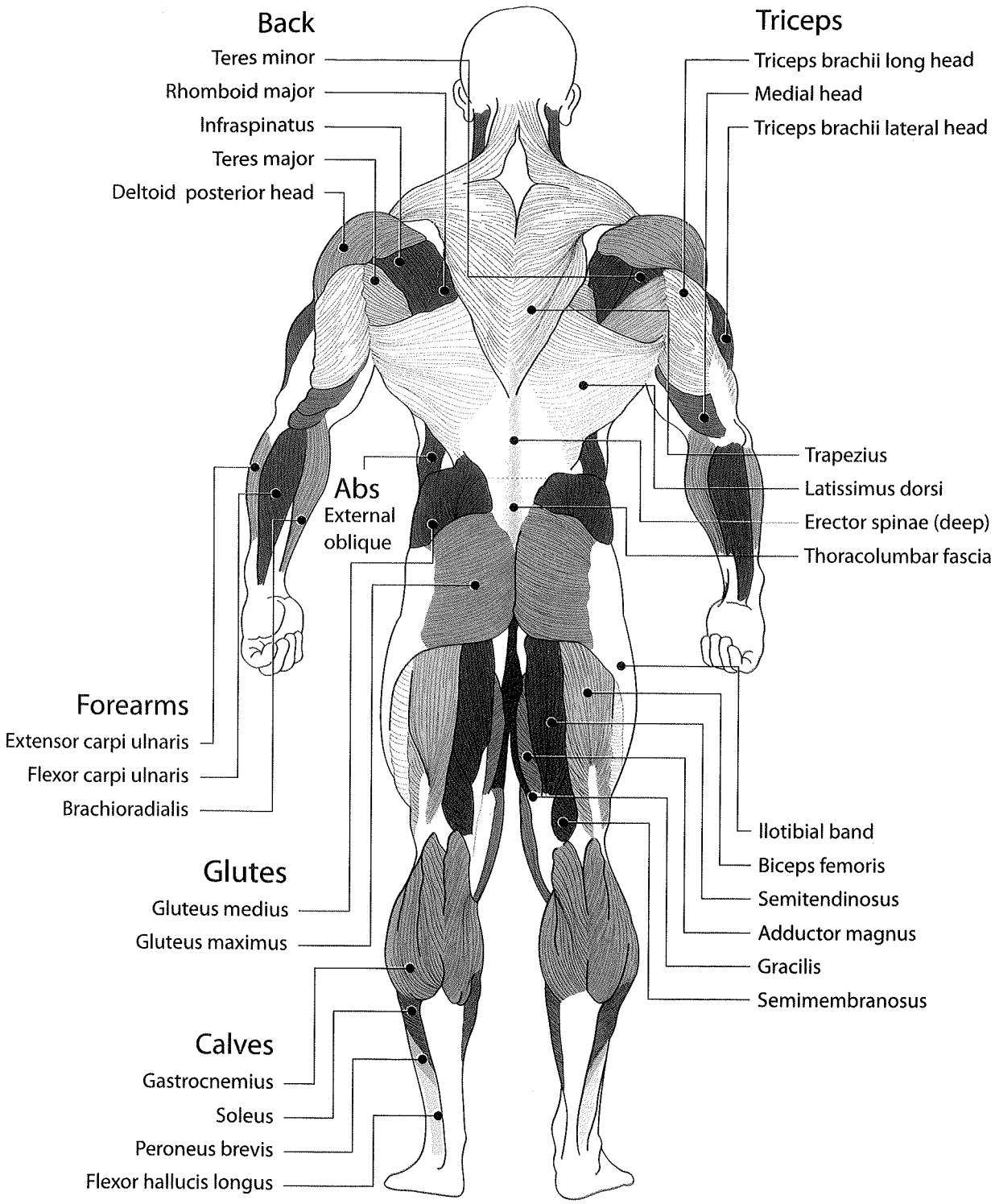
Musculoskeletal System — Musculature Anatomy

FRONT VIEW

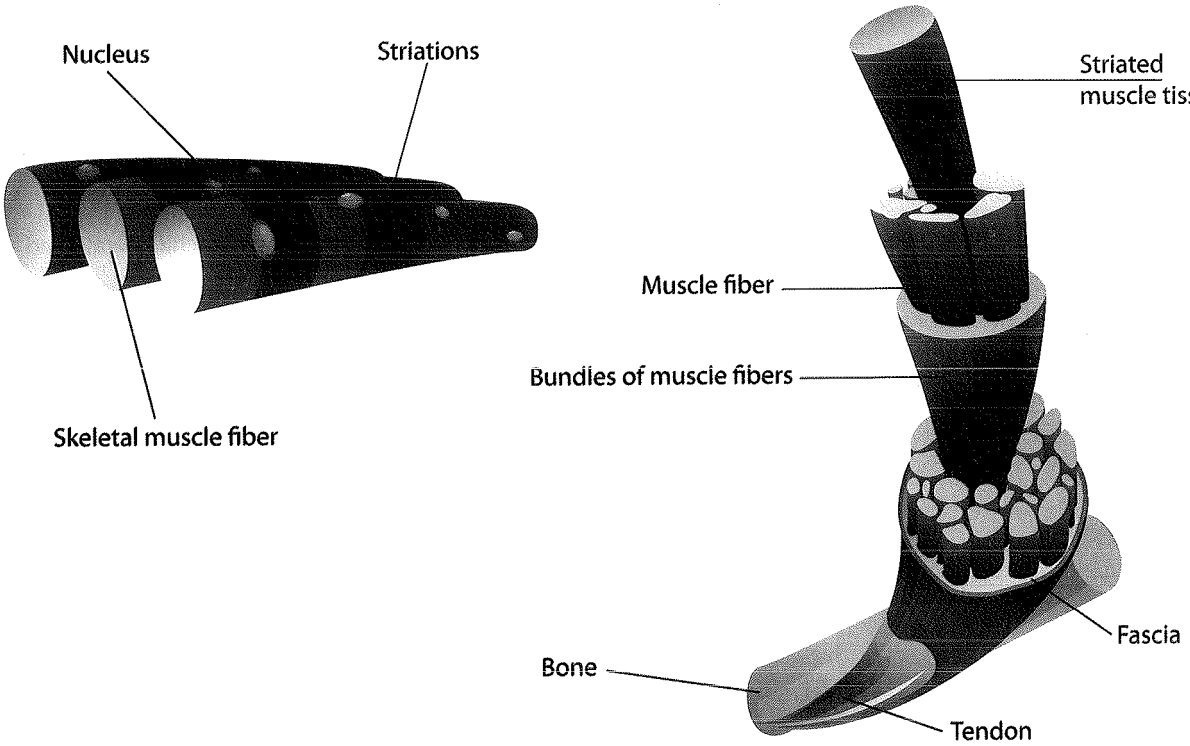


Musculoskeletal System — Musculature Anatomy

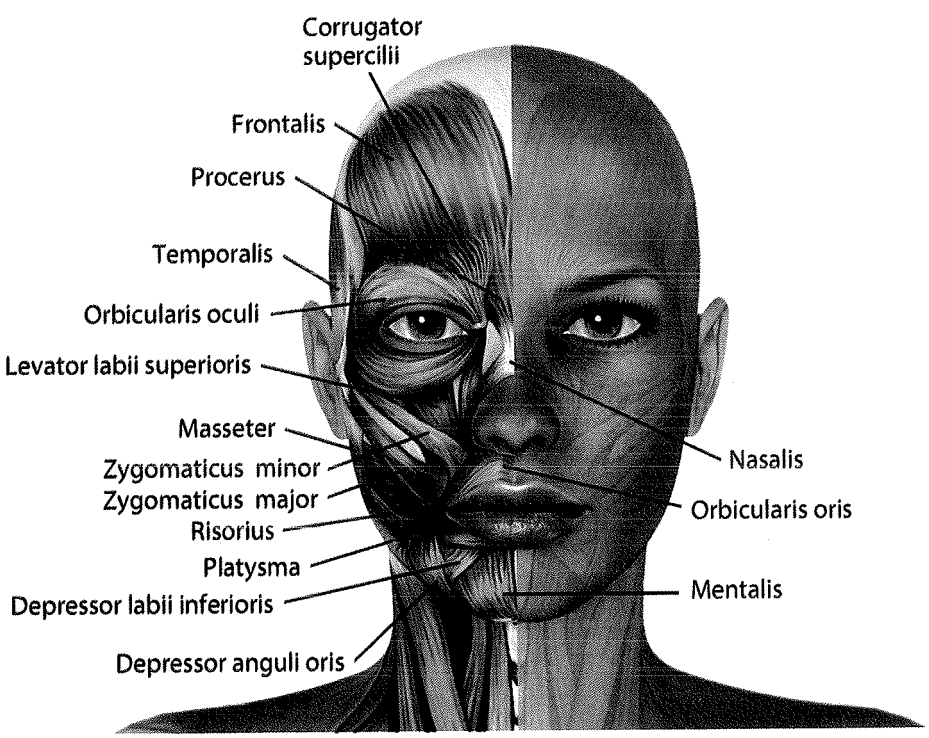
BACK VIEW



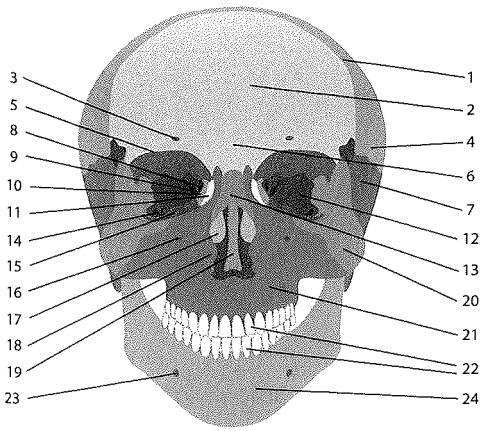
Musculoskeletal System — Muscle Fiber Structure



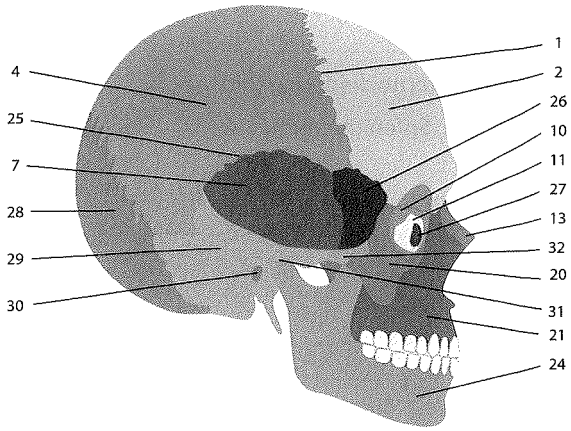
Musculoskeletal System — Facial Muscles



Musculoskeletal System — Skull Anatomy



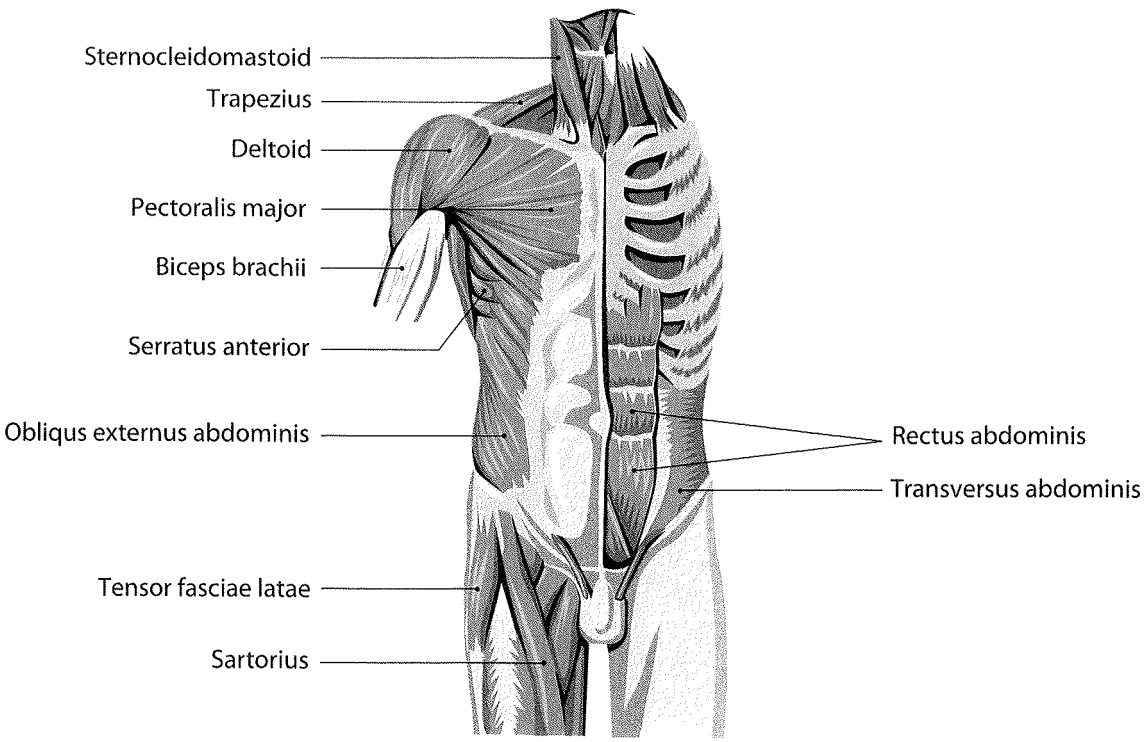
Frontal view



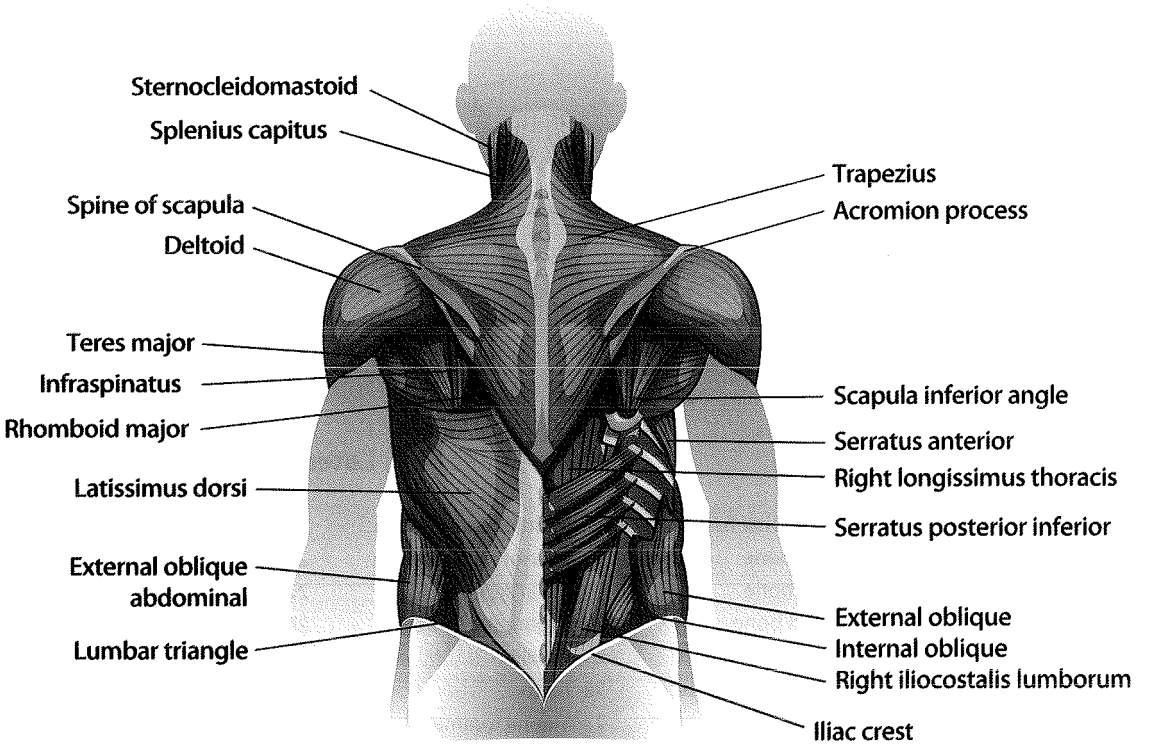
Lateral view

1. Coronal suture
2. Frontal bone
3. Supraorbital foramen
4. Parietal bone
5. Supraorbital margin
6. Glabella
7. Temporal bone
8. Optic canal
9. Superior orbital fissure
10. Ethmoid bone
11. Lacrimal bone
12. Sphenoid bone
13. Nasal bone
14. Inferior orbital fissure
15. Palatine bone
16. Infraorbital foramen
17. Middle nasal concha
18. Inferior nasal concha
19. Nasal septum
20. Zygomatic bone
21. Maxilla
22. Teeth
23. Mental foramen
24. Mandible
25. Squamous suture
26. Greater wing of sphenoid bone
27. Lacrimal fossa
28. Occipital bone
29. Mastoid portion of temporal bone
30. External acoustic meatus
31. Mandibular fossa
32. Zygomatic process

Musculoskeletal System — Neck, Chest, and Thorax Muscles

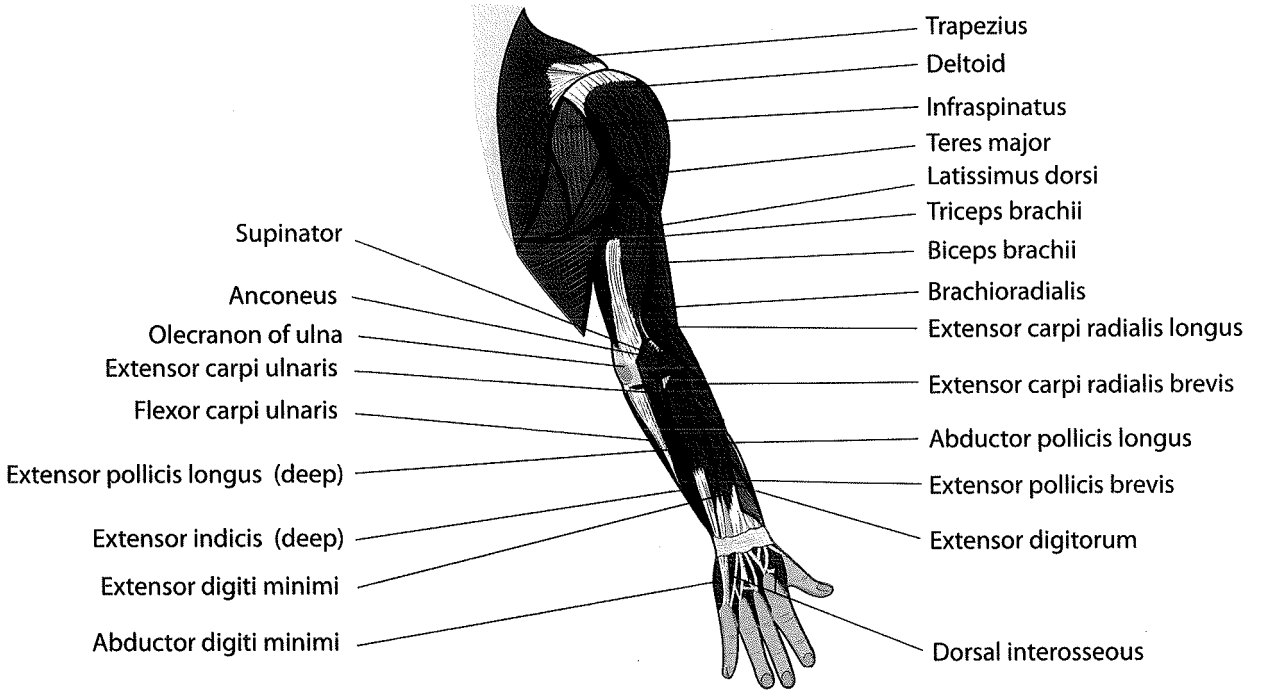


Musculoskeletal System — Back Muscles

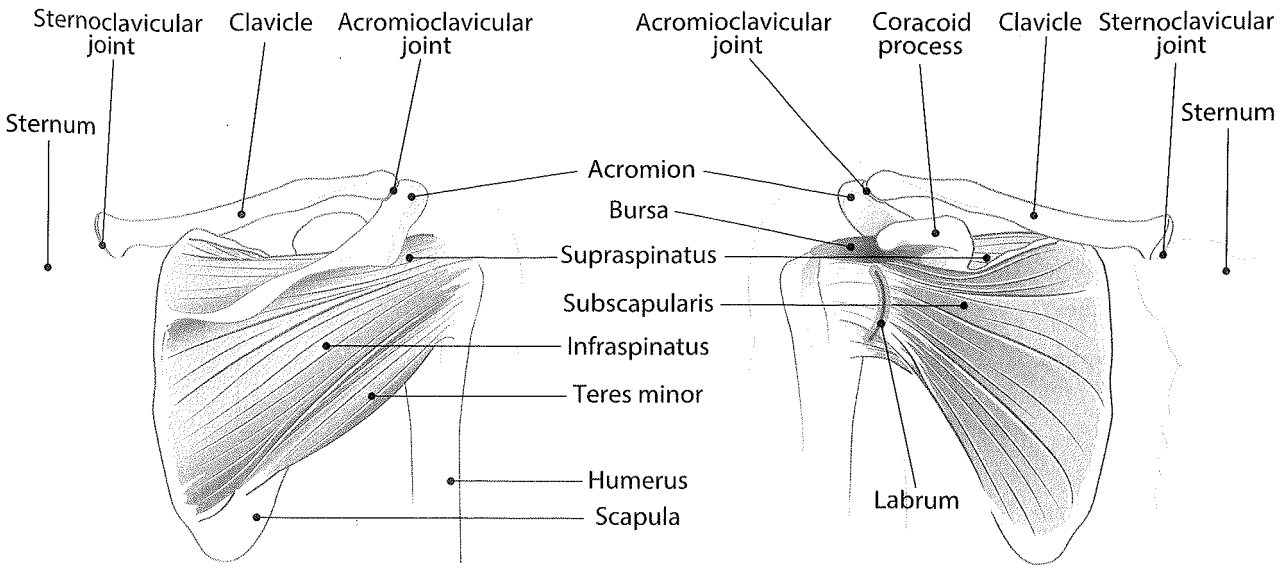


Musculoskeletal System — Arm and Forearm Muscles

Posterior View

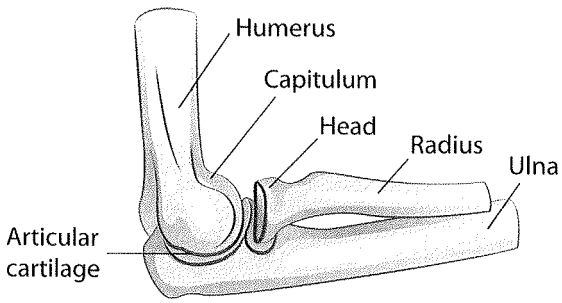


Musculoskeletal System — Shoulder Anatomy

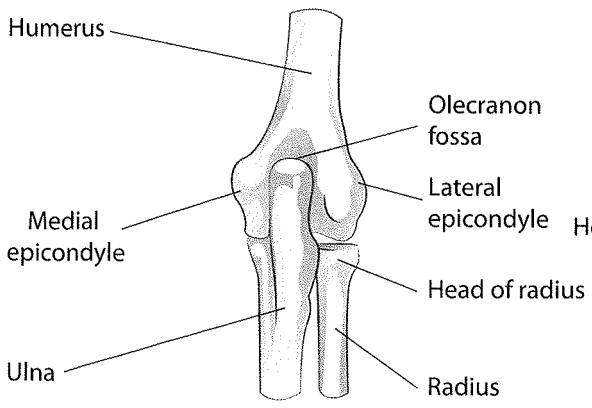


Back view **Front view**

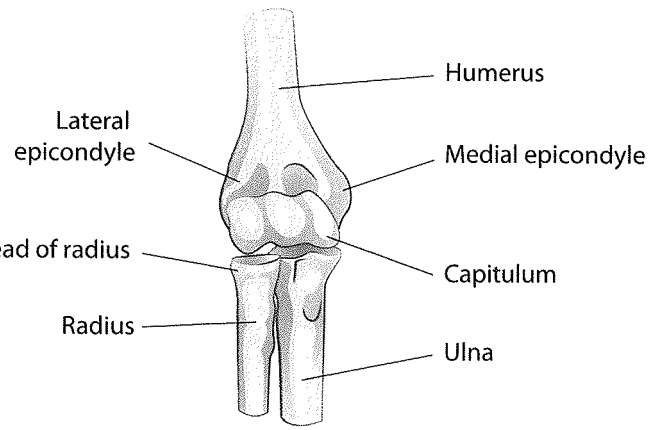
Musculoskeletal System — Elbow Joint Structure



Lateral view

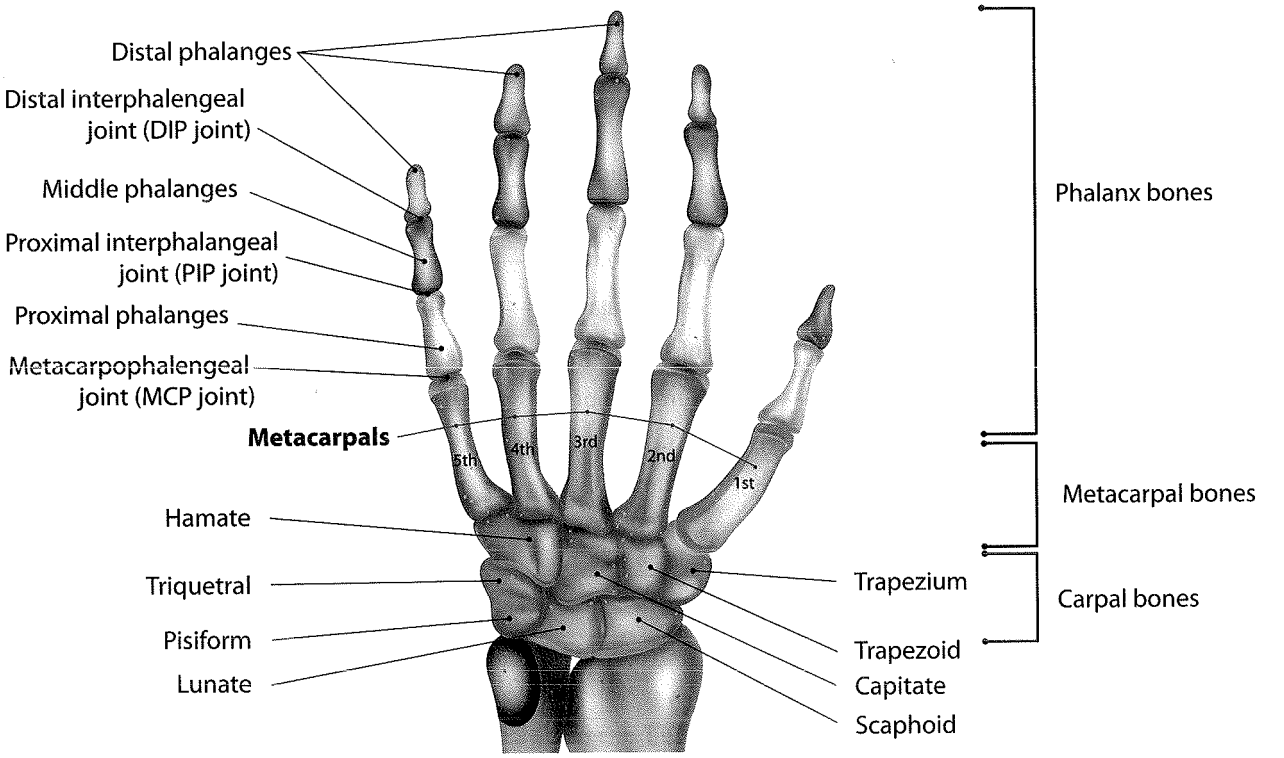


Posterior view



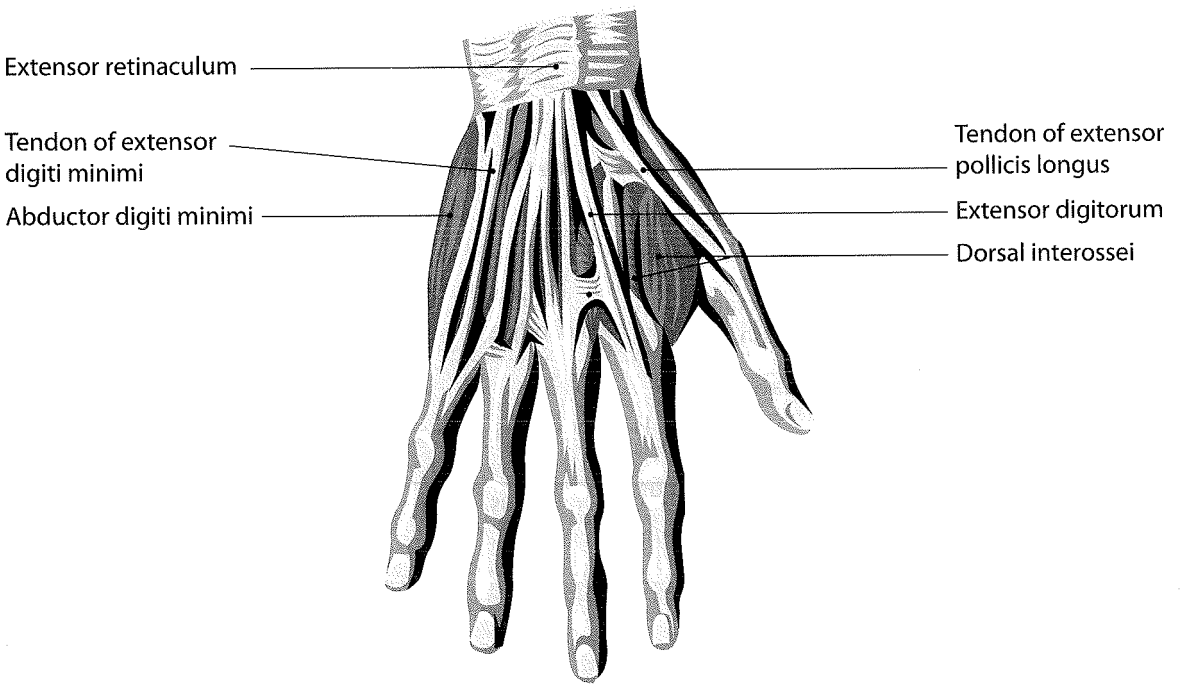
Anterior view

Musculoskeletal System — Hand Bones and Joints



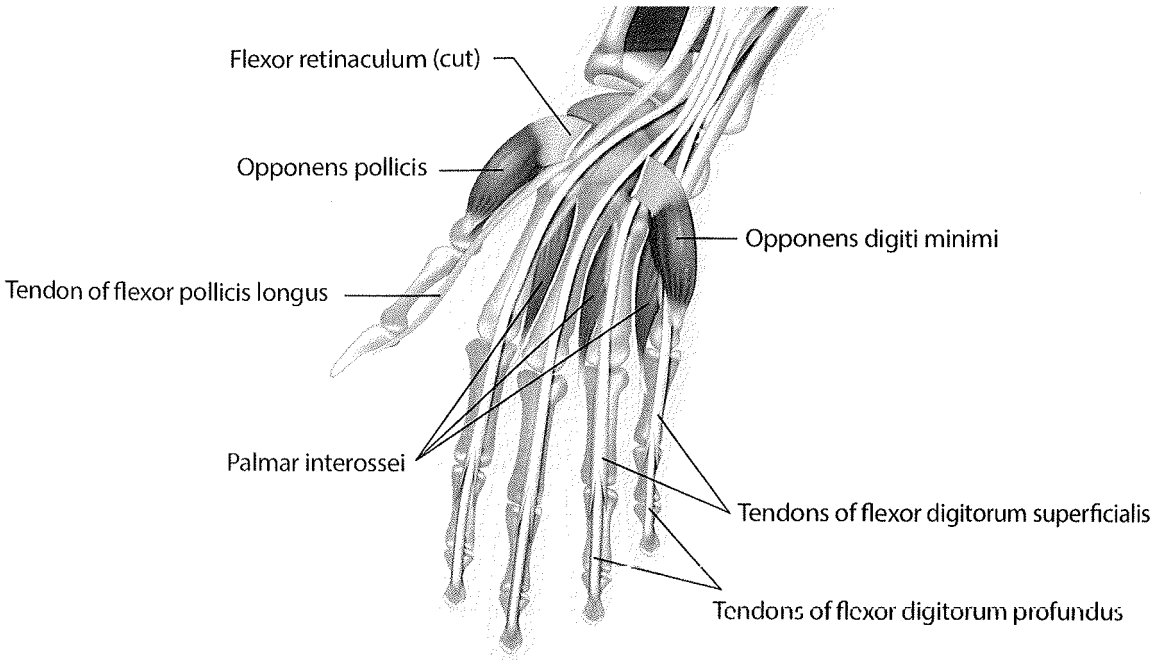
Musculoskeletal System — Hand Anatomy

(Right Hand, Dorsal View)

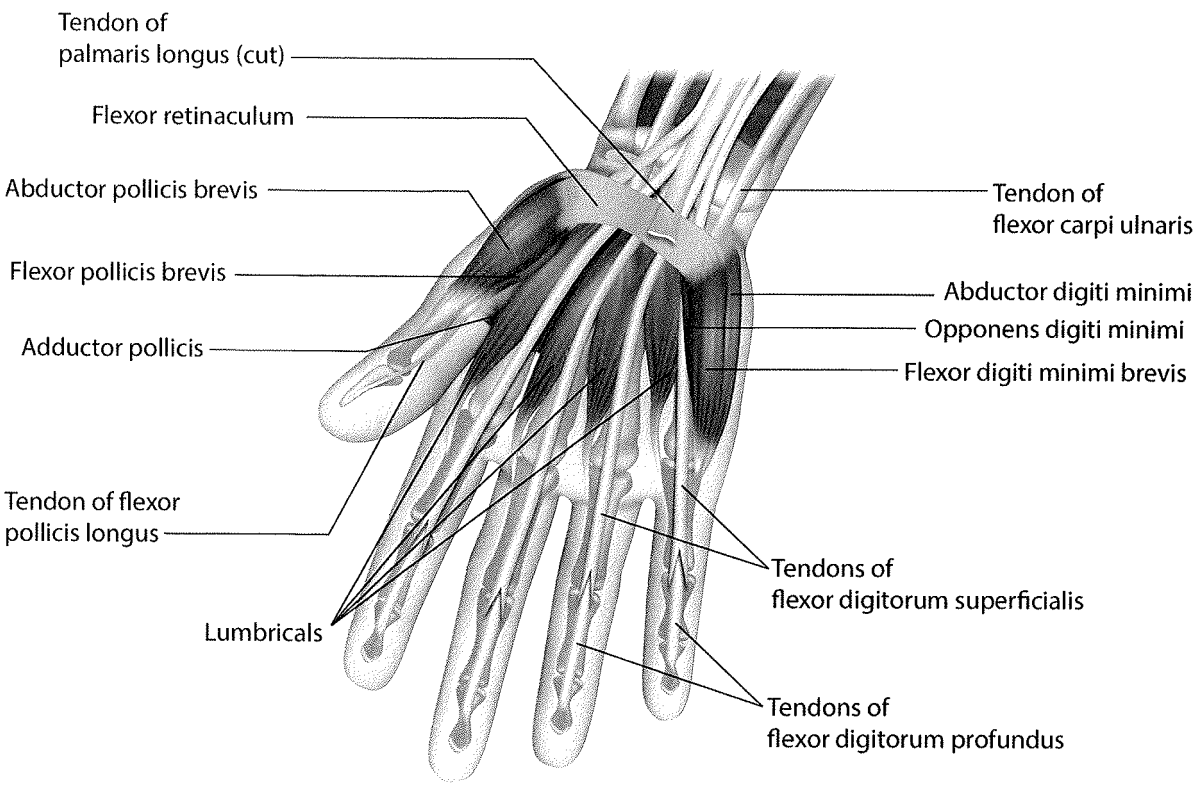


Musculoskeletal System — Hand Anatomy

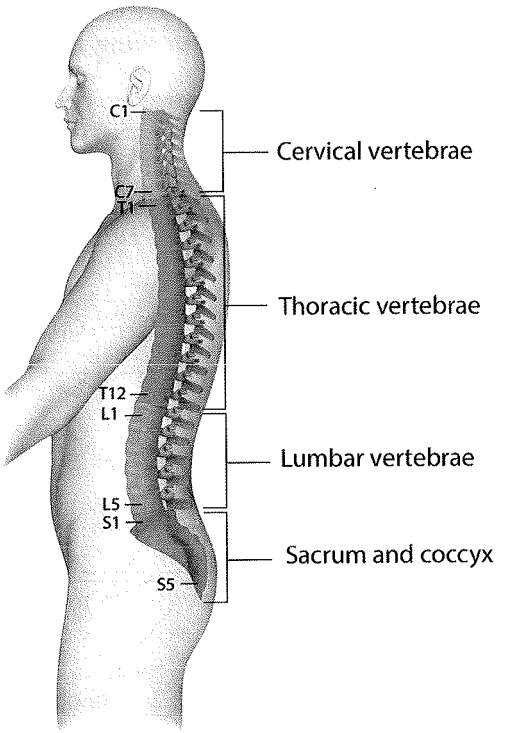
(Right Hand, Palmar View, Deep)



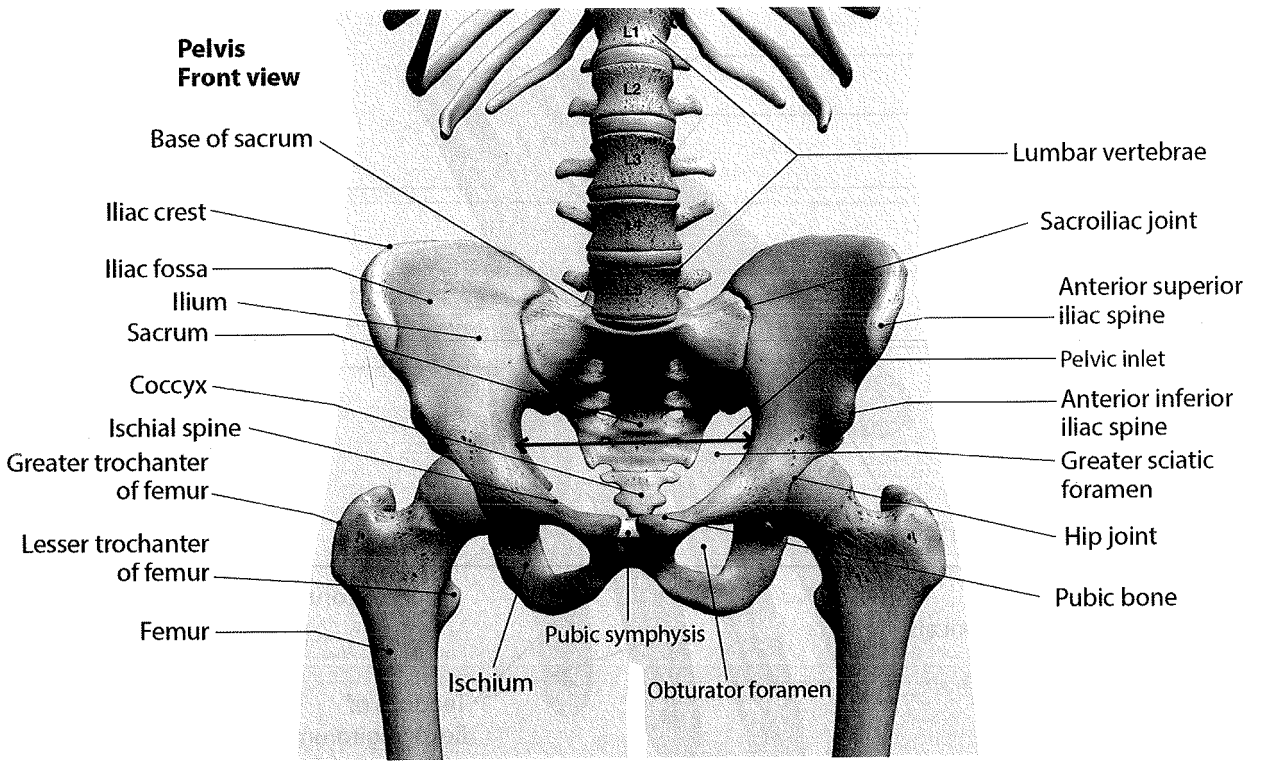
(Right Hand, Palmar View, Superficial)



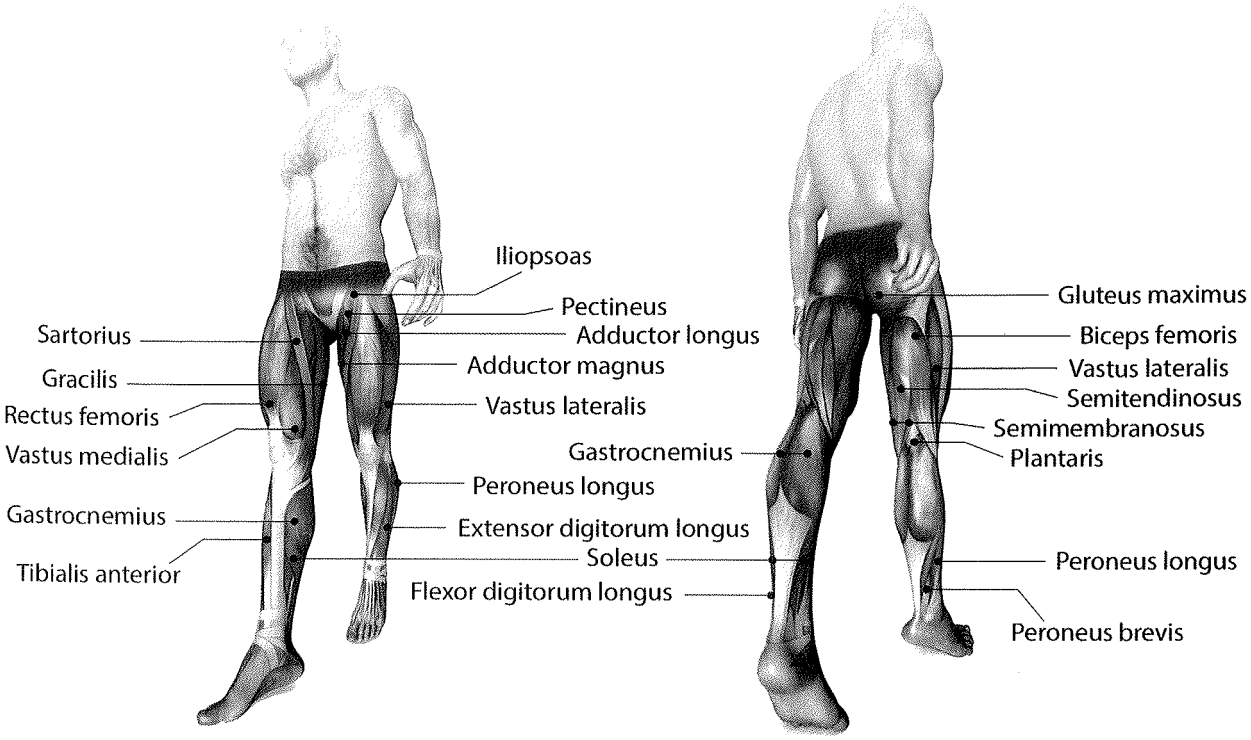
Musculoskeletal System — Spine

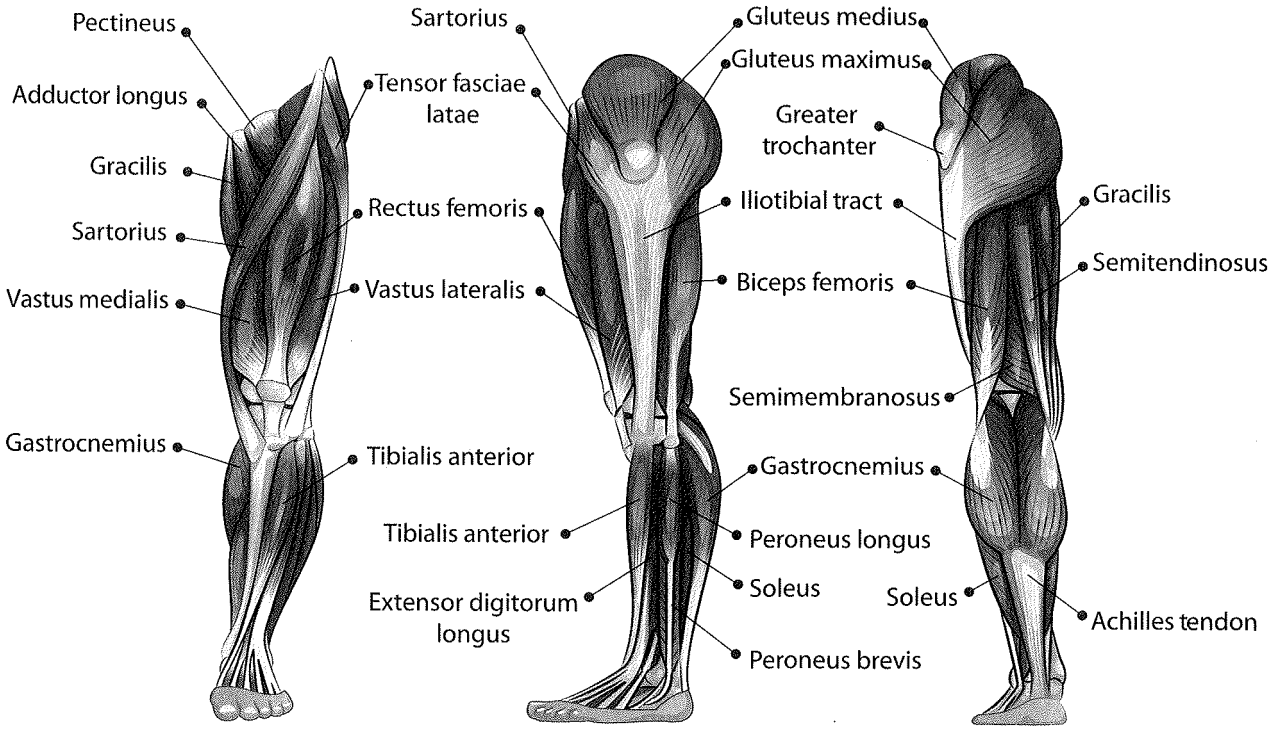


Musculoskeletal System — Pelvic Girdle

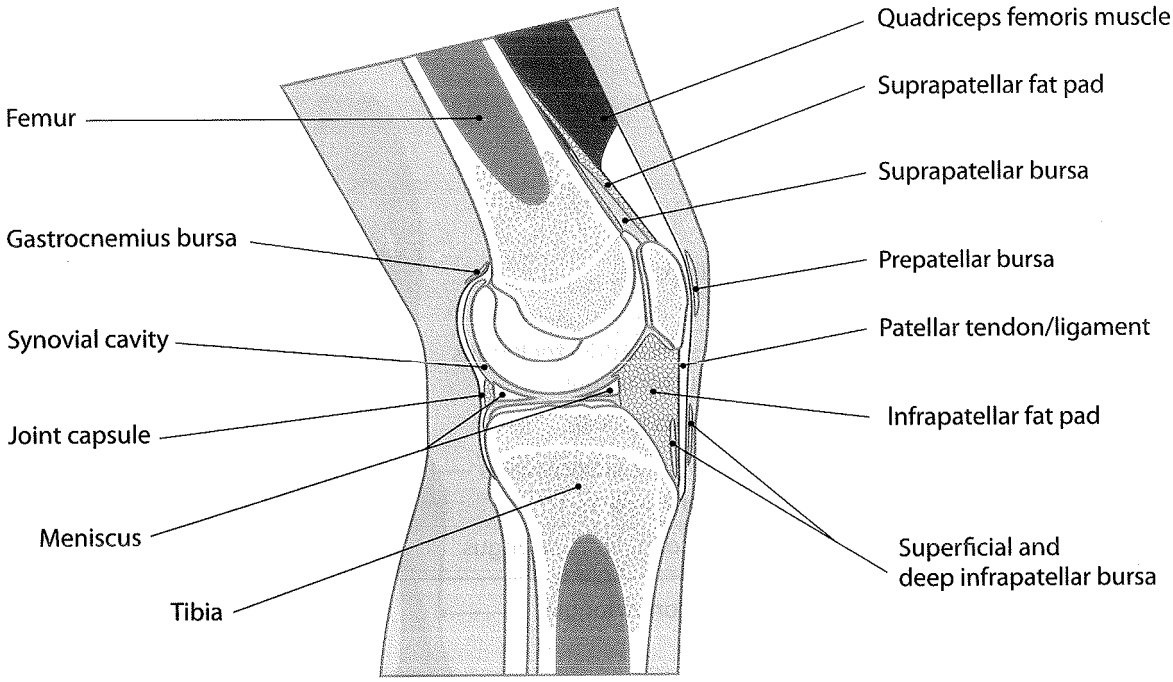


Musculoskeletal System — Leg Muscles



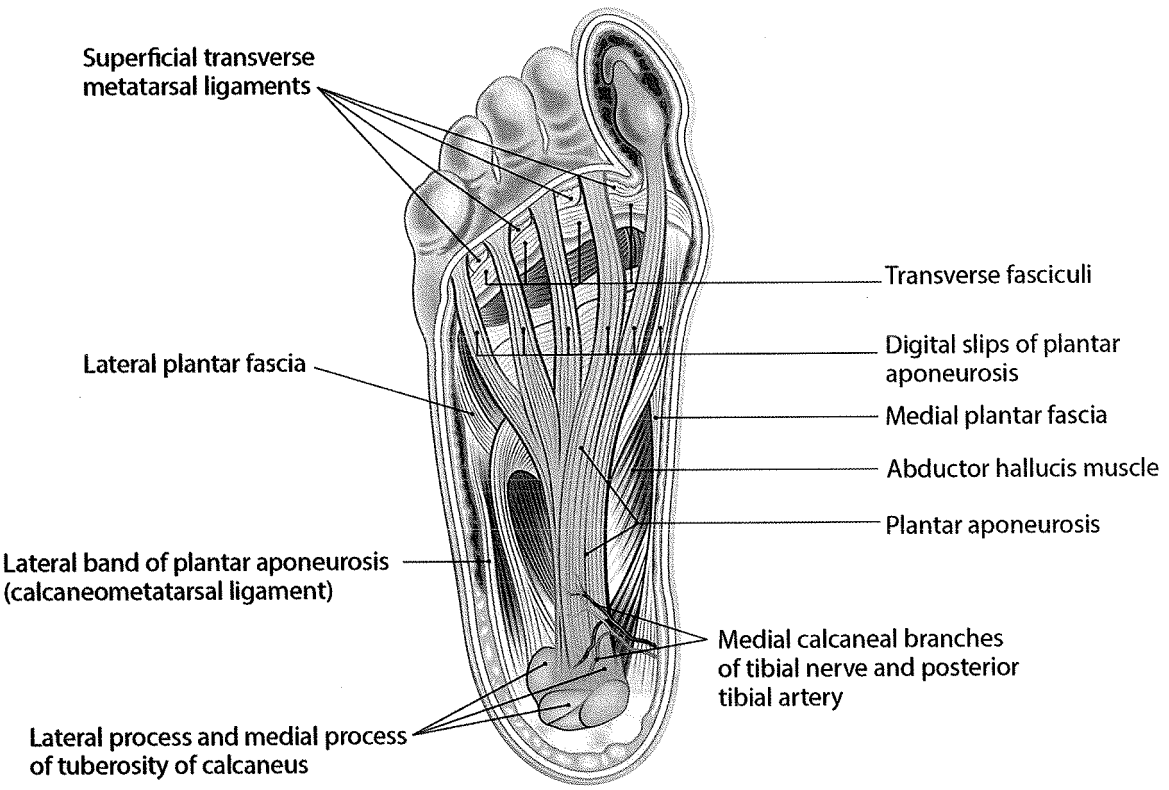


Musculoskeletal System — Knee and Leg Anatomy



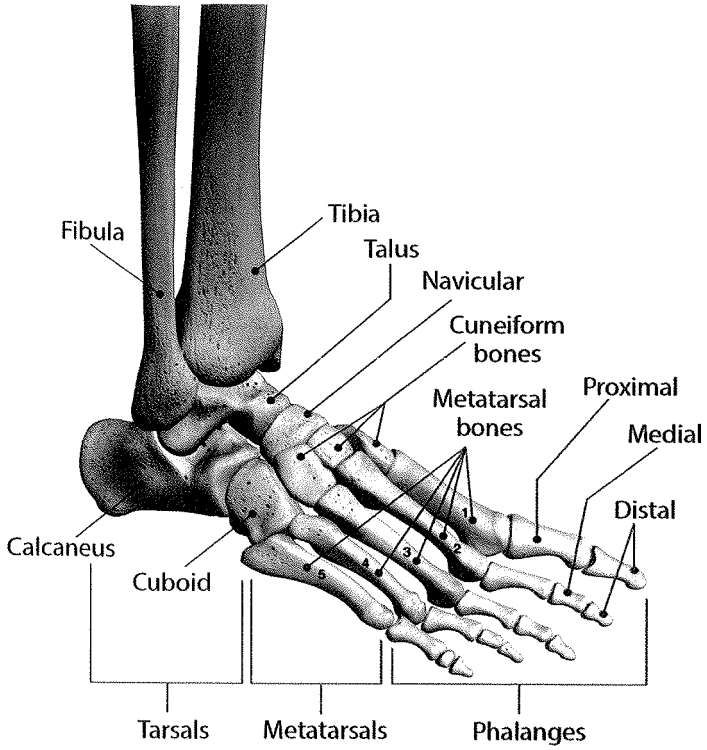
Musculoskeletal System — Foot Anatomy

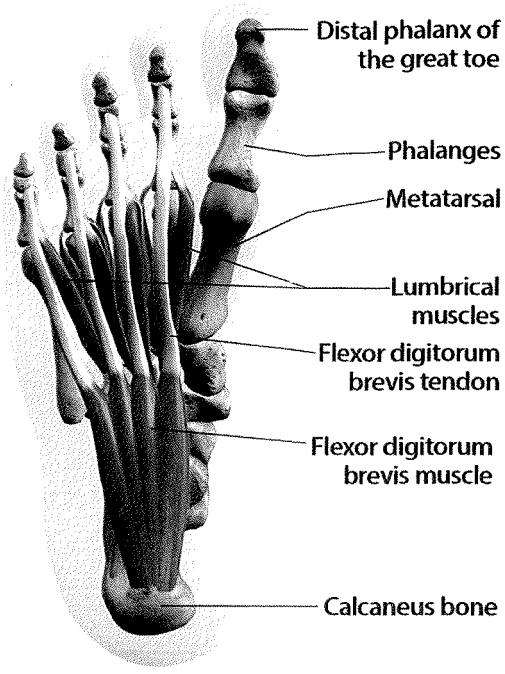
(Right Foot, Plantar (Inferior) View, Superficial)

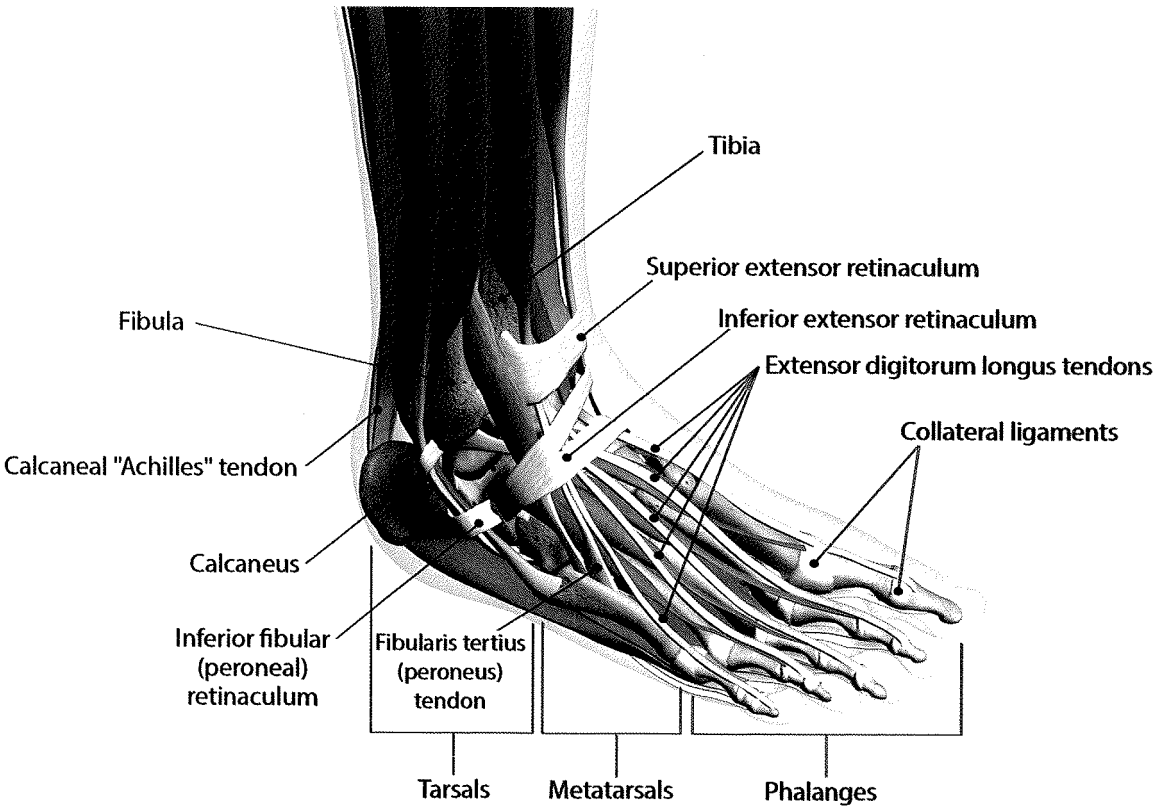


Musculoskeletal System — Foot Bones and Tendons

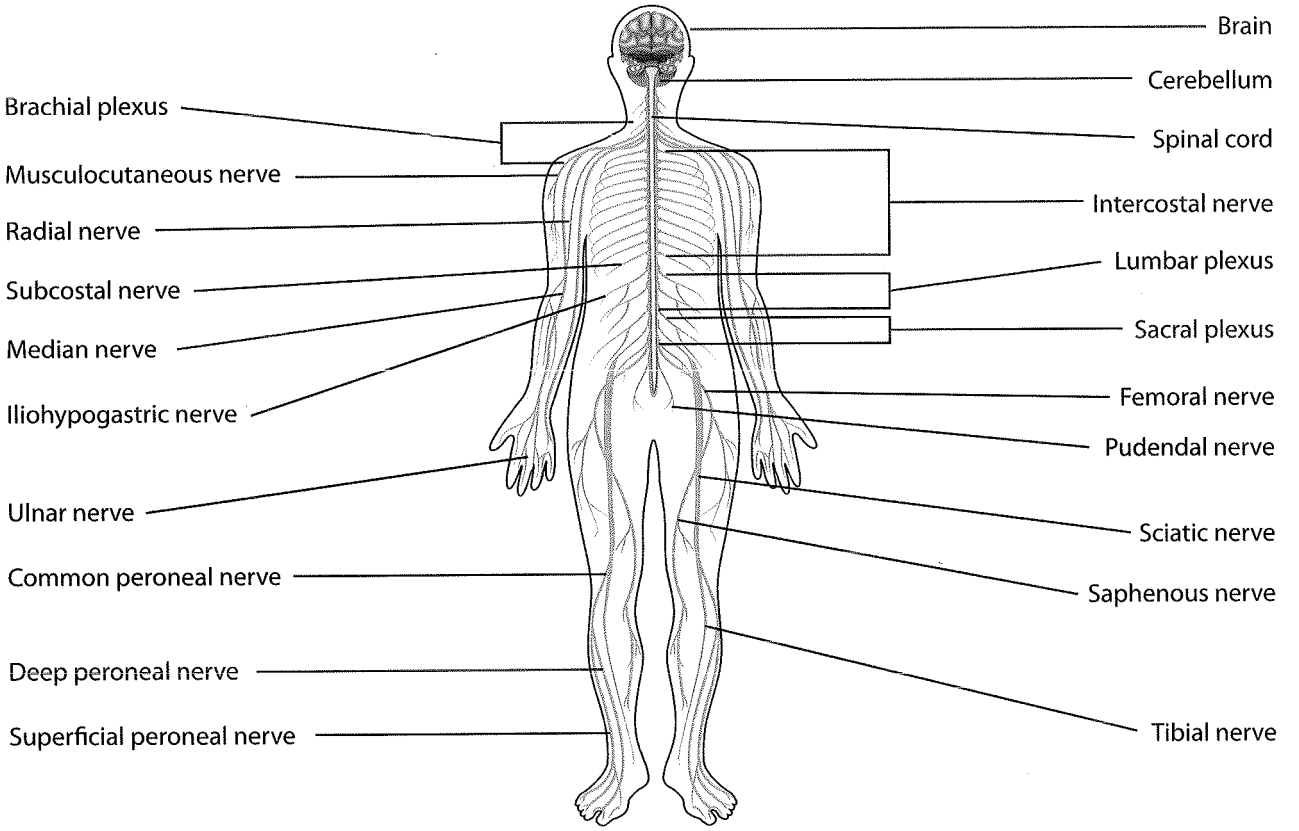
(Right Foot, Plantar (Inferior) View, Deep)





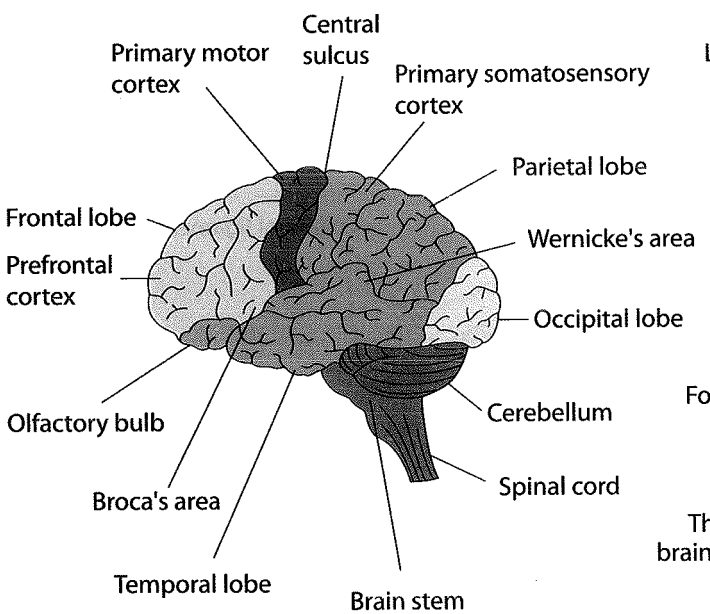


Nervous System Anatomy

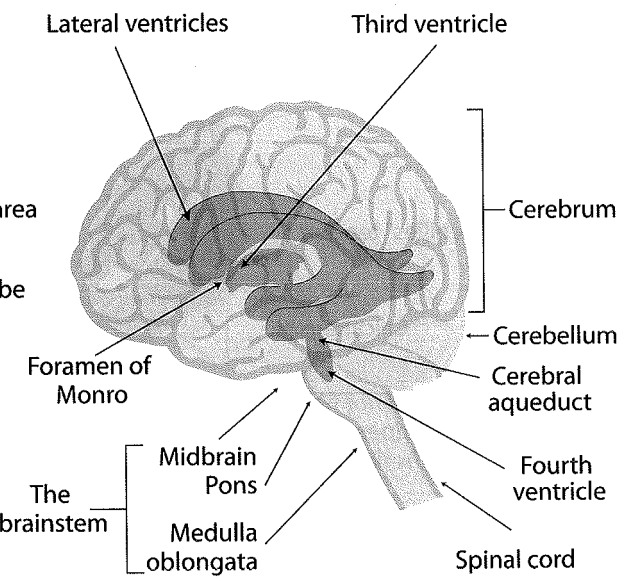


Nervous System — Brain Anatomy

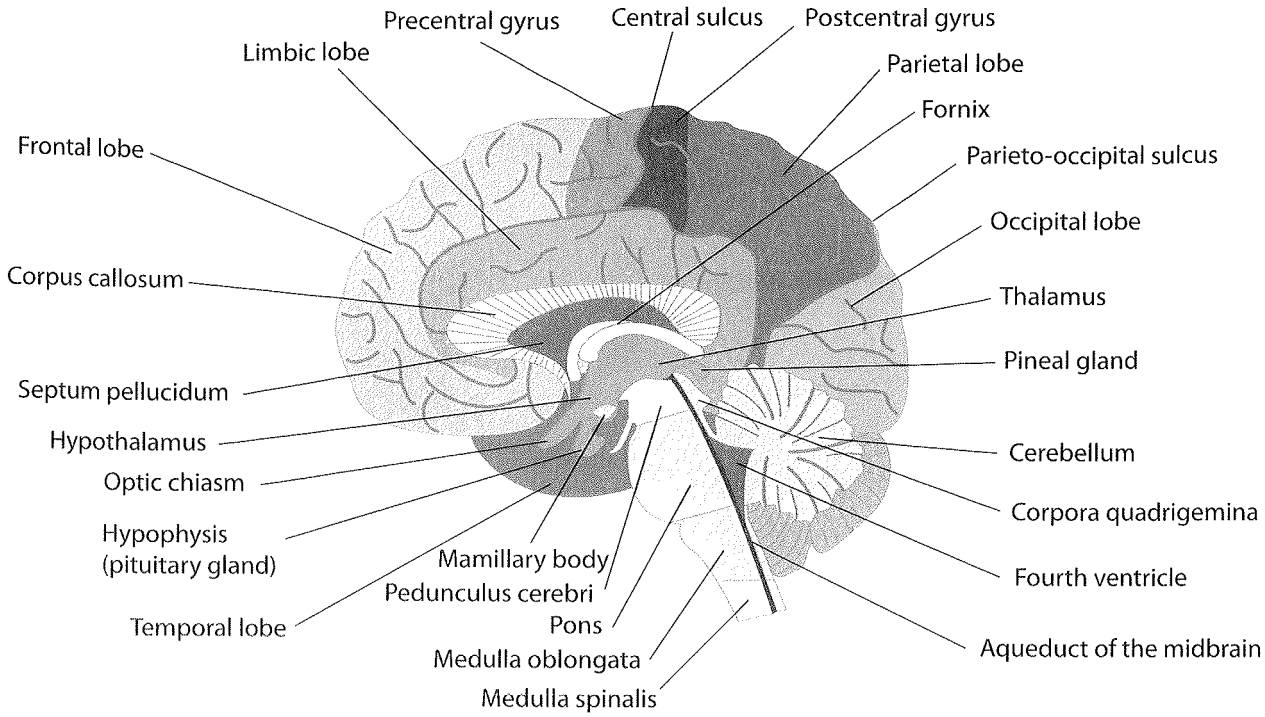
Brain Lobes



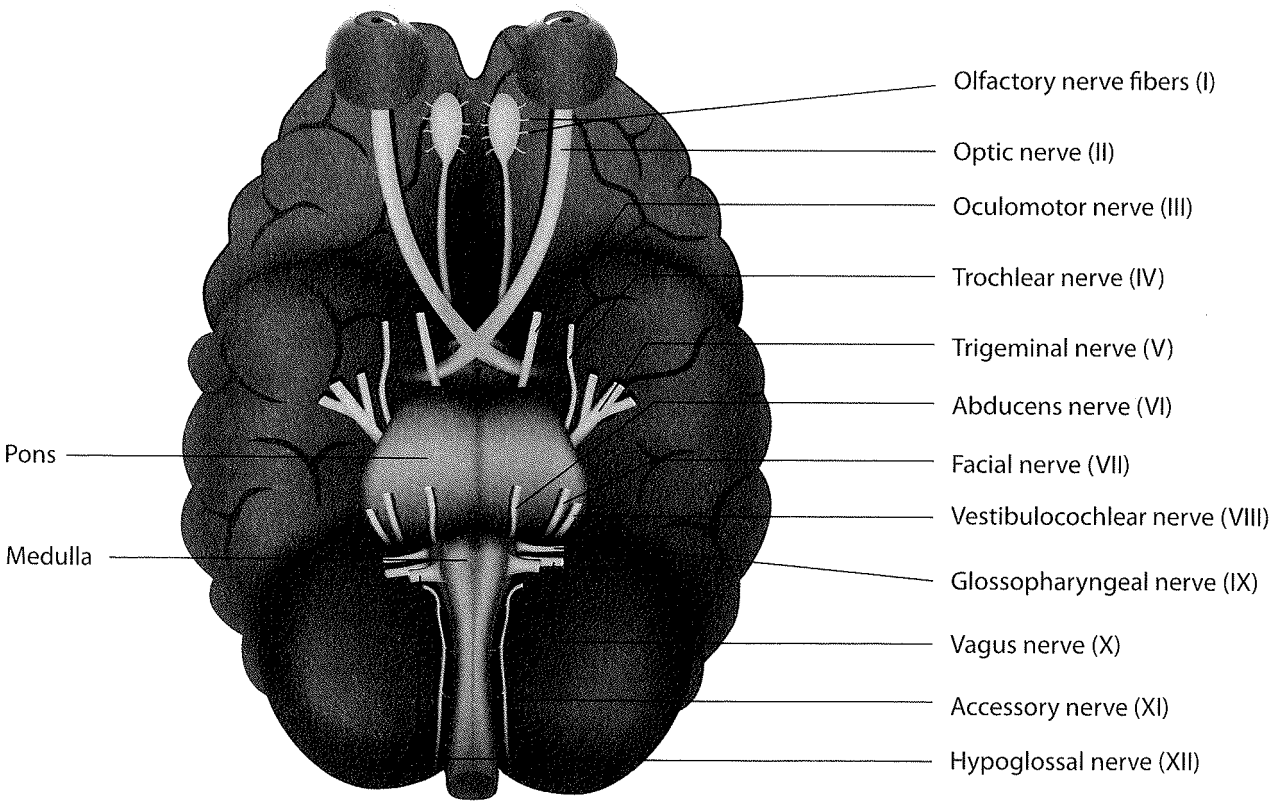
Ventricles in the Brain



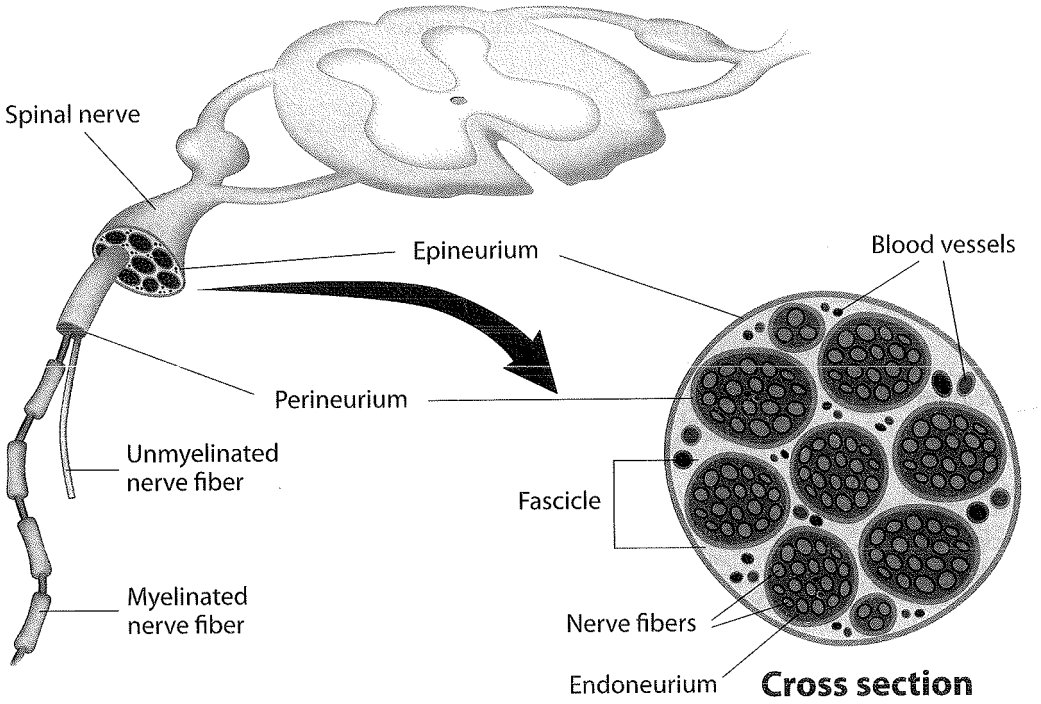
Nervous System — Brain Anatomy (Median Section)



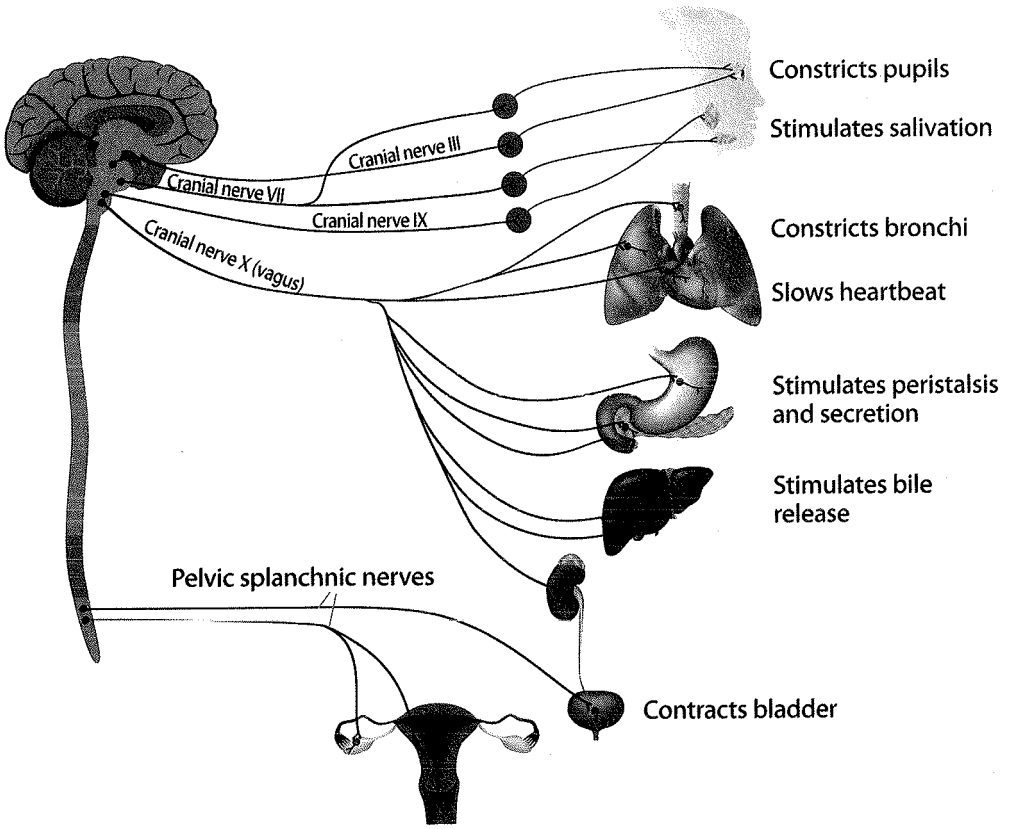
Nervous System — Cranial Nerves



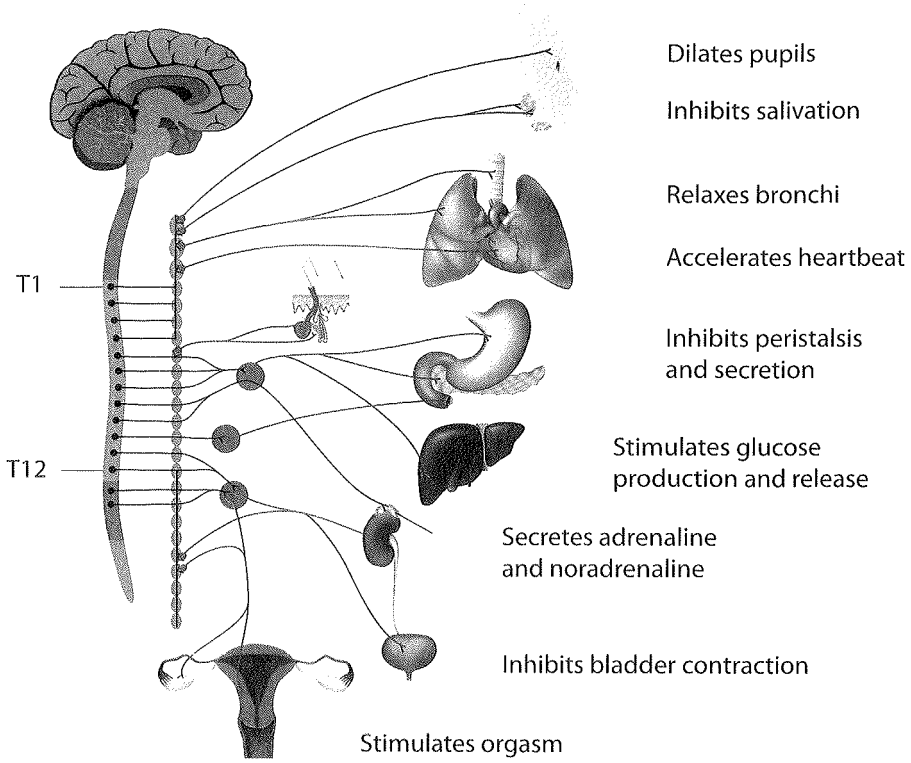
Nervous System — Nerve Structure



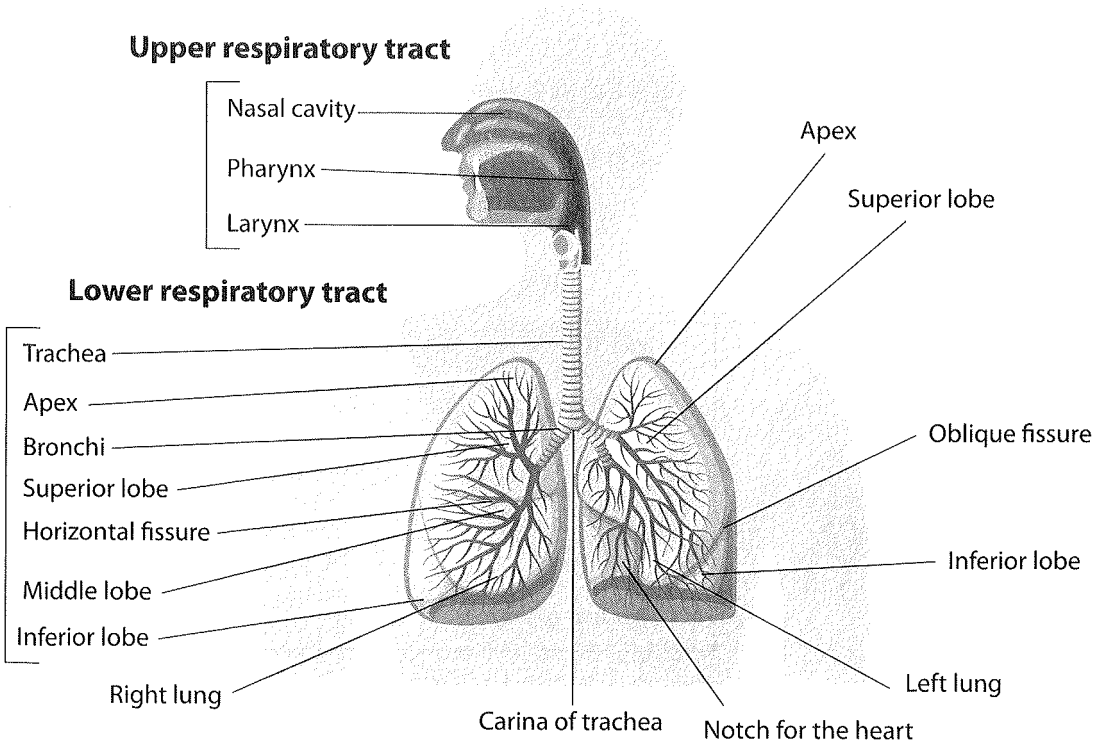
Nervous System — Parasympathetic Nerves



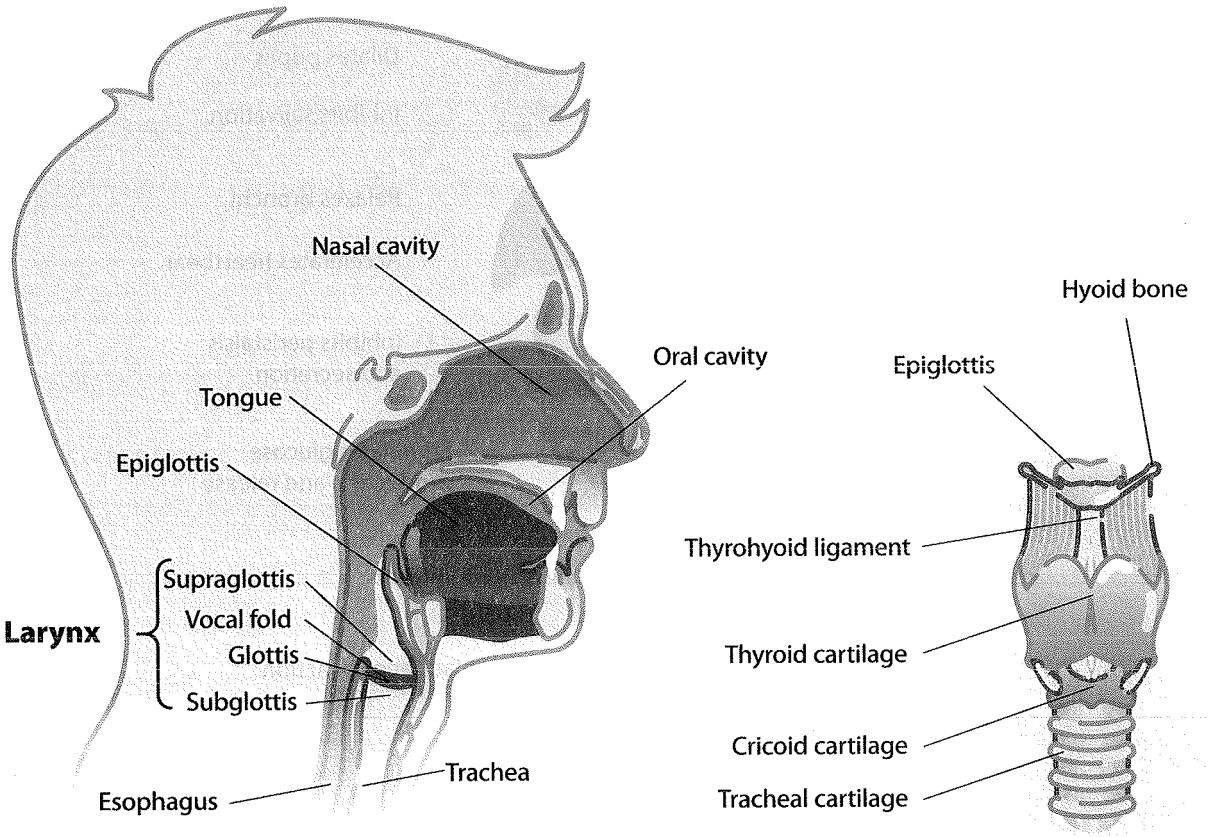
Nervous System — Sympathetic Nerves



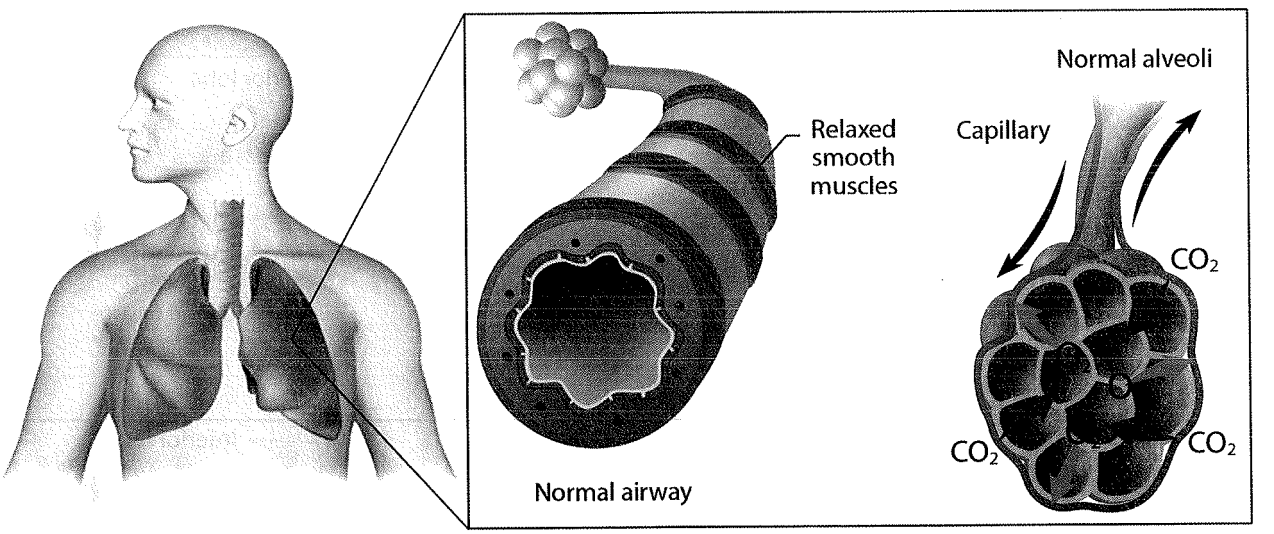
Respiratory System Anatomy



Respiratory System — Larynx Anatomy



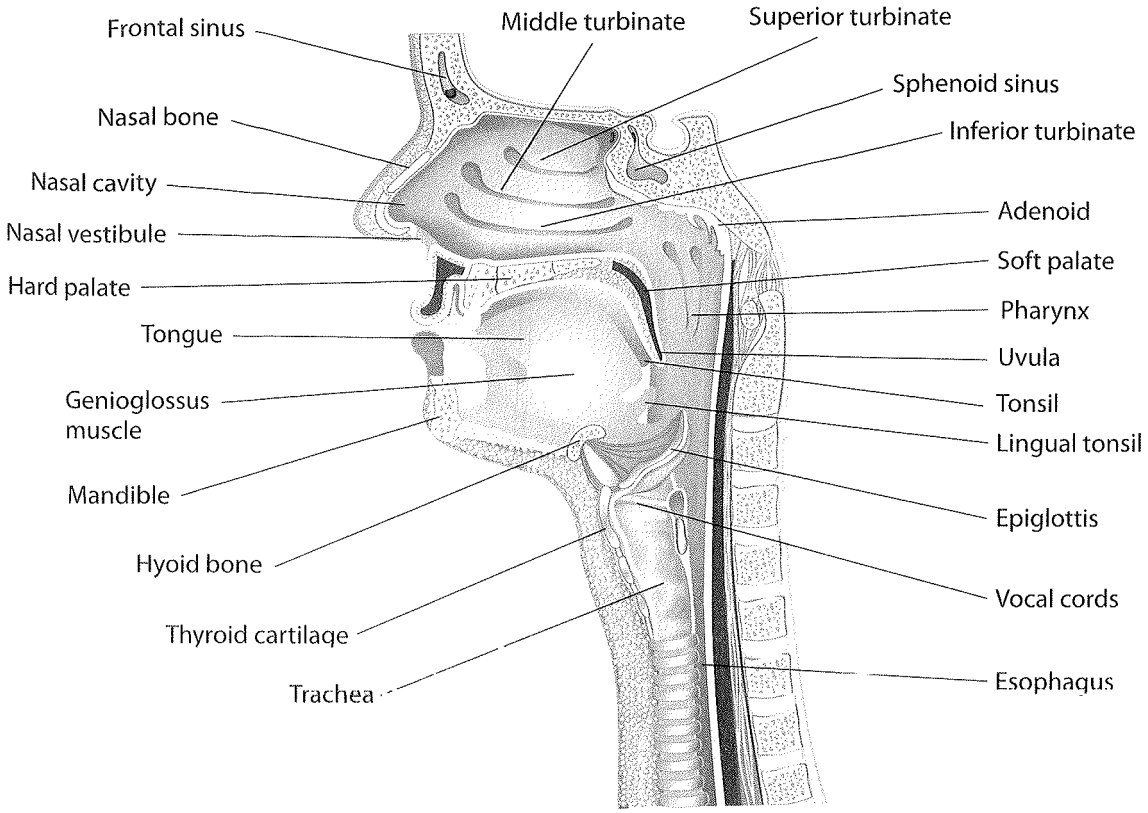
Respiratory System — Lung Function



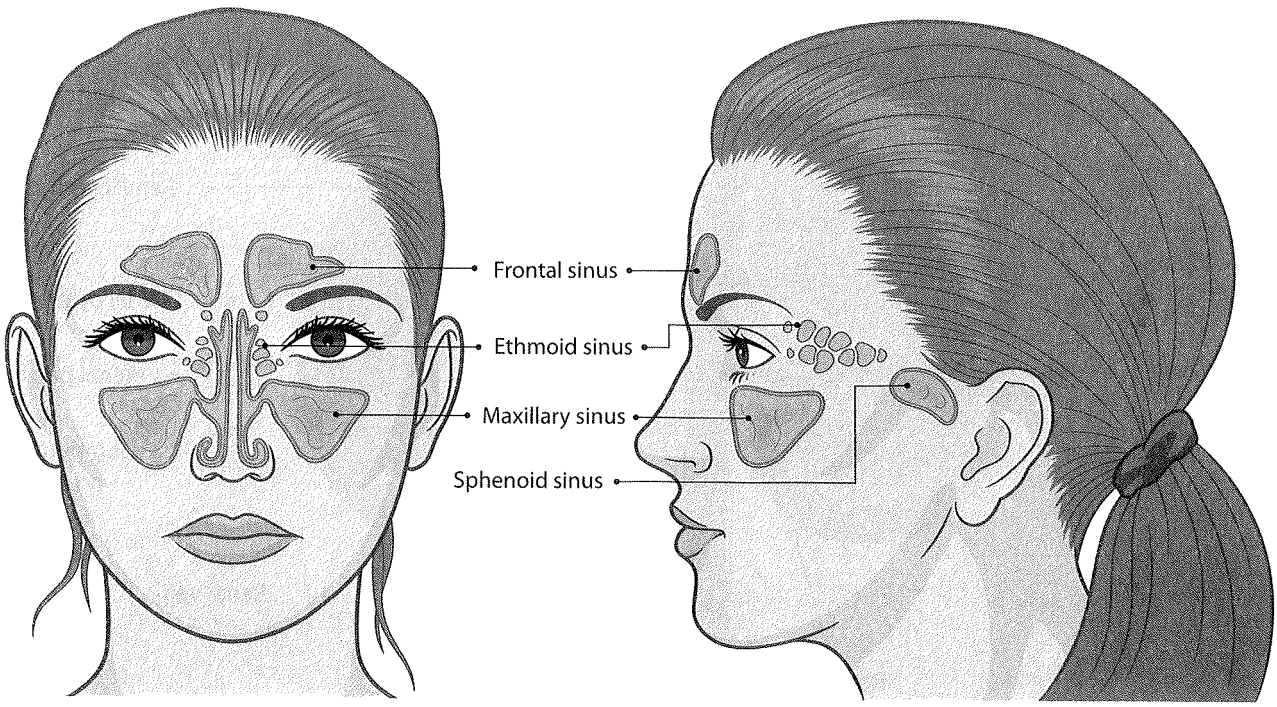
Cross section of a bronchiole with alveoli

Gas exchange within alveoli

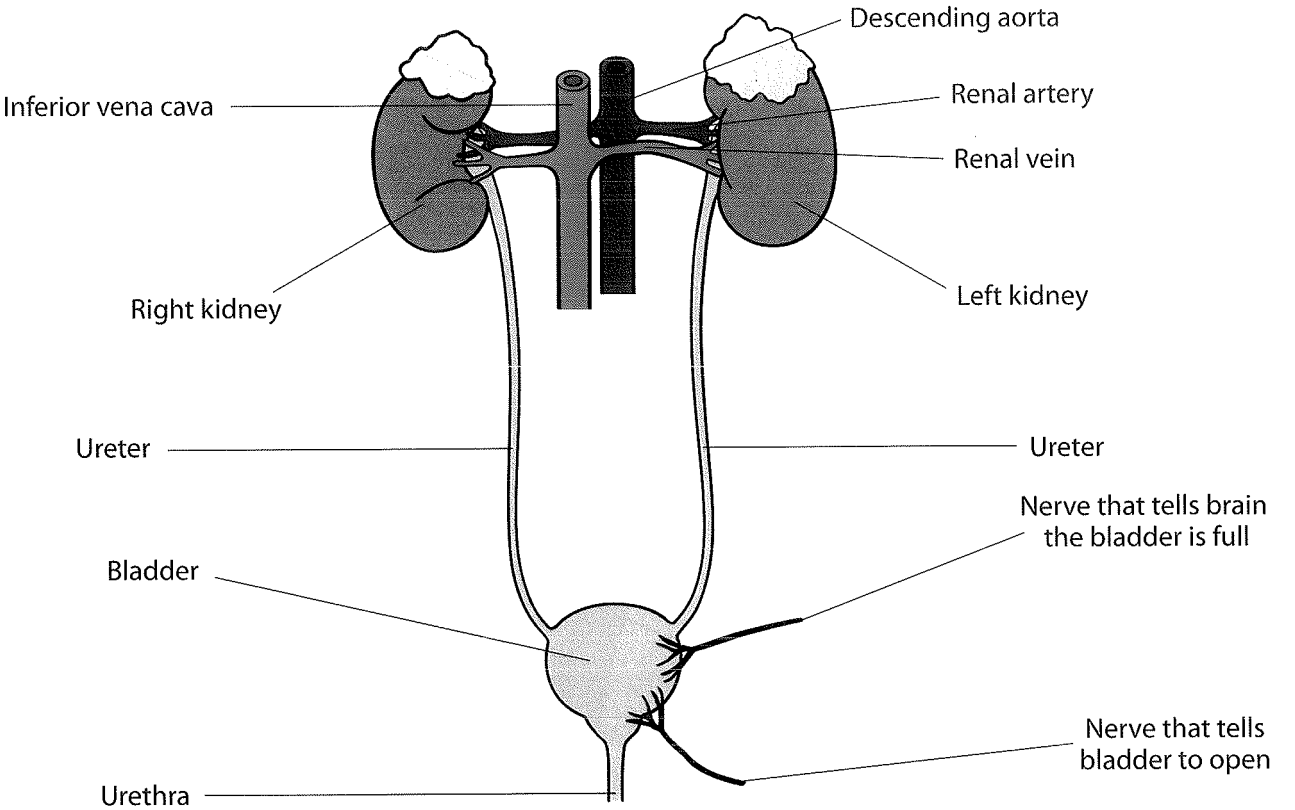
Respiratory System — Nose and Throat Anatomy



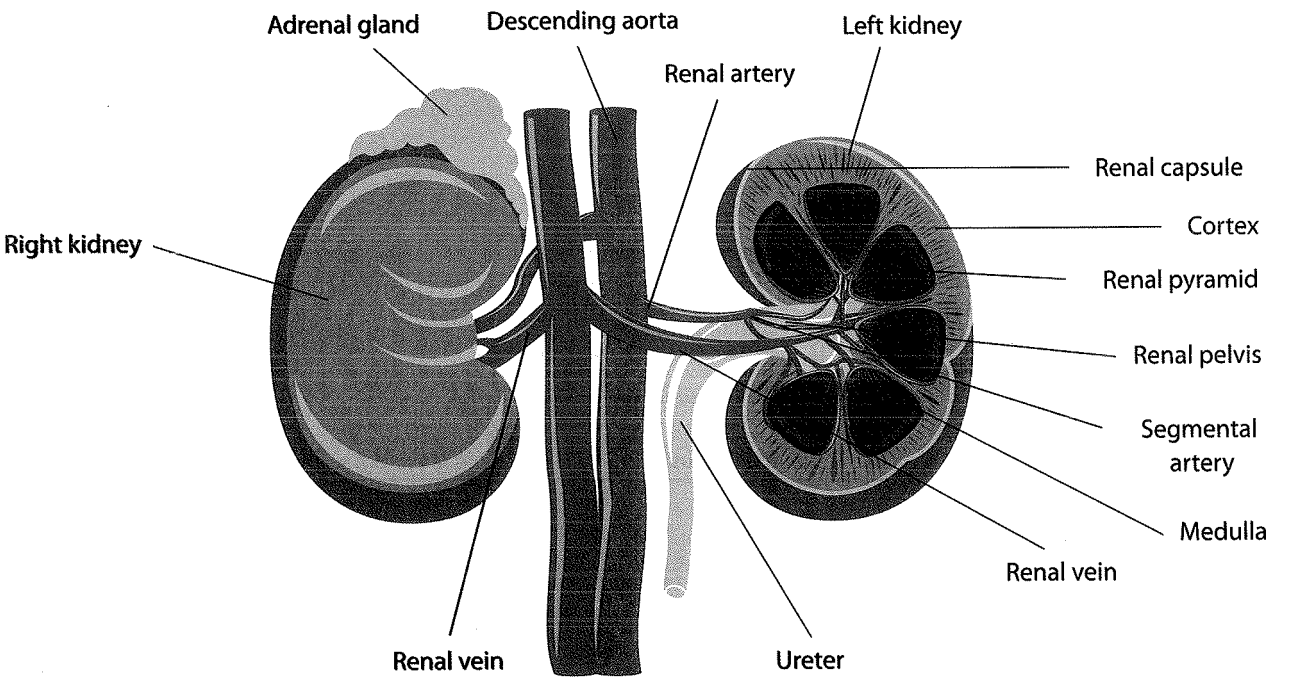
Respiratory System — Sinus Anatomy



Urinary System Anatomy



Urinary System — Kidney Anatomy



A

A-Hydrocort® J1710
Abatacept J0129
Abciximab J0130
Abdominal pad, TLSO L1270
Abduction
- Control, hip orthosis, hip joint
  - Dynamic, adjustable L1680
  - Flexible
    - Frejka type L1600, L1610
    - Pavlik harness L1620
  - Semi-flexible, Van Rosen type L1630
  - Static
    - Adjustable, Ilfeld type, prefabricated L1650
    - Pelvic band or spreader bar L1640
    - Plastic, prefabricated L1660
- Control, lower extremity orthosis, hip joint L2624
- Pillow (miscellaneous durable medical equipment) E1399
- Restrainer, shoulder L3650
  - Canvas and webbing L3660
  - Vest type L3675
- Rotation bar
  - Foot L3150
    - Adjustable shoe-styled positioning device L3160
    - Including shoes L3140
    - Prefabricated, off-the-shelf, each L3170
  - Lower extremity
    - Hip involvement, jointed, adjustable L2300
    - Straight L2310

Abecma Q2055
Ablation
- Catheter
  - Electrophysiological
    - 3D or vector mapping C1732
    - Other than 3D or vector mapping or cool-tip C1733
  - Endovascular, noncardiac C1888
  - Extravascular, any modality C1886
  - Tissue, extravascular C1886
- Transbronchial C9751

Abobotulinumtoxin type A J0586
Abortion, induced
- 17 to 24 weeks S2260
- 25 to 28 weeks S2265
- 29 to 31 weeks S2266
- 32 or greater S2267
- Drug induced, with other services S0199

Absorption dressing A6251-A6256
Acapatch Q4325 N
Access Catheters A4300-A4301
Accessories
- Ambulation devices E0153-E0159
- Beds E0271-E0280, E0300-E0316
- Dialysis E1500-E1699
- Wheelchairs E0950-E1036, E1225-E1228, E2201-E2398, E2626-E2633, K0001-K0195, K0669, K0733 N

Accu-Chek® or similar product
- Blood glucose meter E0607
- Test strips, box of 50 A4253

ACE inhibitor
- Not prescribed M1201-M1203
- Prescribed M1200

Acesso Q4311, Q4312 N
Acetaminophen J0131, J0134, J0136
Acetate concentrate for hemodialysis A4708
Acetazolamide sodium J1120
Acetylcysteine
- Inhalation solution J7604, J7608
- Injection J0132

Acid concentrate for hemodialysis A4709
Activated carbon filter for hemodialysis A4680
Activity therapy
- 45 minutes or more G0176
- Per 15 minutes H2032

Acyclovir J0133
Adalimumab Q5140-Q5145 N
Adapter
- Breast pump A4282
- Electric/pneumatic ventricular assist device Q0478
- Neurostimulator C1883
- Oxygen accessory E1358
- Pacing lead C1883
- Pneumatic ventricular assist device Q0504

Addition, *see also* Orthotic devices
- Cushion socket
  - Above knee L5648
  - Below knee L5646
- Harness upper extremity
  - Dual cable L6676
  - Single cable L6675
- Interface replacement for halo procedure L0861
- Orthotic components, lower extremity K0672, L2750, L2760, L2780-L2861
- Prosthesis components
  - Adjustable heel height L5990
  - SACH foot L5970
- Torsion mechanism, upper extremity joint orthotic L3891
- Wrist unit, flexion, extension L6620

Adenosine J0153
Adhesive
- Bandages
  - Compression
    - High A6452
    - Light A6448-A6450
    - Medium A6451
  - Conforming A6442-A6447
  - Gauze A6216-A6230, A6402-A6404
  - Padding A6441, S8430
  - Self-adherent A6453-A6455
  - With zinc paste A6456
- Barrier C1765
- Disc or foam pad A5126
- Dressing
  - Composite
    - 16 sq. in. or less A6203
    - More than 16 sq. in. but less than or equal to 48 sq. in. A6204
    - More than 48 sq. in A6205
  - Foam A6214
  - Gauze
    - 16 sq. in. or less A6219
    - More than 16 sq. in. but less than or equal to 48 sq. in. A6220
    - More than 48 sq. in. A6221

Hydrocolloid
16 sq. in. or less A6234
More than 16 sq. in. but less than or equal to 48 sq. in. A6238
More than 48 sq. in. A6239
Hydrogel
16 sq. in. or less A6245
More than 16 sq. in. but less than or equal to 48 sq. in. A6246
More than 48 sq. in. A6247
Specialty
16 sq. in. or less A6254
More than 16 sq. in. but less than or equal to 48 sq. in. A6255
More than 48 sq. in. A6256
Liquid A4364
Ostomy A4364
Remover A4455, A4456
Support for breast prosthesis A4280
Tape
Breast prosthesis A4280
Non waterproof A4450
Waterproof A4452
Tissue (wound closure) G0168
Adjustment, gastric band S2083
Administration
Aerosolized drug therapy S9061
Drug at home G0068-G0070, G0088-G0090
Medication
Direct observation H0033
Oral, intramuscular and/or subcutaneous medication T1502
Other than oral and/or injectable T1503
Pain medication G9426, G9427
Vaccine G0008-G0010
COVID-19 M0201, M1417-M1419 N
Hepatitis B G0010, M0201
Influenza G0008, M0201, M1299, M1168-M1170, M1308
Pneumococcal G0009, M0201, M1177-M1179, M1304-M1306
Administrative, miscellaneous and investigational items A9150-A9999
Adolescent depression remission
Not reached 12 months. M1020
Reached 12 months. M1019
Adoptive immunotherapy S2107
Ado-trastuzumab J9354
Adrenal tissue transplant S2103
Adrenalin J0171
Aducanumab-avwa J0172
Aduhelm J0172
Adult day center G0530 N
Advance directive S0257
Aerosol
Compressor E0572
Compressor filter A7013, A7014
Mask A7015
AF, transient or reversible cause G9929
Afamelanotide implant J7352
Aflibercept J0178
AFO (ankle foot orthosis) L1900-L1990
Dynamic adjustable E1815, E1830, L4397
Fracture L2106-L2116
Replace L4392, L4396
Walking boot L4631
Afstyla J7210
Agalsidase beta J0180
Aggrastat J3246
Air
Bubble detector, dialysis E1530
Fluidized bed E0194
Pressure
Elevator, heel E0370
Pad/mattress E0186, E0197, E0372
Travel and nonemergency transportation A0140
Alarm
Alert device A9280
Pressure, dialysis E1540
Alatrofloxacin mesylate J0200
Albumin, human
5%, 50 mL P9041
5%, 250 mL P9045
25%, 20 mL P9046
25%, 50 mL P9047
Albuterol, all formulations, inhalation solution
Concentrated
Compounded J7610
Noncompounded J7611
Unit dose
Compounded J7609
Noncompounded J7613, J7620
Alcohol (and/or drug)
Abuse and prevention services G0443, H0001-H0031, H0034-H0037, H0039, H0040, H0047-H0050, H2000, H2001, H2010-H2020, H2034-H2036, T1006-T1012
Not otherwise specified (NOS) H0047
Screening G9621, G9622, G9624
Structured, with intervention
5-14 minutes G2011
15-30 minutes G0396
Greater than 30 minutes G0397
Per pint A4244
Screening G2196-G2202
Services H0047-H0050
Testing collection and handling only H0048
Unhealthy use of G2196, G2200
Wipes A4245
Aldesleukin (IL2) J9015
Alefacept J0215
Alemtuzumab J0202
Alert device A9280
Alginate dressing A6196, A6197, A6198, A6199
Alglucerase J0205
Alglucosidase alfa J0220, J0221
Alkaline battery
Blood glucose monitor
J cell A4234
Other than J cell A4233
Cochlear implant device replacement L8622
External infusion pump owned by patient, alkaline K0603
Allergen, mechanical filter, cream A7023
AlloDerm® Q4116
AlloGen® Q4212
Allogeneic cord blood harvest S2140
Allograft, small intestine and liver S2053
Alloply Q4323 N
AlloSkin™ Q4115
Alpha-1-proteinase inhibitor, human J0256, J0257
Alphanate J7186
Alprostadil
Injection J0270
Urethral suppository J0275
ALS (advanced life support)
Level 2 A0433

Mileage A0390
Supplies A0392-A0398
Esophageal intubation A0396
IV drug therapy A0394
Alteplase recombinant J2997
Alternating pressure mattress/pad
Air mattress E0277
Powered pressure reducing mattress overlay/pad E0181, E0183
Pump, replacement E0182
Replacement pad A4640
Alternative communication device board E1902
Ambulance and other transport services and supplies A0021-A0999
Air A0424
Fixed wing A0430, A0435, S9960
Rotary wing A0431, A0436, S9961
Advanced life support (ALS) A0426, A0427, A0433
Supplies, disposable A0392-A0398
Attendant A0424
Basic life support (BLS) A0428, A0429
Supplies, disposable A0382, A0384
Conventional A0430, A0431
Mileage A0021, A0380, A0390, A0425, A0434, A0435, A0888
Neonatal A0225
No transport (response and treatment) A0998
Non-emergency A0080-A0160, A0180-A0210, A0426, A0428, S0215
Outside state A0021
Oxygen A0422
Paramedic intercept A0432
Parking fees A0170
Response and treatment only A0998
Specialty care A0434
Supplies A0382, A0384, A0392-A0398, A0422
Unlisted A0999
Waiting time A0422
Ambulation device E0100-E0159
Amchoplast Q4316 N
American Amnion Q4305-Q4307 N
Amifostine J0207
Amikacin sulfate J0278
Aminocaproic acid S0017
Aminolevulinate J7309
Aminolevulinic
Ameluz J7345
Aminolevulinic acid HCl J7308
Aminophylline J0280
Amiodarone HCl J0282, J0283
Amitriptyline HCl J1320
Ammonia N-13 A9526
Ammonia test paper A4774
Amnio wound Q4181
Amnio-maxx™ Q4239
Amnioamp-mp™ Q4250
Amnioarmor Q4188
Amniobind Q4225
Amniocore™ Q4227, Q4298, Q4299
Amniocyte plus™ Q4242
Amnioexcel®/Amnioexcel Plus® Q4137
Amnion bio Q4211
Amnioplast 1 Q4334 N
Amnioplast 2 Q4335 N
Amniorepair® Q4235
Amniotext™ Q4245, Q4247
Amniotic membrane Q4198, Q4294, Q4295, V2790
Amniotic patch
Human health factor 10 Q4224
Amniotx Q4324 N
AmnioWrap2™ Q4221
Amniply™ Q4249
Amobarbital J0300
Amoxicillin as first-line antibiotic
Not prescribed at the time of diagnosis
Medical reason G9313
Reason not documented G9314
Prescribed at the time of diagnosis G9315
Amphotericin B injection J0285
Cholesteryl sulfate complex J0288
Lipid complex J0287
Liposome J0289
Ampicillin sodium J0290
Ampicillin sodium/sulbactam sodium J0295
Amputee
Adapter, wheelchair E0959
Prosthesis L5000-L7600, L7900, L8400-L8465
Stump sock L8470-L8485
Wheelchair E1170-E1190, E1200
Analysis
Dose optimization S3722
Gene analysis S3866
Gene sequence, hypertrophic cardiomyopathy S3865
Semen G0027
Anaphylaxis
Due to
HPV vaccine M1163
Meningococcal vaccine M1160
Pneumococcal vaccine M1306
Tetanus, Diphtheria, Pertussis vaccine M1161
Vaccine M1311
Anastrozole, oral S0170
Anchor/screw C1713
Androgen deprivation therapy
Not prescribed/administered, medical reason G9895
Not prescribed/administered, patient reason G9896
Not prescribed/administered, reason not given G9897
Prescribed/administered G9894
Anesthesia
Care services (MAC) G9654, G9655, G9656, G9658
Injectable A4737
Preop no smoking instructions given G9497
Topical A4736
Anesthetic inhalation G9955
Angiography
Balloon, transluminal C7532
Fluorescent, nonophthalmic C9733
Iliac and/or femoral artery G0278
Magnetic resonance
Abdomen C8901
With contrast C8900
Without contrast followed by with contrast C8902
Breast C8903-C8908
Chest C8910
With contrast C8909
Without contrast followed by with contrast C8911
Lower extremity C8913
With contrast C8912
Without contrast followed by with contrast C8914
Pelvis C8919
With contrast C8918
Without contrast followed by with contrast C8920
Spinal canal and contents C8932
With contrast C8931
Without contrast followed by with contrast C8933

Upper Extremity C8935
With contrast C8934
Without contrast followed by with contrast C8936
Percutaneous transluminal
Coronary C7533
Reconstruction, aorta, CT, for vascular surgery G0288
Angioplasty
Balloon C7563 N
Angiotensin converting enzyme (ACE) or angiotensin receptor blocker (ARB) therapy
Not prescribed
Reason documented G8474, G8936
Reason not documented G8475, G8937
Prescribed G8473, G8935
Anidulafungin J0348
Anifrolumab-Fnia J0491
Ankle-foot orthosis (AFO) L1900-L1990
Dynamic, adjustable E1815
Fabricated L2112, L2114, L2116
Fracture custom-fabricated L2106, L2108
Replace replacement, static AFO L4392
Static or dynamic ankle foot orthosis L4396
Toe E1830
Annual
Gynecological examination
Clinical breast examination without pelvic evaluation S0613
Established patient S0612
New patient S0610
Wellness visit
Initial G0438
Subsequent G0439
Antenna, nerve stimulation device L8696
Anti-emetic J8498, Q0161-Q0181
Anti-inflammatory medication Q5107-Q5111
Anti-platelet agents G9609, G9610, G9611
Anti-sperm antibodies test, immunobead S3655
Antibiotic
Home infusion therapy S9494
Every 3 hours S9497
Every 4 hours S9504
Every 6 hours S9503
Every 8 hours S9502
Every 12 hours S9501
Every 24 hours S9500
Intravenous for surgical site infection (SSI) G8916-G8918
Not prescribed or dispensed G8712
Regimen G9498, G9505
Not prescribed within specified time period G9287
Prescribed within specified time period G9286
Taken within 30 days prior to episode date G9703
Therapy
Not prescribed or dispensed G8708
Prescribed or dispensed G8710, G8711, G9712
Anticoagulant
Not prescribed
Medical reason G8968
Patient reason G8969
Reason not given G9928
Prescribed G8967
Use G9724
Anticoagulation clinic S9401
Anti-epidermal growth factor receptor monoclonal antibodies G9839-G9845
Antipsychotic
Filled two prescriptions during performance period M1380 N
Antiseptic
Chlorhexidine A4248
Solution used to clean dialysis equipment A4674
Antithrombotic/aspirin therapy G8598, G8599, G9277, G9278
Anti-TNF therapy for Hepatitis B
Documented immunity G8869
Hepatitis
Hep B status assessed prior to therapy G9912
Hep B status not assessed prior to therapy G9913
No record HBV results G9915
Patient initiated anti-TNF agent G9914
Antiviral
Home infusion therapy S9494-S9504
Aortic aneurysm G9598, G9599
Apheresis, low density lipid (LDL) S2120
Apligraf® Q4101
Apnea hypopnea index
Measured G8842
Not measured
Reason documented G8843
Reason not documented G8844
Apnea monitor E0530, E0618
Electrodes A4556
Lead wires A4557
With recording feature E0619
Apomorphine hydrochloride J0364
Application
Low cost skin substitute
Other areas C5275, C5276, C5277, C5278
Trunk, arms, legs C5271, C5272, C5273, C5274
Tantalum ring(s) scleral S8030
Aprepitant injection C9145, J0185
Aprotonin J0365
AquaPedic® sectional gel flotation E0196
Arbutamine HCl J0395
Ardeograft Q4333 N
Arformoterol, inhalation solution J7605
Argatroban injection J0883, J0884, J0891, J0892, J0898, J0899
Argus® II Retinal Prosthesis System, com/sup/acc misc L8608
Aripiprazole J0400, J0401
Aripiprazole lauroxil injection J1944
Aristada initio injection J1943
Arsenic trioxide J9017
Artacent® Q4169, Q4189, Q4190, Q4216, Q4336-Q4339 N
Arthrodesis C7506
Arthroereisis, subtalar S2117
Arthroscopy
Knee
Harvesting of cartilage S2112
Removal foreign body G0289
Shoulder
With capsulorrhaphy S2300
With implantation of spacer C9781
Artificial
Cornea L8609
Heart system accessories L8698
Kidney, ***see also*** Dialysis
Larynx L8500
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Training
Alcohol and/or drug training service H0021
Caregiver G0539-G0543 N
Child development, family T1027
Diabetes self management G0108, G0109
Medication training and support H0034
Skills training and development H2014, H2038
Transcatheter occlusion or embolization S2095
Transcutaneous electrical nerve stimulator (TENS)
Conductive garment E0731
Electrical stimulator supplies A4438, A4543-A4545, A4595 N
Four-lead or more E0730
Two-lead E0720
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Transducer protector, dialysis E1575
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Doppler measurement G9157
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Real time with 2D image documentation C8925
Pacing (catheter) C1756
Transfer
Device E0705
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Transluminal
Angioplasty

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Transplant
Adrenal tissue to brain S2103
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Laparotomy G0343
Percutaneous G0341
Kidney and pancreas, simultaneous S2065
Lobar lung S2060
Multiple visceral organs S2054
Related lodging, meals, transportation S9975, S9976
Small intestine and liver S2053
Stem cells, cord blood derived S2142
Waitlist M1261, M1267, M1268, M1270, M1272
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Transportation
Ambulance *see* Ambulance and other transport services and supplies
Conventional air A0430, A0431
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EKG equipment, portable R0076
Neonatal, emergency ambulance service A0225
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Air A0140, T2007
Ancillary
Lodging A0180, A0200
Meals A0190, A0210, S9977
Out-of-state ambulance transport A0021
Parking fees/tolls A0170
Bus A0110
Case worker or social worker A0160
Mini-bus A0120
Stretcher van T2005, T2049
Taxi A0100
Van, wheelchair A0130, S0209
Vehicle provided by
Individual A0090
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Services T2001-T2007
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Trastuzumab J9316, J9355, J9358, Q5112-Q5114, Q5116, Q5117, Q5146 N
Trastuzumab and hyaluronidase J9316, J9356
Trauma response team G0390
Travel allowance for specimen collection P9603, P9604
Tray
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Irrigation A4320
Surgical A4550
Wheelchair E0950
Treatment
Acute care at NF G9679-G9685
Community H0039, H0040
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Tretinoin, topical S0117
Triamcinolone J3301-J3303
Acetonide J3299
Not otherwise specified (NOS) J3301
Preservative free J3300, J3304
Diacetate J3302
Hexacetonide J3303
Inhalation solution
Concentrated J7683
Unit dose J7684
Triferic avnu J1445
Trifluprazine HCl J3400
Trifocal, glass or plastic V2300-V2399
Trilaciclib J1448
Triluron J7332
Tri-membrane wrap Q4344 N
Trimethobenzamide HCl
Injection J3250
Oral Q0173
Trimetrexate glucuronate J3305
Trimming, routine foot care
Corns/calluses/nails S0390
Triptorelin
Extended release J3316
Pamoate J3315
TriVisc™ J7329
Truss L8300, L8310, L8320, L8330
Tube/Tubing
Anchoring device A5200
Blood A4750, A4755
Breast pump A4281
Calibrated microcapillary A4651
Corrugated, nebulizer A7010
Drainage extension A4331
Enema A4457
Gastrostomy/Jejunostomy B4087, B4088
Irrigation A4355
IV extension S1015
Nasogastric B4081, B4082
Oxygen A4616
Restrictive
Elbow E0711
Sealant, microcapillary tube A4652
Serum clotting time A4771
Stomach B4083
Suction pump, each A7002
Urinary drainage A4331
Vacuum blood collection A4770
With heating element A4604
"Y set" A4719
Tumor
Category documented G8721
Not included in pathology report
Medical reason G8722
Reason not given G8724
Specimen site
Other than anatomic location G8723
Tympanostomy G0561 N

U

Ultrafiltration monitor S9007
Ultrasonic
Diathermy treatment device, low frequency K1004, K1036
Nebulizer E0575
Ultrasound
Catheter, intravascular C1753
Gel A4559
Guidance for placement of radiation therapy fields G6001

Intravascular C1753
Transabdominal or transvaginal
Not performed, no reason given G8808
Not performed, reason documented G8807
Ultraviolet light therapy system A4633, E0691-E0694
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ESRD J3591
Underpads
Bed T4537
Chair T4540
Disposable A4554, T4541, T4542
Large T4521
Small T4542
Non-disposable A4553
Underwear, protective
Adult
Above extra-large T4544
Extra-large T4524
Large T4523
Medium T4522
Small T4521
Pediatric T4531, T4532
Large T4532
Small/Medium T4531
Youth T4534
Unipuncture control system, dialysis E1580
Unspecified oral dosage form Q0181
Upper extremity
Addition, locking elbow L6693
Orthosis L3980-L3999
Addition of joint L3956
Prosthesis L6000-L7499
Urea J3350
Ureteral
Catheter C1758
Ureterostomy
Supplies A4450-A4554
Tube change C7549
Urethral suppository J0275
Urgent care center
Global fee S9083
Services M1054, S9088
Visits during performance period M1021
URI
With competing diagnosis G2097
With prior antibiotic prescription G2174
With prior comorbid condition G2173
Urinal
Jug-type, female E0326
Jug-type, male E0325
Urine/Urinary
Care M1423 N
Catheter A4326-A4328, A4338-A4346, A4349, A4351-A4353, A6590, A6591
Collection and retention (supplies) A4310-A4360
Culture, bacterial P7001
Drainage device, intraurethral A4341, A4342
Pump, suction E2001
Reagent strips A4250
Repair device without sling graft C2631
Sphincter prosthesis C1815
Tract implant
Collagen L8603
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Urofollitropin J3355
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Uterine, monitor S9001
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Vabra aspirator A4480
Vaccination
Administration
Hepatitis B G0010, M0201
Influenza G0008, M0201, M1168-M1170, M1299, M1308
Pneumococcal G0009, G9280, G8864-G8867, M0201, M1177-M1179, M1304-M1306
Screening performed G9281
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COVID-19 M0201, M1417-M1419 N
Influenza M0201, M1299, M1308, Q2034-Q2039
Pneumococcal M0201, M1177-M1179, M1304-M1306
Value pathways G0053-G0059, M0001-M0005, M1366-M1370
Vancomycin HCl J3370-J3372
Vaporizer E0605
Vascular
Catheter and supplies A4300-A4306
Graft material, synthetic L8670
Vedolizumab J3380
Vehicle
Power operated K0800-K0812
Velaglucerase alfa J3385
Venipuncture S9529
Venous pressure clamp, dialysis A4918
Ventilator
Battery A4611, A4612, A4613
Home
Any type E0465, E0466, E0468 N
Multi-function E0467
Moisture exchanger A4483
System, intrapulmonary percussive E0481
Ventricular assist device Q0477-Q0509
Vertebral
Augmentation C7507, C7508
Axial decompression S9090
Vertebroplasty C7504, C7505
Verteporfin J3396
Vest, safety, wheelchair E0980
Vestibular rehabilitation program S9476
Vestronidase alfa-vjbk J3397
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Via matrix Q4309 N
Vinblastine sulfate J9360
Vincristine sulfate J9370
Vinorelbine tartrate J9390
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Virtual
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Achieved G0913
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B-12 cyanocobalamin J3420
Dialysis stress supplement S0194

K J3430
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Prenatal S0197
Vitograft Q4317 N
Vocal cord
Medialization material C1878
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Volume management G8955, G8958
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Post-operative G9954
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W

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Attachments E0154-E0159
Walking
Aids E0100-E0149
Accessories A4636, A4637
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Boot
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Warming device
Card E0232
Wound E0231
Washer
Gravlee jet A4470
Water
Distilled, for nebulizer A7018
Pressure pad/mattress E0187, E0198
Purification system (ESRD) E1610, E1615
Softening system (ESRD) E1625
Sterile A4216-A4218, A4714
Wedges, shoe L3340-L3420
Well-child visit G9964, G9965
Wellness visit
Initial G0438
Subsequent G0439
Wet mount Q0111
Wheel attachment, rigid pickup walker E0155
Wheelchair E0950-E1298, K0001-K0014
Accessories E0950-E1036, E1225-E1228, E2201-E2398, E2626-E2633, K0001-K0195, K0669, K0733 N
Interface, head or extremity control E2328, E2329
Amputee E1170-E1200
Arm support E2626-E2633
Armrest E0973
Back E1226, E2291, E2293, E2398
Component or accessory K0001-K0195
Cushions, seat and back E2601-E2625
Custom fabricated E2617
General use
Width 22 inches or greater E2612
Width less than 22 inches E2611
Positioning
Posterior, width 22 inches or greater E2614
Posterior, width less than 22 inches E2613
Posterior-lateral, width 22 inches or greater E2616
Posterior-lateral, width less than 22 inches E2615
Evaluation G9156
Foot box E0954
Fully-reclining
Detachable arms/detachable footrests E1070
Detachable arms/detachable leg rests E1060
Fixed arms/detachable leg rests E1050
Group 2
Extra heavy duty, single power option, sling/solid seat/back K0840
Heavy duty, single power option
Captain's chair K0838
Sling/solid seat/back K0837
Very heavy duty, single power option sling/solid seat/back K0839
Group 3
Extra heavy duty captain's chair K0855
Sling/solid seat/back K0854
Heavy duty captain's chair K0851
Sling/solid seat/back K0850
Very heavy duty captain's chair K0853
Sling/solid seat/back K0852
Heavy duty E1092, E1093, E1280-E1298
Hemi
Detachable arms/detachable leg rests E1084
Fixed arms/detachable footrest E1085, E1086
Fixed arms/detachable leg rest E1083
Standard, low seat K0002
Lateral thigh or knee support E0953
Lightweight E1240-E1270
High-strength E1087-E1090
Portable motorized K0012
Narrowing device E0969
Pediatric E1229-E1239
Folding E1236
Not otherwise specified (NOS) E1229
Power operated E1239
Power add-on E0983-E0984
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Specially sized E1220, E1229
Standard E1130-E1161, K0001
Hemi, low seat K0002
Weight frame motorized K0010
With programmable control parameters K0011
Stump support system E1020
Tire, pneumatic E2381-E2385
Transfer board or device E0705
Tray E0950
Van, nonemergency A0130, S0209
WHFO (wrist hand finger orthosis) L3807
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WHO, wrist extension L3908
Wig A9282
Wipes A4245, A4247
Wood
Canes, all materials E0100
Crutches
Other than wood E0114, E0116
Wood E0112, E0113
Wound *see also* Dressings
Cleanser A6260
Cover
Alginate dressing A6196-A6198
Collagen dressing A6021-A6024
Foam dressing A6209-A6214
Hydrocolloid dressing A6234-A6239

Hydrogel dressing A6242-A6247
Specialty absorptive dressing A6251-A6256
Wound warming device, noncontact E0231, E0232
Dressing K0744, K0745, K0746, L3254, L3255
Filler
Adhesive tissue G0168
Alginate dressing A6199
Collagen based A6010
Foam dressing per gram A6215
Hydrocolloid dressing A6240, A6241
Hydrogel dressing A6248
Not elsewhere classified (NEC) A6261, A6262
Matrix A2001-A2029, A4100 N
Pouch A6154
Supplies and dressings A4450-A4456, A4461-A4467, A6000-A6550
Suction A9272, K0743
Treatment
Autologous platelet rich plasma G0460
Biologicals and skin substitutes A2001-A2029, A4100, Q4100-Q4304, S9055 N
Compression burn mask A6513
Electric or electromagnetic stimulation E0769, G0295, G0329
Gel sheet A6025
Packing strips A6407
WoundEx® Q4162, Q4163
WoundFix™ Q4217
Woundplus Q4326 N
Wrap
Chest E0459
Heat and/or cold A9273
Penile T4545
Wrist
Disarticulation prosthesis L6050, L6055
Electronic wrist rotator L7259
Hand/finger orthosis (WHFO) E1805, E1825, L3808, L3809, L3900, L3901, L3904
Wrong site/side/patient/procedure/implant G8907, G8912-G8913

X

Xceed matrix Q4353 N
Xcellerate® Q4234
Xenon (Xe) A9558, A9610 N
Xwrap® Q4204
X-ray equipment, portable Q0092, R0070, R0075

Y

Yttrium-90 (Y-90) ibritumomab A9543

Z

Ziconotide J2278
Zidovudine J3485, S0104
Ziprasidone mesylate J3486
Zoledronic acid J3489
Zynlonta J9359

CMS includes parenthetical coding guidelines for several codes throughout the Tabular List, which are effective for 2025. Some of these guidelines include deleted CPT® or HCPCS Level II codes, even though the guidelines were from the latest updates from CMS for 2025. Please check the CMS website for further updates or guideline changes.

Generic and brand-name drugs found throughout the Tabular List are from the latest CMS updates. Please check the CMS website and the FDA website for further information on valid or discontinued drugs.

TRANSPORTATION SERVICES INCLUDING AMBULANCE (A0021-A0999)

HCPCS Level II codes for ambulance services (A0021-A0999) must be reported with modifiers indicating pick-up origins and destinations. The modifier describing the arrangement (QM, QN) is listed first. The modifiers describing the origin and destination are listed second. Origin and destination modifiers are created by combining two alpha characters from the following list. Each alpha character, with the exception of X, represents either an origin or destination. Each pair of the alpha characters creates one modifier. The first position represents the origin and the second the destination. The modifiers most commonly used are:

D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Free standing ESRD facility
N	Skilled nursing facility (SNF)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

AMBULANCE AND OTHER TRANSPORT SERVICES AND SUPPLIES (A0021-A0999)

A0021 Ambulance service, outside state per mile, transport (Medicaid only) E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0080 Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0090 Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0100 Non-emergency transportation; taxi E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0110 Non-emergency transportation and bus, intra or inter state carrier E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0120 Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0130 Non-emergency transportation: wheelchair van E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0140 Non-emergency transportation and air travel (private or commercial) intra or inter state E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0160 Non-emergency transportation: per mile - case worker or social worker E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0170 Transportation ancillary: parking fees, tolls, other E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0180 Non-emergency transportation: ancillary: lodging-recipient E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0190 Non-emergency transportation: ancillary: meals-recipient E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0200 Non-emergency transportation: ancillary: lodging escort E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0210 Non-emergency transportation: ancillary: meals-escort E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0225 Ambulance service, neonatal transport, base rate, emergency transport, one way Ⓐ E1
BETOS: O1A Ambulance
Service not separately priced by Part B

A0380 BLS mileage (per mile) E1
BETOS: O1A Ambulance
Service not separately priced by Part B

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I **A0382** BLS routine disposable supplies E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0384** BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances) E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0390** ALS mileage (per mile) E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0392** ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances) E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0394** ALS specialized service disposable supplies; IV drug therapy E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0396** ALS specialized service disposable supplies; esophageal intubation E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0398** ALS routine disposable supplies E1
BETOS: O1A Ambulance
Service not separately priced by Part B

Waiting Time Units for Ambulance Services

Units	Total Time
1	1/2 to 1 hour
2	1 to 1-1/2 hours
3	1-1/2 to 2 hours
4	2 to 2-1/2 hours
5	2-1/2 to 3 hours
6	3 to 3-1/2 hours
7	3-1/2 to 4 hours
8	4 to 4-1/2 hours
9	4-1/2 to 5 hours
10	5 to 5-1/2 hours

I **A0420** Ambulance waiting time (ALS or BLS), one half (1/2) hour increments E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0422** Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation E1
BETOS: O1A Ambulance
Service not separately priced by Part B

I **A0424** Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review) E1
BETOS: O1A Ambulance
Service not separately priced by Part B

C **A0425** Ground mileage, per statute mile A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4
Pub: 100-4, Chapter-15, 20.6

C **A0426** Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

C **A0427** Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-emergency) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

C **A0428** Ambulance service, basic life support, non-emergency transport, (BLS) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4
Pub: 100-4, Chapter-15, 20.6

C **A0429** Ambulance service, basic life support, emergency transport (BLS-emergency) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

C **A0430** Ambulance service, conventional air services, transport, one way (fixed wing) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4
Pub: 100-4, Chapter-15, 20.3; 100-4, Chapter-15, 30.2; 100-4, Chapter-15, 30.2.1

C **A0431** Ambulance service, conventional air services, transport, one way (rotary wing) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

C **A0432** Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

C **A0433** Advanced life support, level 2 (ALS 2) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

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C **A0434** Specialty care transport (SCT) A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4

C **A0435** Fixed wing air mileage, per statute mile A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4
Pub: 100-4, Chapter-15, 20.3

C **A0436** Rotary wing air mileage, per statute mile A
BETOS: O1A Ambulance
Reasonable charge
Coding Clinic: 2012, Q4
Pub: 100-4, Chapter-15, 20.3

M **A0888** Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility) E1
BETOS: O1A Ambulance
Service not separately priced by Part B
Pub: 100-4, Chapter-15, 30.2.4

I **A0998** Ambulance response and treatment, no transport E1
BETOS: O1A Ambulance
Service not separately priced by Part B

D **A0999** Unlisted ambulance service A
BETOS: O1A Ambulance
Other carrier priced
Coding Clinic: 2009, Q2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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NOTES

MEDICAL AND SURGICAL SUPPLIES (A2001-A8004)

MATRIX FOR WOUND MANAGEMENT (PLACENTAL, EQUINE, SYNTHETIC) (A2001-A2029)

C **A2001** Innovamatrix ac, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2002** Mirragen advanced wound matrix, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2004** Xcellistem, 1 mg N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2005** Microlyte matrix, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2006** Novosorb synpath dermal matrix, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2007** Restrata, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2008** Theragenesis, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2009** Symphony, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2010** Apis, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q1

C **A2011** Supra sdrm, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q2

C **A2012** Suprathel, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q2

C **A2013** Innovamatrix fs, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q2

C **A2014** Omeza collagen matrix, per 100 mg N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q4

C **A2015** Phoenix wound matrix, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q4

C **A2016** Permeaderm b, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q4

C **A2017** Permeaderm glove, each N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q4

C **A2018** Permeaderm c, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q4

C **A2019** Kerecis omega3 marigen shield, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q2

C **A2020** Ac5 advanced wound system (ac5) N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q2

C **A2021** Neomatrix, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q2

C **A2022** Innovaburn or innovamatrix xl, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q4

C **A2023** Innovamatrix pd, 1 mg N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q4

▲ C **A2024** Resolve matrix or xenopatch, per square centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q4

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment Indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **A2025** Miro3d, per cubic centimeter N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2023, Q4

● C **A2026** Restrata minimatrix, 5 mg N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2024, Q2

● C **A2027** Matriderm, per square centimeter
BETOS: P5A Ambulatory procedures - skin
Price established by carriers

● C **A2028** Micromatrix flex, per mg
BETOS: P5A Ambulatory procedures - skin
Price established by carriers

● C **A2029** Mirotract wound matrix sheet, per cubic centimeter
BETOS: P5A Ambulatory procedures - skin
Price established by carriers

SKIN SUBSTITUTE DEVICE (A4100)

C **A4100** Skin substitute, fda cleared as a device, not otherwise specified N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Price established by carriers
Coding Clinic: 2022, Q2; 2022, Q2

INJECTION AND INFUSION SUPPLIES (A4206-A4232)

C **A4206** Syringe with needle, sterile, 1 cc or less, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4207** Syringe with needle, sterile 2 cc, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4208** Syringe with needle, sterile 3 cc, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4209** Syringe with needle, sterile 5 cc or greater, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4210** Needle-free injection device, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4211** Supplies for self-administered injections N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4212** Non-coring needle or stylet with or without catheter N
BETOS: D1A Medical/surgical supplies
Other carrier priced

C **A4213** Syringe, sterile, 20 cc or greater, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4215** Needle, sterile, any size, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4216** Sterile water, saline and/or dextrose, diluent/flush, 10 ml DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4217** Sterile water/saline, 500 ml DME N
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: AU

D **A4218** Sterile saline or water, metered dose dispenser, 10 ml N
BETOS: O1E Other drugs

D **A4220** Refill kit for implantable infusion pump N
BETOS: D1A Medical/surgical supplies
Other carrier priced

C **A4221** Supplies for maintenance of non-insulin drug infusion catheter, per week (list drugs separately) DME N
BETOS: D1E Other DME

C **A4222** Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) DME N
BETOS: D1E Other DME

C **A4223** Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately) N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4224** Supplies for maintenance of insulin infusion catheter, per week DME N
BETOS: D1E Other DME

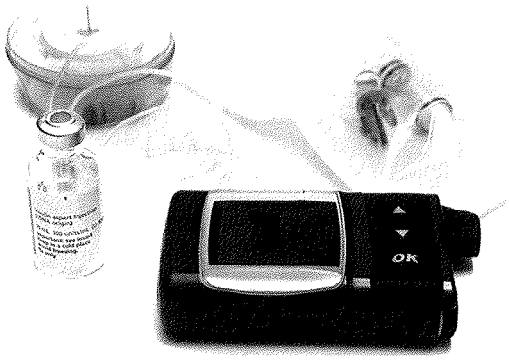
D **A4225** Supplies for external insulin infusion pump, syringe type cartridge, sterile, each DME N
BETOS: D1E Other DME

I **A4226** Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **A4230** Infusion set for external insulin pump, non needle cannula type N
BETOS: D1E Other DME

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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Insulin pump

D **A4231** Infusion set for external insulin pump, needle type N
BETOS: D1E Other DME

I **A4232** Syringe with needle for external insulin pump, sterile, 3 cc E1
BETOS: D1E Other DME
Service not separately priced by Part B

REPLACEMENT BATTERIES (A4233-A4236)

C **A4233** Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each DME E1
BETOS: D1E Other DME
DME Modifier: NU

C **A4234** Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each DME E1
BETOS: D1E Other DME
DME Modifier: NU

C **A4235** Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each DME E1
BETOS: D1E Other DME
DME Modifier: NU

C **A4236** Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each DME E1
BETOS: D1E Other DME
DME Modifier: NU

OTHER SUPPLIES INCLUDING DIABETES SUPPLIES AND CONTRACEPTIVES (A4238-A4290)

C **A4238** Supply allowance for adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service DME Y
BETOS: D1E Other DME
DME Modifier: KF

C **A4239** Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service DME Y
BETOS: D1E Other DME
DME Modifier: KF

C **A4244** Alcohol or peroxide, per pint N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4245** Alcohol wipes, per box N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4246** Betadine or pHisoHex solution, per pint N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4247** Betadine or iodine swabs/wipes, per box N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4248** Chlorhexidine containing antiseptic, 1 ml N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

M **A4250** Urine test or reagent strips or tablets (100 tablets or strips) E1
BETOS: T1E Lab tests - glucose
Service not separately priced by Part B

S **A4252** Blood ketone test or reagent strip, each E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1861(n)

D **A4253** Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips DME N
BETOS: D1E Other DME
DME Modifier: NU

D **A4255** Platforms for home blood glucose monitor, 50 per box DME N
BETOS: D1E Other DME

D **A4256** Normal, low and high calibrator solution / chips DME N
BETOS: D1E Other DME

C **A4257** Replacement lens shield cartridge for use with laser skin piercing device, each DME E1
BETOS: D1E Other DME
Coding Clinic: 2002, Q1

D **A4258** Spring-powered device for lancet, each DME N
BETOS: D1E Other DME

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
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D **A4259** Lancets, per box of 100 DME N
BETOS: D1E Other DME

S **A4261** Cervical cap for contraceptive use ♀ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1862a1

D **A4262** Temporary, absorbable lacrimal duct implant, each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4263** Permanent, long term, non-dissolvable lacrimal duct implant, each N
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

I **A4264** Permanent implantable contraceptive intratubal occlusion device(s) and delivery system ♀ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **A4265** Paraffin, per pound DME N
BETOS: D1E Other DME

I **A4266** Diaphragm for contraceptive use ♀ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **A4267** Contraceptive supply, condom, male, each ♂ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **A4268** Contraceptive supply, condom, female, each ♀ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **A4269** Contraceptive supply, spermicide (e.g., foam, gel), each ♀ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4270** Disposable endoscope sheath, each N
BETOS: P8D Endoscopy - colonoscopy
Service not separately priced by Part B

▲ D **A4271** Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests DME A
BETOS: D1E Other DME
Coding Clinic: 2024, Q2

C **A4280** Adhesive skin support attachment for use with external breast prosthesis, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4281** Tubing for breast pump, replacement ♀ A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4282** Adapter for breast pump, replacement ♀ A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4283** Cap for breast pump bottle, replacement ♀ A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4284** Breast shield and splash protector for use with breast pump, replacement ♀ A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4285** Polycarbonate bottle for use with breast pump, replacement ♀ A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4286** Locking ring for breast pump, replacement ♀ A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4287** Disposable collection and storage bag for breast milk, any size, any type, each Y
BETOS: Z2 Undefined codes

C **A4290** Sacral nerve stimulation test lead, each N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

ACCESS CATHETERS AND DRUG DELIVERY SYSTEMS (A4300-A4306)

D **A4300** Implantable access catheter, (e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.) external access N
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

C **A4301** Implantable access total catheter, port/reservoir (e.g., venous, arterial, epidural, subarachnoid, peritoneal, etc.) N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4305** Disposable drug delivery system, flow rate of 50 ml or greater per hour N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A4306** Disposable drug delivery system, flow rate of less than 50 ml per hour N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

INCONTINENCE DEVICES AND SUPPLIES (A4310-A4360), SEE ALSO INCONTINENCE DEVICES AND SUPPLIES (A5102-A5200)

D **A4310** Insertion tray without drainage bag and without catheter (accessories only) DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4311** Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.) DME N
BETOS: D1F Prosthetic/Orthotic devices

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D A4312 Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way, all silicone DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4313** Insertion tray without drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4314** Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.) DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4315** Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way, all silicone DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4316** Insertion tray with drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4320** Irrigation tray with bulb or piston syringe, any purpose DME N
BETOS: D1A Medical/surgical supplies

D **A4321** Therapeutic agent for urinary catheter irrigation DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4322** Irrigation syringe, bulb or piston, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4326** Male external catheter with integral collection chamber, any type, each ♂ DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4327** Female external urinary collection device; meatal cup, each ♀ DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4328** Female external urinary collection device; pouch, each ♀ DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4330** Perianal fecal collection pouch with adhesive, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4331** Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4332** Lubricant, individual sterile packet, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4333** Urinary catheter anchoring device, adhesive skin attachment, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4334** Urinary catheter anchoring device, leg strap, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4335** Incontinence supply; miscellaneous N
BETOS: D1F Prosthetic/Orthotic devices

D **A4336** Incontinence supply, urethral insert, any type, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4337** Incontinence supply, rectal insert, any type, each N
BETOS: D1F Prosthetic/Orthotic devices

D **A4338** Indwelling catheter; Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each DME N
BETOS: D1F Prosthetic/Orthotic devices

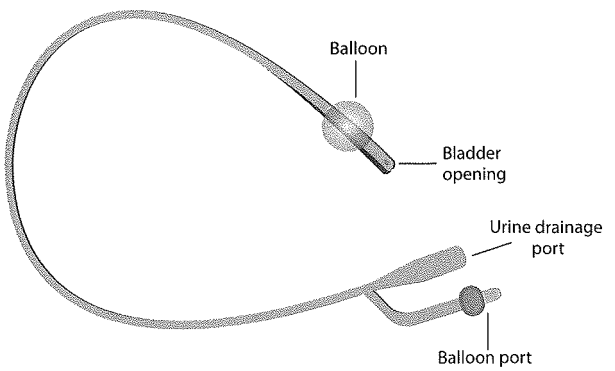
D **A4340** Indwelling catheter; specialty type, (e.g., coude, mushroom, wing, etc.), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4341** Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each ♀ DME Ⓐ
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2023, Q2

C **A4342** Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each ♀ DME Ⓐ N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2023, Q2

D **A4344** Indwelling catheter, foley type, two-way, all silicone or polyurethane, each N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2023, Q4

D **A4346** Indwelling catheter; Foley type, three way for continuous irrigation, each DME N
BETOS: D1F Prosthetic/Orthotic devices



Foley catheter

D **A4349** Male external catheter, with or without adhesive, disposable, each ♂ DME N
BETOS: D1A Medical/surgical supplies

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **A4351** Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4352** Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4353** Intermittent urinary catheter, with insertion supplies DME N
BETOS: D1F Prosthetic/Orthotic devices

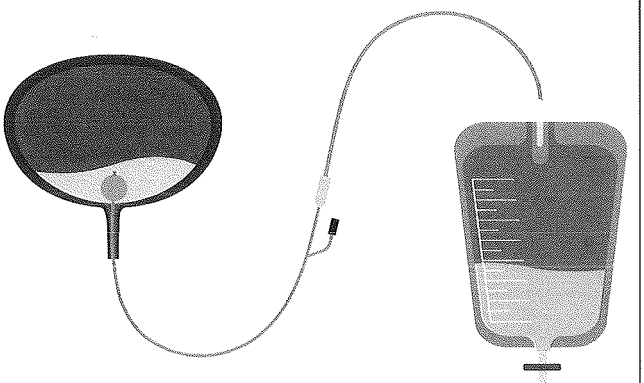
D **A4354** Insertion tray with drainage bag but without catheter DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4355** Irrigation tubing set for continuous bladder irrigation through a 3-way indwelling Foley catheter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4356** External urethral clamp or compression device (not to be used for catheter clamp), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4357** Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4358** Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each DME N
BETOS: D1F Prosthetic/Orthotic devices



Urinary drainage bag

D **A4360** Disposable external urethral clamp or compression device, with pad and/or pouch, each DME N
BETOS: D1F Prosthetic/Orthotic devices

OSTOMY POUCHES AND SUPPLIES (A4361-A4437), SEE ALSO OSTOMY POUCHES AND SUPPLIES (A5051-A5093)

D **A4361** Ostomy faceplate, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4362** Skin barrier; solid, 4 x 4 or equivalent; each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4363** Ostomy clamp, any type, replacement only, each DME E1
BETOS: D1F Prosthetic/Orthotic devices

D **A4364** Adhesive, liquid or equal, any type, per oz DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4366** Ostomy vent, any type, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4367** Ostomy belt, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4368** Ostomy filter, any type, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4369** Ostomy skin barrier, liquid (spray, brush, etc), per oz DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4371** Ostomy skin barrier, powder, per oz DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4372** Ostomy skin barrier, solid 4x4 or equivalent, standard wear, with built-in convexity, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4373** Ostomy skin barrier, with flange (solid, flexible or accordian), with built-in convexity, any size, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4375** Ostomy pouch, drainable, with faceplate attached, plastic, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4376** Ostomy pouch, drainable, with faceplate attached, rubber, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4377** Ostomy pouch, drainable, for use on faceplate, plastic, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4378** Ostomy pouch, drainable, for use on faceplate, rubber, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4379** Ostomy pouch, urinary, with faceplate attached, plastic, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4380** Ostomy pouch, urinary, with faceplate attached, rubber, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4381** Ostomy pouch, urinary, for use on faceplate, plastic, each DME N
BETOS: D1F Prosthetic/Orthotic devices

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D A4382 Ostomy pouch, urinary, for use on faceplate, heavy plastic, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4383** Ostomy pouch, urinary, for use on faceplate, rubber, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4384** Ostomy faceplate equivalent, silicone ring, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4385** Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4387** Ostomy pouch, closed, with barrier attached, with built-in convexity (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4388** Ostomy pouch, drainable, with extended wear barrier attached, (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

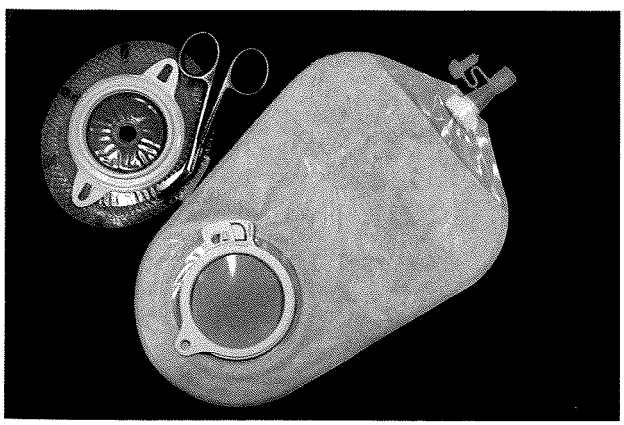
D **A4389** Ostomy pouch, drainable, with barrier attached, with built-in convexity (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4390** Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4391** Ostomy pouch, urinary, with extended wear barrier attached (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4392** Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4393** Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices



Ostomy pouch

D **A4394** Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4395** Ostomy deodorant for use in ostomy pouch, solid, per tablet DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4396** Ostomy belt with peristomal hernia support DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4398** Ostomy irrigation supply; bag, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4399** Ostomy irrigation supply; cone/ catheter, with or without brush DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4400** Ostomy irrigation set DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4402** Lubricant, per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4404** Ostomy ring, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4405** Ostomy skin barrier, non-pectin based, paste, per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4406** Ostomy skin barrier, pectin-based, paste, per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4407** Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4408** Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4409** Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4410** Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4411** Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4412** Ostomy pouch, drainable, high output, for use on a barrier with flange (2-piece system), without filter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

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D **A4413** Ostomy pouch, drainable, high output, for use on a barrier with flange (2-piece system), with filter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4414** Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4415** Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4x4 inches, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4416** Ostomy pouch, closed, with barrier attached, with filter (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4417** Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4418** Ostomy pouch, closed; without barrier attached, with filter (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4419** Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4420** Ostomy pouch, closed; for use on barrier with locking flange (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4421** Ostomy supply; miscellaneous N
BETOS: D1F Prosthetic/Orthotic devices

D **A4422** Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4423** Ostomy pouch, closed; for use on barrier with locking flange, with filter (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4424** Ostomy pouch, drainable, with barrier attached, with filter (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4425** Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2-piece system), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4426** Ostomy pouch, drainable; for use on barrier with locking flange (2-piece system), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4427** Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2-piece system), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4428** Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4429** Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4430** Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4431** Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4432** Ostomy pouch, urinary; for use on barrier with non-locking flange, with faucet-type tap with valve (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4433** Ostomy pouch, urinary; for use on barrier with locking flange (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4434** Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4435** Ostomy pouch, drainable, high output, with extended wear barrier (1-piece system), with or without filter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4436** Irrigation supply; sleeve, reusable, per month DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4437** Irrigation supply; sleeve, disposable, per month DME N
BETOS: D1F Prosthetic/Orthotic devices

VARIOUS MEDICAL SUPPLIES INCLUDING TAPES AND SURGICAL DRESSINGS (A4438-A4608)

● C **A4438** Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2024, Q2

D **A4450** Tape, non-waterproof, per 18 square inches DME N
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: AU, AV, AW

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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D **A4452** Tape, waterproof, per 18 square inches DME N
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: AU, AV, AW

C **A4453** Rectal catheter for use with the manual pump-operated enema system, replacement only N
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **A4455** Adhesive remover or solvent (for tape, cement or other adhesive), per ounce DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4456** Adhesive remover, wipes, any type, each DME N
BETOS: D1F Prosthetic/Orthotic devices

S **A4457** Enema tube, with or without adapter, any type, replacement only, each E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861s8

C **A4458** Enema bag with tubing, reusable N
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4459** Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type N
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A4461** Surgical dressing holder, non-reusable, each DME N
BETOS: D1A Medical/surgical supplies

C **A4463** Surgical dressing holder, reusable, each DME N
BETOS: D1A Medical/surgical supplies

C **A4465** Non-elastic binder for extremity N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4467** Belt, strap, sleeve, garment, or covering, any type E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S **A4468** Exsufflation belt, includes all supplies and accessories E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1834(A)(3)

D **A4470** Gravlee jet washer ♀ N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4480** Vabra aspirator ♀ N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A4481** Tracheostoma filter, any type, any size, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4483** Moisture exchanger, disposable, for use with invasive mechanical ventilation DME N
BETOS: D1F Prosthetic/Orthotic devices

M **A4490** Surgical stockings above knee length, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4495** Surgical stockings thigh length, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4500** Surgical stockings below knee length, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4510** Surgical stockings full length, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4520** Incontinence garment, any type, (e.g., brief, diaper), each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

S **A4540** Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2024, Q1

C **A4541** Monthly supplies for use of device coded at E0733 DME Y
BETOS: D1E Other DME

C **A4542** Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist DME Y
BETOS: D1E Other DME

• C **A4543** Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month
BETOS: D1E Other DME

• C **A4544** Electrode for external lower extremity nerve stimulator for restless legs syndrome DME
BETOS: D1E Other DME

• C **A4545** Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month DME
BETOS: D1E Other DME

D **A4550** Surgical trays B
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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M **A4553** Non-disposable underpads, all sizes E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A4554** Disposable underpads, all sizes E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

I **A4555** Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **A4556** Electrodes, (e.g., apnea monitor), per pair DME N
BETOS: D1E Other DME

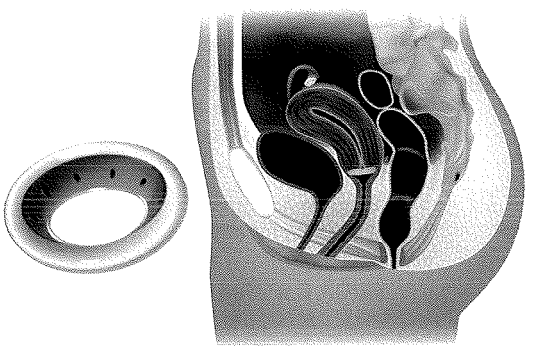
C **A4557** Lead wires, (e.g., apnea monitor), per pair DME N
BETOS: D1E Other DME

C **A4558** Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz DME N
BETOS: D1E Other DME

C **A4559** Coupling gel or paste, for use with ultrasound device, per oz DME N
BETOS: D1E Other DME

S **A4560** Neuromuscular electrical stimulator (nmes), disposable, replacement only E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2023, Q2

▲ C **A4561** Pessary, reusable, rubber, any type ♀ DME N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2024, Q2



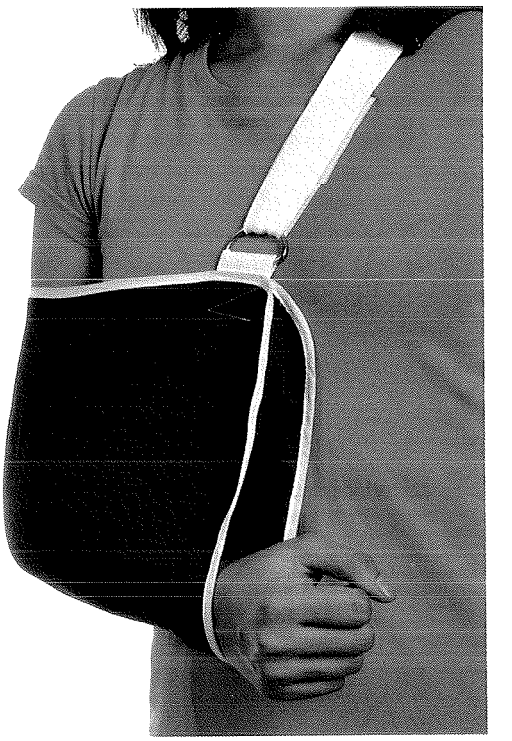
Pessary

▲ C **A4562** Pessary, reusable, non rubber, any type ♀ DME N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2024, Q2

C **A4563** Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each ♀ DME A
BETOS: D1F Prosthetic/Orthotic devices

● C **A4564** Pessary, disposable, any type ♀ A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2024, Q2

C **A4565** Slings DME N
BETOS: D1A Medical/surgical supplies



Arm Sling

I **A4566** Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **A4570** Splint E1
BETOS: D1A Medical/surgical supplies
Reasonable charge

C **A4575** Topical hyperbaric oxygen chamber, disposable A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

I **A4580** Cast supplies (e.g., plaster) E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

I **A4590** Special casting material (e.g., fiberglass) E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

● C **A4593** Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controller Ⓐ E1
BETOS: D1E Other DME
Coding Clinic: 2024, Q2

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● C **A4594** Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each Ⓐ E1
BETOS: D1E Other DME
Coding Clinic: 2024, Q2

D **A4595** Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES) DME N
BETOS: D1E Other DME

C **A4596** Cranial electrotherapy stimulation (ces) system supplies and accessories, per month DME N
BETOS: D1E Other DME
Coding Clinic: 2022, Q4

C **A4600** Sleeve for intermittent limb compression device, replacement only, each E1
BETOS: D1E Other DME

C **A4601** Lithium ion battery, rechargeable, for non-prosthetic use, replacement E1
BETOS: D1E Other DME

C **A4602** Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each DME N
BETOS: D1E Other DME
DME Modifier: NU

C **A4604** Tubing with integrated heating element for use with positive airway pressure device DME N
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A4605** Tracheal suction catheter, closed system, each DME N
BETOS: D1E Other DME
DME Modifier: NU

C **A4606** Oxygen probe for use with oximeter device, replacement N
BETOS: D1E Other DME
Service not separately priced by Part B

C **A4608** Transtracheal oxygen catheter, each DME N
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

RESPIRATORY SUPPLIES AND EQUIPMENT (A4611-A4629)

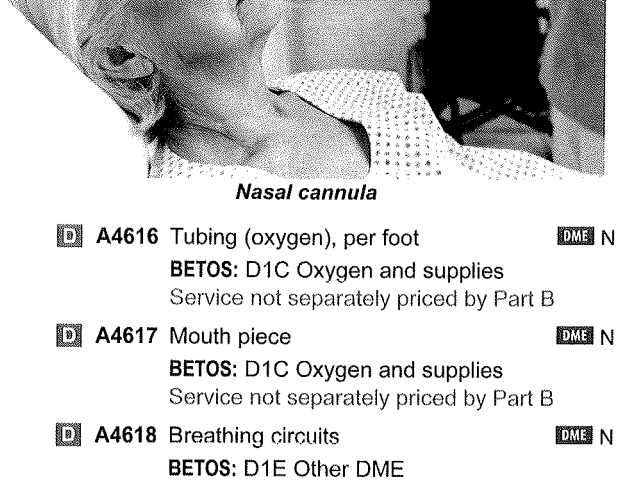
S **A4611** Battery, heavy duty; replacement for patient owned ventilator E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1834a3A

S **A4612** Battery cables; replacement for patient-owned ventilator E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1834a3A

S **A4613** Battery charger; replacement for patient-owned ventilator E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1834a3A

C **A4614** Peak expiratory flow rate meter, hand held DME N
BETOS: Z2 Undefined codes

D **A4615** Cannula, nasal DME N
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B


Nasal cannula

D **A4616** Tubing (oxygen), per foot DME N
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **A4617** Mouth piece DME N
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **A4618** Breathing circuits DME N
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **A4619** Face tent DME N
BETOS: D1E Other DME
DME Modifier: NU

D **A4620** Variable concentration mask DME N
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **A4623** Tracheostomy, inner cannula DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A4624** Tracheal suction catheter, any type other than closed system, each DME N
BETOS: D1E Other DME
DME Modifier: NU

D **A4625** Tracheostomy care kit for new tracheostomy DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A4626** Tracheostomy cleaning brush, each DME N
BETOS: D1F Prosthetic/Orthotic devices

M **A4627** Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

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C **A4628** Oral and/or oropharyngeal suction catheter, each DME N
BETOS: D1E Other DME
DME Modifier: NU
Coding Clinic: 2023, Q2

D **A4629** Tracheostomy care kit for established tracheostomy DME N
BETOS: D1F Prosthetic/Orthotic devices

REPLACEMENT PARTS (A4630-A4640)

D **A4630** Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient DME E1
BETOS: D1E Other DME
DME Modifier: NU

C **A4633** Replacement bulb/lamp for ultraviolet light therapy system, each DME E1
BETOS: D1E Other DME
DME Modifier: NU

C **A4634** Replacement bulb for therapeutic light box, tabletop model N
BETOS: D1E Other DME
Service not separately priced by Part B

D **A4635** Underarm pad, crutch, replacement, each DME E1
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **A4636** Replacement, handgrip, cane, crutch, or walker, each DME E1
BETOS: D1E Other DME
DME Modifier: KE, NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

D **A4637** Replacement, tip, cane, crutch, walker, each. DME E1
BETOS: D1E Other DME
DME Modifier: KE, NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

C **A4638** Replacement battery for patient-owned ear pulse generator, each DME E1
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **A4639** Replacement pad for infrared heating pad system, each DME E1
BETOS: D1E Other DME
DME Modifier: RR
Pub: 100-4, Chapter-5, 20.4

D **A4640** Replacement pad for use with medically necessary alternating pressure pad owned by patient DME E1
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

DIAGNOSTIC RADIOPHARMACEUTICALS (A4641-A4642), SEE ALSO DIAGNOSTIC AND THERAPEUTIC RADIOPHARMACEUTICALS (A9500-A9800)

C **A4641** Radiopharmaceutical, diagnostic, not otherwise classified N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4
Pub: 100-4, Chapter-13, 60.3

C **A4642** Indium In-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2002, Q2; 2005, Q4

OTHER SUPPLIES (A4648-A4652)

C **A4648** Tissue marker, implantable, any type, each N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2013, Q3; 2018, Q2; 2024, Q3

C **A4649** Surgical supply; miscellaneous N
BETOS: D1A Medical/surgical supplies
Coding Clinic: 2023, Q3

C **A4650** Implantable radiation dosimeter, each N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced

D **A4651** Calibrated microcapillary tube, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4652** Microcapillary tube sealant N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

DIALYSIS EQUIPMENT AND SUPPLIES (A4653-A4932)

C **A4653** Peritoneal dialysis catheter anchoring device, belt, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

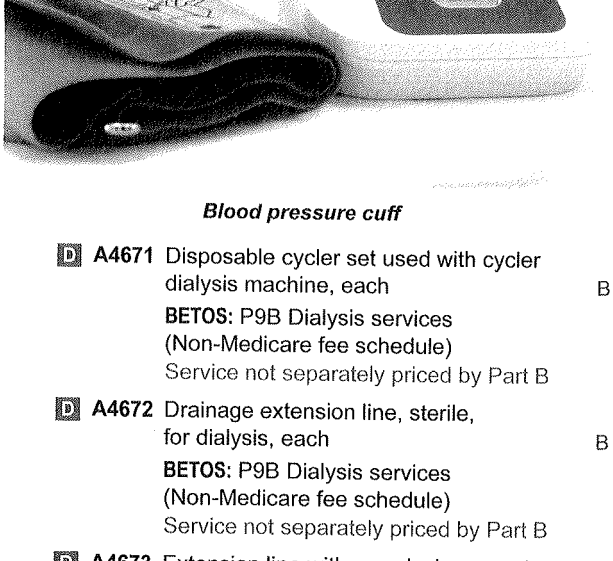
D **A4657** Syringe, with or without needle, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1
Pub: 100-4, Chapter-8, 60.6

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D A4660 Sphygmomanometer/blood pressure apparatus with cuff and stethoscope N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4663** Blood pressure cuff only N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

M **A4670** Automatic blood pressure monitor E1
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B



Blood pressure cuff

D **A4671** Disposable cycler set used with cycler dialysis machine, each B
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4672** Drainage extension line, sterile, for dialysis, each B
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4673** Extension line with easy lock connectors, used with dialysis B
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4674** Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz B
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4680** Activated carbon filter for hemodialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4690** Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4706** Bicarbonate concentrate, solution, for hemodialysis, per gallon N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4707** Bicarbonate concentrate, powder, for hemodialysis, per packet N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4708** Acetate concentrate solution, for hemodialysis, per gallon N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4709** Acid concentrate, solution, for hemodialysis, per gallon N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4714** Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4719** "Y set" tubing for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4720** Dialysate solution, any concentration of dextrose, fluid volume greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4721** Dialysate solution, any concentration of dextrose, fluid volume greater than 999 cc but less than or equal to 1999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

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D **A4722** Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc but less than or equal to 2999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4723** Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc but less than or equal to 3999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4724** Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc but less than or equal to 4999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4725** Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc but less than or equal to 5999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4726** Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

C **A4728** Dialysate solution, non-dextrose containing, 500 ml B
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4730** Fistula cannulation set for hemodialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4736** Topical anesthetic, for dialysis, per gram N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4737** Injectable anesthetic, for dialysis, per 10 ml N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4740** Shunt accessory, for hemodialysis, any type, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4750** Blood tubing, arterial or venous, for hemodialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4755** Blood tubing, arterial and venous combined, for hemodialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4760** Dialysate solution test kit, for peritoneal dialysis, any type, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4765** Dialysate concentrate, powder, additive for peritoneal dialysis, per packet N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4766** Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4770** Blood collection tube, vacuum, for dialysis, per 50 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4771** Serum clotting time tube, for dialysis, per 50 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4772** Blood glucose test strips, for dialysis, per 50 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4773** Occult blood test strips, for dialysis, per 50 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4774** Ammonia test strips, for dialysis, per 50 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

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D **A4802** Protamine sulfate, for hemodialysis, per 50 mg N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4860** Disposable catheter tips for peritoneal dialysis, per 10 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4870** Plumbing and/or electrical work for home hemodialysis equipment N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4890** Contracts, repair and maintenance, for hemodialysis equipment N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4911** Drain bag/bottle, for dialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4913** Miscellaneous dialysis supplies, not otherwise specified N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4918** Venous pressure clamp, for hemodialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4927** Gloves, non-sterile, per 100 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **A4928** Surgical mask, per 20 N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4929** Tourniquet for dialysis, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A4930** Gloves, sterile, per pair N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

C **A4931** Oral thermometer, reusable, any type, each N
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

C **A4932** Rectal thermometer, reusable, any type, each N
BETOS: Z2 Undefined codes
Service not separately priced by Part B

OSTOMY POUCHES AND SUPPLIES (A5051-A5093), SEE ALSO OSTOMY POUCHES AND SUPPLIES (A4361-A4437)

D **A5051** Ostomy pouch, closed; with barrier attached (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5052** Ostomy pouch, closed; without barrier attached (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5053** Ostomy pouch, closed; for use on faceplate, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5054** Ostomy pouch, closed; for use on barrier with flange (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5055** Stoma cap DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5056** Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5057** Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A5061** Ostomy pouch, drainable; with barrier attached, (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5062** Ostomy pouch, drainable; without barrier attached (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5063** Ostomy pouch, drainable; for use on barrier with flange (2-piece system), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5071** Ostomy pouch, urinary; with barrier attached (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5072** Ostomy pouch, urinary; without barrier attached (1-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5073** Ostomy pouch, urinary; for use on barrier with flange (2-piece), each DME N
BETOS: D1F Prosthetic/Orthotic devices

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D **A5081** Stoma plug or seal, any type DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5082** Continent device; catheter for continent stoma DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A5083** Continent device, stoma absorptive cover for continent stoma DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5093** Ostomy accessory; convex insert DME N
BETOS: D1F Prosthetic/Orthotic devices

INCONTINENCE DEVICES AND SUPPLIES (A5102-A5200), SEE ALSO INCONTINENCE DEVICES AND SUPPLIES (A4310-A4360)

D **A5102** Bedside drainage bottle with or without tubing, rigid or expandable, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5105** Urinary suspensory with leg bag, with or without tube, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5112** Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5113** Leg strap; latex, replacement only, per set DME E1
BETOS: D1F Prosthetic/Orthotic devices

D **A5114** Leg strap; foam or fabric, replacement only, per set DME E1
BETOS: D1F Prosthetic/Orthotic devices

D **A5120** Skin barrier, wipes or swabs, each DME N
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: AU, AV

D **A5121** Skin barrier; solid, 6 x 6 or equivalent, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5122** Skin barrier; solid, 8 x 8 or equivalent, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5126** Adhesive or non-adhesive; disk or foam pad DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5131** Appliance cleaner, incontinence and ostomy appliances, per 16 oz DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A5200** Percutaneous catheter/tube anchoring device, adhesive skin attachment DME N
BETOS: D1F Prosthetic/Orthotic devices

DIABETIC FOOTWEAR (A5500-A5514)

D **A5500** For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi- density insert(s), per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5501** For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5503** For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5504** For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5505** For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5506** For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5507** For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5508** For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5510** For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

D **A5512** For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each DME Y
BETOS: D1F Prosthetic/Orthotic devices

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D **A5513** For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each DME Y
BETOS: D1F Prosthetic/Orthotic devices

D **A5514** For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each DME Y
BETOS: D1F Prosthetic/Orthotic devices

MISCELLANEOUS DRESSING AND WOUND SUPPLIES (A6000-A6208)

M **A6000** Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card E1
BETOS: D1E Other DME
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **A6010** Collagen based wound filler, dry form, sterile, per gram of collagen DME N
BETOS: D1A Medical/surgical supplies
Coding Clinic: 2002, Q1

D **A6011** Collagen based wound filler, gel/paste, per gram of collagen DME N
BETOS: D1A Medical/surgical supplies

D **A6021** Collagen dressing, sterile, size 16 sq. in. or less, each DME N
BETOS: D1A Medical/surgical supplies

D **A6022** Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each DME N
BETOS: D1A Medical/surgical supplies

D **A6023** Collagen dressing, sterile, size more than 48 sq. in., each DME N
BETOS: D1A Medical/surgical supplies

D **A6024** Collagen dressing wound filler, sterile, per 6 inches DME N
BETOS: D1A Medical/surgical supplies

C **A6025** Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A6154** Wound pouch, each DME N
BETOS: D1A Medical/surgical supplies

D **A6196** Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6197** Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6198** Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing N
BETOS: D1A Medical/surgical supplies

D **A6199** Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches DME N
BETOS: D1A Medical/surgical supplies

D **A6203** Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6204** Composite dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6205** Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6206** Contact layer, sterile, 16 sq. in. or less, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6207** Contact layer, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6208** Contact layer, sterile, more than 48 sq. in., each dressing N
BETOS: D1A Medical/surgical supplies

FOAM DRESSINGS (A6209-A6215)

D **A6209** Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6210** Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6211** Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

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D **A6212** Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6213** Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6214** Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6215** Foam dressing, wound filler, sterile, per gram N
BETOS: D1A Medical/surgical supplies

GAUZE DRESSINGS (A6216-A6233)

D **A6216** Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6217** Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6218** Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6219** Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6220** Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6221** Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6222** Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6223** Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6224** Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6228** Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6229** Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6230** Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6231** Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in. or less, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6232** Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6233** Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing DME N
BETOS: D1A Medical/surgical supplies

HYDROCOLLOID DRESSINGS (A6234-A6241)

D **A6234** Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6235** Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6236** Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6237** Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6238** Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

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D **A6239** Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6240** Hydrocolloid dressing, wound filler, paste, sterile, per ounce DME N
BETOS: D1A Medical/surgical supplies

D **A6241** Hydrocolloid dressing, wound filler, dry form, sterile, per gram DME N
BETOS: D1A Medical/surgical supplies

HYDROGEL DRESSINGS (A6242-A6248)

D **A6242** Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6243** Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6244** Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6245** Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6246** Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6247** Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6248** Hydrogel dressing, wound filler, gel, per fluid ounce DME N
BETOS: D1A Medical/surgical supplies

OTHER DRESSINGS, COVERINGS, AND WOUND TREATMENT SUPPLIES (A6250-A6412)

D **A6250** Skin sealants, protectants, moisturizers, ointments, any type, any size N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A6251** Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6252** Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6253** Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6254** Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6255** Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6256** Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

D **A6257** Transparent film, sterile, 16 sq. in. or less, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6258** Transparent film, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6259** Transparent film, sterile, more than 48 sq. in., each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6260** Wound cleansers, any type, any size N
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A6261** Wound filler, gel/paste, per fluid ounce, not otherwise specified N
BETOS: D1A Medical/surgical supplies

D **A6262** Wound filler, dry form, per gram, not otherwise specified N
BETOS: D1A Medical/surgical supplies

D **A6266** Gauze, impregnated, other than water, normal saline, or zinc paste, sterile, any width, per linear yard DME N
BETOS: D1A Medical/surgical supplies

D **A6402** Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

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D **A6403** Gauze, non-impregnated, sterile, pad size more than 16 sq. in. less than or equal to 48 sq. in., without adhesive border, each dressing DME N
BETOS: D1A Medical/surgical supplies

D **A6404** Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

C **A6407** Packing strips, non-impregnated, sterile, up to 2 inches in width, per linear yard DME N
BETOS: D1A Medical/surgical supplies

D **A6410** Eye pad, sterile, each DME N
BETOS: D1A Medical/surgical supplies

D **A6411** Eye pad, non-sterile, each DME N
BETOS: D1A Medical/surgical supplies

C **A6412** Eye patch, occlusive, each N
BETOS: Z2 Undefined codes
Service not separately priced by Part B

BANDAGES (A6413-A6461)

S **A6413** Adhesive bandage, first-aid type, any size, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B
Statute: 1861(s)(5)

C **A6441** Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6442** Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than 3 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6443** Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6444** Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6445** Conforming bandage, non-elastic, knitted/woven, sterile, width less than 3 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6446** Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

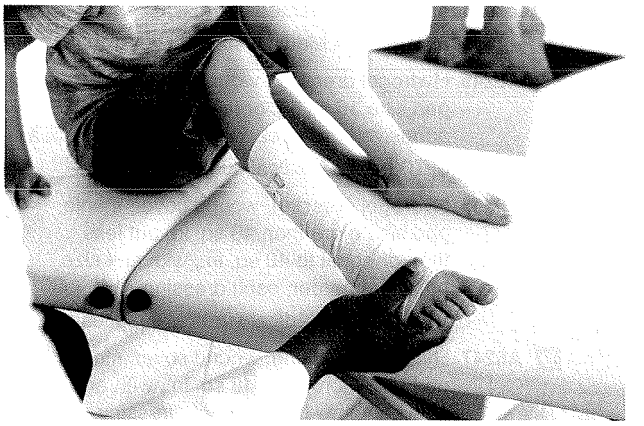
C **A6447** Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6448** Light compression bandage, elastic, knitted/woven, width less than 3 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6449** Light compression bandage, elastic, knitted/woven, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6450** Light compression bandage, elastic, knitted/woven, width greater than or equal to 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6451** Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies



Elastic ACE compression bandage

C **A6452** High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6453** Self-adherent bandage, elastic, non-knitted/non-woven, width less than 3 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6454** Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

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C **A6455** Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6456** Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to 3 inches and less than 5 inches, per yard DME N
BETOS: D1A Medical/surgical supplies

C **A6457** Tubular dressing with or without elastic, any width, per linear yard DME N
BETOS: D1A Medical/surgical supplies

C **A6460** Synthetic resorbable wound dressing, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

C **A6461** Synthetic resorbable wound dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing N
BETOS: D1A Medical/surgical supplies

COMPRESSION GARMENTS AND STOCKINGS (A6501-A6589)

D **A6501** Compression burn garment, bodysuit (head to foot), custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6502** Compression burn garment, chin strap, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6503** Compression burn garment, facial hood, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6504** Compression burn garment, glove to wrist, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6505** Compression burn garment, glove to elbow, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6506** Compression burn garment, glove to axilla, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6507** Compression burn garment, foot to knee length, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6508** Compression burn garment, foot to thigh length, custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6509** Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6510** Compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6511** Compression burn garment, lower trunk including leg openings (panty), custom fabricated DME N
BETOS: D1A Medical/surgical supplies

D **A6512** Compression burn garment, not otherwise classified N
BETOS: D1A Medical/surgical supplies

C **A6513** Compression burn mask, face and/or neck, plastic or equal, custom fabricated DME B
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

C **A6520** Gradient compression garment, glove, padded, for nighttime use, each DME A

C **A6521** Gradient compression garment, glove, padded, for nighttime use, custom, each DME A

C **A6522** Gradient compression garment, arm, padded, for nighttime use, each DME A

C **A6523** Gradient compression garment, arm, padded, for nighttime use, custom, each DME A

C **A6524** Gradient compression garment, lower leg and foot, padded, for nighttime use, each DME A

C **A6525** Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each DME A

C **A6526** Gradient compression garment, full leg and foot, padded, for nighttime use, each DME A

C **A6527** Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each DME A

C **A6528** Gradient compression garment, bra, for nighttime use, each DME A

C **A6529** Gradient compression garment, bra, for nighttime use, custom, each DME A

C **A6530** Gradient compression stocking, below knee, 18-30 mmHg, each DME A

D **A6531** Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each DME A
BETOS: D1A Medical/surgical supplies
DME Modifier: AW

D **A6532** Gradient compression stocking, below knee, 40-50 mmhg, used as a surgical dressing, each DME A
BETOS: D1A Medical/surgical supplies
DME Modifier: AW

C **A6533** Gradient compression stocking, thigh length, 18-30 mmHg, each DME A

C **A6534** Gradient compression stocking, thigh length, 30-40 mmHg, each DME A

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **A6535** Gradient compression stocking, thigh length, 40 mmhg or greater, each DME A

C **A6536** Gradient compression stocking, full length/chap style, 18-30 mmHg, each DME A

C **A6537** Gradient compression stocking, full length/chap style, 30-40 mmHg, each DME A

C **A6538** Gradient compression stocking, full length/chap style, 40 mmhg or greater, each DME A

C **A6539** Gradient compression stocking, waist length, 18-30 mmHg, each DME A

C **A6540** Gradient compression stocking, waist length, 30-40 mmHg, each DME A

C **A6541** Gradient compression stocking, waist length, 40 mmhg or greater, each DME A

M **A6544** Gradient compression stocking, garter belt E1

BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

D **A6545** Gradient compression wrap, non-elastic, below knee, 30-50 mmhg, used as a surgical dressing, each DME A

BETOS: D1A Medical/surgical supplies
DME Modifier: AW
Coding Clinic: 2008, Q4

C **A6549** Gradient compression garment, not otherwise specified A

C **A6550** Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories DME N

BETOS: D1E Other DME

C **A6552** Gradient compression stocking, below knee, 30-40 mmhg, each DME A

C **A6553** Gradient compression stocking, below knee, 30-40 mmhg, custom, each DME A

C **A6554** Gradient compression stocking, below knee, 40 mmhg or greater, each DME A

C **A6555** Gradient compression stocking, below knee, 40 mmhg or greater, custom, each DME A

C **A6556** Gradient compression stocking, thigh length, 18-30 mmhg, custom, each DME A

C **A6557** Gradient compression stocking, thigh length, 30-40 mmhg, custom, each DME A

C **A6558** Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each DME A

C **A6559** Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each A

C **A6560** Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each A

C **A6561** Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each A

C **A6562** Gradient compression stocking, waist length, 18-30 mmhg, custom, each DME A

C **A6563** Gradient compression stocking, waist length, 30-40 mmhg, custom, each DME A

C **A6564** Gradient compression stocking, waist length, 40 mmhg or greater, custom, each DME A

C **A6565** Gradient compression gauntlet, custom, each DME A

C **A6566** Gradient compression garment, neck/head, each DME A

C **A6567** Gradient compression garment, neck/head, custom, each DME A

C **A6568** Gradient compression garment, torso and shoulder, each DME A

C **A6569** Gradient compression garment, torso/shoulder, custom, each DME A

C **A6570** Gradient compression garment, genital region, each DME A

C **A6571** Gradient compression garment, genital region, custom, each DME A

C **A6572** Gradient compression garment, toe caps, each DME A

C **A6573** Gradient compression garment, toe caps, custom, each DME A

C **A6574** Gradient compression arm sleeve and glove combination, custom, each DME A

C **A6575** Gradient compression arm sleeve and glove combination, each DME A

C **A6576** Gradient compression arm sleeve, custom, medium weight, each DME A

C **A6577** Gradient compression arm sleeve, custom, heavy weight, each DME A

C **A6578** Gradient compression arm sleeve, each DME A

C **A6579** Gradient compression glove, custom, medium weight, each DME A

C **A6580** Gradient compression glove, custom, heavy weight, each DME A

C **A6581** Gradient compression glove, each DME A

C **A6582** Gradient compression gauntlet, each DME A

C **A6583** Gradient compression wrap with adjustable straps, below knee, 30-50 mmhg, each DME A

C **A6584** Gradient compression wrap with adjustable straps, not otherwise specified A

C **A6585** Gradient pressure wrap with adjustable straps, above knee, each DME A

C **A6586** Gradient pressure wrap with adjustable straps, full leg, each DME A

C **A6587** Gradient pressure wrap with adjustable straps, foot, each DME A

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C **A6588** Gradient pressure wrap with adjustable straps, arm, each DME A

C **A6589** Gradient pressure wrap with adjustable straps, bra, each DME A

EXTERNAL URINARY CATHETERS (DISPOSABLE AND NON-DISPOSABLE) (A6590-A6610)

C **A6590** External urinary catheters; disposable, with wicking material, for use with suction pump, per month DME N
BETOS: D1E Other DME
Coding Clinic: 2023, Q2

C **A6591** External urinary catheter; non-disposable, for use with suction pump, per month DME N
BETOS: D1E Other DME
Coding Clinic: 2023, Q2

C **A6593** Accessory for gradient compression garment or wrap with adjustable straps, not-otherwise specified A

C **A6594** Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each DME A

C **A6595** Gradient compression bandaging supply, bandage liner, upper extremity, any size or length, each DME A

C **A6596** Gradient compression bandaging supply, conforming gauze, per linear yard, any width, each DME A

C **A6597** Gradient compression bandage roll, elastic long stretch, linear yard, any width, each DME A

C **A6598** Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each DME A

C **A6599** Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each DME A

C **A6600** Gradient compression bandaging supply, high density foam sheet, per 250 square centimeters, each DME A

C **A6601** Gradient compression bandaging supply, high density foam pad, any size or shape, each DME A

C **A6602** Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each DME A

C **A6603** Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each DME A

C **A6604** Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each DME A

C **A6605** Gradient compression bandaging supply, padded foam, per linear yard, any width, each DME A

C **A6606** Gradient compression bandaging supply, padded textile, per linear yard, any width, each DME A

C **A6607** Gradient compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each DME A

C **A6608** Gradient compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each DME A

C **A6609** Gradient compression bandaging supply, not otherwise specified A

C **A6610** Gradient compression stocking, below knee, 18-30 mmhg, custom, each DME A

BREATHING AIDS (A7000-A7049), SEE ALSO INTERMITTENT POSITIVE PRESSURE BREATHING DEVICES (E0500; OTHER BREATHING AIDS (E0605, E0606); ASSISTED BREATHING SUPPLIES (S8096-S8210)

C **A7000** Canister, disposable, used with suction pump, each DME Y
BETOS: D1E Other DME
DME Modifier: KE, NU

C **A7001** Canister, non-disposable, used with suction pump, each DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7002** Tubing, used with suction pump, each DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7003** Administration set, with small volume nonfiltered pneumatic nebulizer, disposable DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7004** Small volume nonfiltered pneumatic nebulizer, disposable DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7005** Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7006** Administration set, with small volume filtered pneumatic nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7007** Large volume nebulizer, disposable, unfilled, used with aerosol compressor DME Y
BETOS: D1E Other DME
DME Modifier: NU

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C **A7008** Large volume nebulizer, disposable, prefilled, used with aerosol compressor DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7009** Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7010** Corrugated tubing, disposable, used with large volume nebulizer, 100 feet DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7012** Water collection device, used with large volume nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7013** Filter, disposable, used with aerosol compressor or ultrasonic generator DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7014** Filter, nondisposable, used with aerosol compressor or ultrasonic generator DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7015** Aerosol mask, used with DME nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7016** Dome and mouthpiece, used with small volume ultrasonic nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: NU

D **A7017** Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **A7018** Water, distilled, used with large volume nebulizer, 1000 ml DME Y
BETOS: D1E Other DME

C **A7020** Interface for cough stimulating device, includes all components, replacement only DME Y
BETOS: D1E Other DME
DME Modifier: NU

● C **A7021** Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter) DME
BETOS: D1E Other DME
DME Modifier: NU

S **A7023** Mechanical allergen particle barrier/ inhalation filter, cream, nasal, topical E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

C **A7025** High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each DME N
BETOS: D1E Other DME
DME Modifier: RR

C **A7026** High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7027** Combination oral/nasal mask, used with continuous positive airway pressure device, each DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7028** Oral cushion for combination oral/nasal mask, replacement only, each DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7029** Nasal pillows for combination oral/ nasal mask, replacement only, pair DME Y
BETOS: D1E Other DME
DME Modifier: NU

C **A7030** Full face mask used with positive airway
pressure device, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7031** Face mask interface, replacement for full face mask, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7032** Cushion for use on nasal mask interface, replacement only, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7033** Pillow for use on nasal cannula type interface, replacement only, pair DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7034** Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

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C A7035 Headgear used with positive airway pressure device DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7036** Chinstrap used with positive airway pressure device DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7037** Tubing used with positive airway pressure device DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7038** Filter, disposable, used with positive airway pressure device DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7039** Filter, non disposable, used with positive airway pressure device DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7040** One way chest drain valve DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7041** Water seal drainage container and tubing for use with implanted chest tube DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7044** Oral interface used with positive airway pressure device, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

D **A7045** Exhalation port with or without swivel used with accessories for positive airway devices, replacement only DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

D **A7046** Water chamber for humidifier, used with positive airway pressure device, replacement, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Pub: 100-4, Chapter-36, 50.14

C **A7047** Oral interface used with respiratory suction pump, each DME N
BETOS: D1E Other DME
DME Modifier: NU

C **A7048** Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each DME N
BETOS: D1F Prosthetic/Orthotic devices

S **A7049** Expiratory positive airway pressure intranasal resistance valve E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2023, Q2

TRACHEOSTOMY SUPPLIES (A7501-A7527)

D **A7501** Tracheostoma valve, including diaphragm, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7502** Replacement diaphragm/faceplate for tracheostoma valve, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7503** Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7504** Filter for use in a tracheostoma heat and moisture exchange system, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7505** Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7506** Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7507** Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7508** Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each DME N
BETOS: D1F Prosthetic/Orthotic devices

D **A7509** Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7520** Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each DME N
BETOS: D1F Prosthetic/Orthotic devices

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C **A7521** Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7522** Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7523** Tracheostomy shower protector, each N
BETOS: D1F Prosthetic/Orthotic devices

C **A7524** Tracheostoma stent/stud/button, each DME N
BETOS: D1F Prosthetic/Orthotic devices

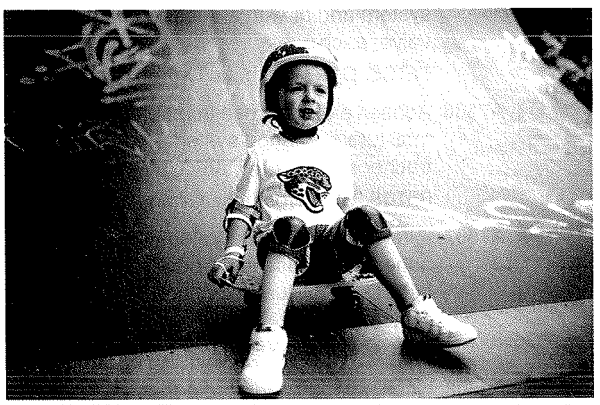
C **A7525** Tracheostomy mask, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7526** Tracheostomy tube collar/holder, each DME N
BETOS: D1F Prosthetic/Orthotic devices

C **A7527** Tracheostomy/laryngectomy tube plug/stop, each DME N
BETOS: D1A Medical/surgical supplies

HELMETS (A8000-A8004)

C **A8000** Helmet, protective, soft, prefabricated, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE



Helmet

C **A8001** Helmet, protective, hard, prefabricated, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **A8002** Helmet, protective, soft, custom fabricated, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **A8003** Helmet, protective, hard, custom fabricated, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **A8004** Soft interface for helmet, replacement only DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

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ADMINISTRATIVE, MISCELLANEOUS AND INVESTIGATIONAL (A9150-A9999)

MISCELLANEOUS SUPPLIES AND EQUIPMENT (A9150-A9300)

D **A9150** Non-prescription drugs B
BETOS: O1E Other drugs
Other carrier priced

I **A9152** Single vitamin/mineral/trace element, oral, per dose, not otherwise specified E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **A9153** Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **A9155** Artificial saliva, 30 ml B
BETOS: Z2 Undefined codes
Other carrier priced

D **A9156** Oral mucoadhesive, any type (liquid, gel, paste, etc.), per 1 ml N1 ASC N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q4

I **A9180** Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S **A9268** Programmer for transient, orally ingested capsule Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2023, Q4

S **A9269** Programable, transient, orally ingested capsule, for use with external programmer, per month E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2023, Q4

M **A9270** Non-covered item or service E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **A9272** Wound suction, disposable, includes dressing, all accessories and components, any type, each A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **A9273** Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S **A9274** External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B
Statute: 1861(n)

M **A9275** Home glucose disposable monitor, includes test strips E1
BETOS: T1E Lab tests - glucose
Service not separately priced by Part B

S **A9276** Sensor; invasive (e.g., subcutaneous), disposable, for use with non-durable medical equipment interstitial continuous glucose monitoring system, one unit = 1 day supply E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

S **A9277** Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

S **A9278** Receiver (monitor); external, for use with non-durable medical equipment interstitial continuous glucose monitoring system E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

S **A9279** Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified E1
BETOS: T2D Other tests - other
Service not separately priced by Part B
Statute: 1861(n)

S **A9280** Alert or alarm device, not otherwise classified E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861

S **A9281** Reaching/grabbing device, any type, any length, each E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1862 SSA

S **A9282** Wig, any type, each E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861SSA

S **A9283** Foot pressure off loading/supportive device, any type, each E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1862a(i)13

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **A9284** Spirometer, non-electronic, includes all accessories N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **A9285** Inversion/eversion correction device A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S **A9286** Hygienic item or device, disposable or non-disposable, any type, each E1
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B
Statute: 1834

C **A9291** Prescription digital cognitive and/or behavioral therapy, fda cleared, per course of treatment Ⓐ E1
BETOS: Z2 Undefined codes
Value not established
Coding Clinic: 2022, Q4

C **A9292** Prescription digital visual therapy, software-only, fda cleared, per course of treatment Ⓐ E1
BETOS: Z2 Undefined codes
Value not established
Coding Clinic: 2023, Q4

● C **A9293** Fertility cycle (contraception & conception) tracking software application, fda cleared, per month, includes accessories (e.g., thermometer) ♀ Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q2

M **A9300** Exercise equipment E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

DIAGNOSTIC AND THERAPEUTIC RADIOPHARMACEUTICALS (A9500-A9800), SEE ALSO DIAGNOSTIC RADIOPHARMACEUTICALS (A4641-A4642)

C **A9500** Technetium Tc-99m sestamibi, diagnostic, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4; 2006, Q2

C **A9501** Technetium Tc-99m teboroxime, diagnostic, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q1

C **A9502** Technetium Tc-99m tetrofosmin, diagnostic, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4; 2006, Q2

C **A9503** Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2002, Q2; 2004, Q3; 2005, Q4

C **A9504** Technetium Tc-99m apcitide, diagnostic, per study dose, up to 20 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2001, Q4; 2002, Q2

C **A9505** Thallium Tl-201 thallous chloride, diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2002, Q2; 2004, Q3; 2005, Q4

● C **A9506** Graphite crucible for preparation of technetium tc 99m-labeled carbon aerosol, one crucible K2 ASC G
BETOS: Z2 Undefined codes
Value not established
Drugs: TECHNEGAS
Coding Clinic: 2024, Q3

C **A9507** Indium In-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries N1 ♂ ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9508** Iodine I-131 iobenguane sulfate, diagnostic, per 0.5 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2002, Q2; 2005, Q4

C **A9509** Iodine I-123 sodium iodide, diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q1

C **A9510** Technetium Tc-99m disofenin, diagnostic, per study dose, up to 15 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9512** Technetium Tc-99m pertechnetate, diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

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D A9513 Lutetium lu 177, dotatate, therapeutic, 1 millicurie K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: LUTATHERA
Coding Clinic: 2005, Q4; 2019, Q1

C A9515 Choline c-11, diagnostic, per study dose up to 20 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9516 Iodine I-123 sodium iodide, diagnostic, per 100 microcuries, up to 999 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9517 Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4; 2008, Q3

C A9520 Technetium Tc-99m, tilmanocept, diagnostic, up to 0.5 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4; 2013, Q4

C A9521 Technetium Tc-99m exametazime, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9524 Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9526 Nitrogen N-13 ammonia, diagnostic, per study dose, up to 40 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4; 2022, Q1
Pub: 100-4, Chapter-13, 60.3

C A9527 Iodine I-125, sodium iodide solution, therapeutic, per millicurie H2 ASC U
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

C A9528 Iodine I-131 sodium iodide capsule(s), diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9529 Iodine I-131 sodium iodide solution, diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9530 Iodine I-131 sodium iodide solution, therapeutic, per millicurie K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9531 Iodine I-131 sodium iodide, diagnostic, per microcurie (up to 100 microcuries) N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9532 Iodine I-125 serum albumin, diagnostic, per 5 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9536 Technetium Tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9537 Technetium Tc-99m mebrofenin, diagnostic, per study dose, up to 15 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9538 Technetium Tc-99m pyrophosphate, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C A9539 Technetium Tc-99m pentetate, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

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C **A9540** Technetium Tc-99m macroaggregated albumin, diagnostic, per study dose, up to 10 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9541** Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 20 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9542** Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9543** Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries K
BETOS: I1E Standard imaging - nuclear medicine
Drugs: ZEVALIN Y-90, ZEVALIN Y-91
Coding Clinic: 2005, Q4

C **A9546** Cobalt Co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9547** Indium In-111 oxyquinoline, diagnostic, per 0.5 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9548** Indium In-111 pentetate, diagnostic, per 0.5 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9550** Technetium Tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9551** Technetium Tc-99m succimer, diagnostic, per study dose, up to 10 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9552** Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4; 2008, Q3; 2022, Q1
Pub: 100-4, Chapter-13, 60.16

C **A9553** Chromium Cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9554** Iodine I-125 sodium iothalamate, diagnostic, per study dose, up to 10 microcuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4

C **A9555** Rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Value not established
Coding Clinic: 2005, Q4; 2022, Q1

C **A9556** Gallium Ga-67 citrate, diagnostic, per millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9557** Technetium Tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9558** Xenon Xe-133 gas, diagnostic, per 10 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9559** Cobalt Co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

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C **A9560** Technetium Tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4; 2008, Q3

C **A9561** Technetium Tc-99m oxidronate, diagnostic, per study dose, up to 30 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9562** Technetium Tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9563** Sodium phosphate P-32, therapeutic, per millicurie N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9564** Chromic phosphate P-32 suspension, therapeutic, per millicurie E1
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9566** Technetium Tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9567** Technetium Tc-99m pentetate, diagnostic, aerosol, per study dose, up to 75 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

C **A9568** Technetium Tc-99m arcitumomab, diagnostic, per study dose, up to 45 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine

C **A9569** Technetium Tc-99m exametazime labeled autologous white blood cells, diagnostic, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q1

C **A9570** Indium In-111 labeled autologous white blood cells, diagnostic, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q1

C **A9571** Indium In-111 labeled autologous platelets, diagnostic, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q1

C **A9572** Indium In-111 pentetreotide, diagnostic, per study dose, up to 6 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q1

C **A9573** Injection, gadopiclenol, 1 ml N1 Ⓐ ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: ELUCIREM, VUEWAY
Coding Clinic: 2023, Q4

C **A9575** Injection, gadoterate meglumine, 0.1 ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: CLARISCAN, DOTAREM, GADOTERATE MEGLUMINE
Coding Clinic: 2014, Q1

C **A9576** Injection, gadoteridol, (ProHance multipack), per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: PROHANCE MULTIPACK
Coding Clinic: 2008, Q1

C **A9577** Injection, gadobenate dimeglumine (MultiHance), per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: MULTIHANCE
Coding Clinic: 2008, Q1

C **A9578** Injection, gadobenate dimeglumine (MultiHance multipack), per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: MULTIHANCE MULTIPACK
Coding Clinic: 2008, Q1

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C **A9579** Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: MAGNEVIST, OMNISCAN, PROHANCE, PROHANCE PREFILLED SYRINGES
Coding Clinic: 2008, Q1

C **A9580** Sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2008, Q4; 2009, Q1
Pub: 100-4, Chapter-13, 60.18

C **A9581** Injection, gadoxetate disodium, 1 ml N1 ASC N
BETOS: I2D Advanced imaging - MRI/MRA: other
Drugs: EOVIST, GADOXETATE DISODIUM

C **A9582** Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine

C **A9583** Injection, gadofosveset trisodium, 1 ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine

C **A9584** Iodine 1-123 ioflupane, diagnostic, per study dose, up to 5 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced

C **A9585** Injection, gadobutrol, 0.1 ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: GADAVIST, GADOBUTROL
Coding Clinic: 2012, Q1

D **A9586** Florbetapir F18, diagnostic, per study dose, up to 10 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Service not separately priced by Part B
Coding Clinic: 2014, Q1; 2014, Q3

C **A9587** Gallium ga-68, dotatate, diagnostic, 0.1 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2017, Q1

C **A9588** Fluciclovine f-18, diagnostic, 1 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2017, Q1

C **A9589** Instillation, hexaminolevulinate hydrochloride, 100 mg N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: CYSVIEW
Coding Clinic: 2019, Q1

C **A9590** Iodine i-131, iobenguane, 1 millicurie K2 ASC K
BETOS: I1E Standard imaging - nuclear medicine

C **A9591** Fluoroestradiol f 18, diagnostic, 1 millicurie N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2021, Q1

C **A9592** Copper cu-64, dotatate, diagnostic, 1 millicurie N1 ⓪ ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2021, Q1

C **A9593** Gallium ga-68 psma-11, diagnostic, (ucsf), 1 millicurie N1 ♂ ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2021, Q3

C **A9594** Gallium ga-68 psma-11, diagnostic, (ucla), 1 millicurie N1 ♂ ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2021, Q3

C **A9595** Piflufolastat f-18, diagnostic, 1 millicurie K2 ♂ ASC G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: PYLARIFY
Coding Clinic: 2022, Q1

C **A9596** Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie K2 ♂ ASC G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: ILLUCCIX
Coding Clinic: 2022, Q3

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C **A9597** Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2017, Q1; 2017, Q1
Pub: 100-4, Chapter-13, 60.3.2

C **A9598** Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2017, Q1; 2017, Q1
Pub: 100-4, Chapter-13, 60.3.2

C **A9600** Strontium Sr-89 chloride, therapeutic, per millicurie K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: STRONTIUM CHLORIDE SR 89
Coding Clinic: 2002, Q2; 2005, Q4

C **A9601** Flortaucipir f 18 injection, diagnostic, 1 millicurie K2 Ⓐ ASC G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: TAUVID
Coding Clinic: 2022, Q3

C **A9602** Fluorodopa f-18, diagnostic, per millicurie K2 Ⓐ ASC G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: FLUORODOPA F18
Coding Clinic: 2022, Q4

C **A9603** Injection, pafolacianine, 0.1 mg N1 ♀ Ⓐ ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2023, Q4

C **A9604** Samarium Sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: QUADRAMET

C **A9606** Radium Ra-223 dichloride, therapeutic, per microcurie ♂ K
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: XOFIGO
Coding Clinic: 2014, Q4

C **A9607** Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie ♂ Ⓐ G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: PLUVICTO
Coding Clinic: 2022, Q4

C **A9608** Flotufolastat f 18, diagnostic, 1 millicurie K2 ♂ ASC G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: POSLUMA
Coding Clinic: 2024, Q1

C **A9609** Fludeoxyglucose f18 up to 15 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2024, Q1

● C **A9610** Xenon xe-129 hyperpolarized gas, diagnostic, per study dose Ⓐ N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced

● C **A9615** Injection, pegulicianine, 1 mg Ⓐ
BETOS: O1E Other drugs

C **A9697** Injection, carboxydextran-coated superparamagnetic iron oxide, per study dose N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2023, Q4

D **A9698** Non-radioactive contrast imaging material, not otherwise classified, per study N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q4; 2017, Q1

C **A9699** Radiopharmaceutical, therapeutic, not otherwise classified N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2005, Q4

D **A9700** Supply of injectable contrast material for use in echocardiography, per study N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Coding Clinic: 2001, Q4; 2003, Q2; 2017, Q1
Pub: 100-4, Chapter-12, 30.4

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C **A9800** Gallium ga-68 gozetotide, diagnostic, (locametz), 1 millicurie K2 ♂ ⓪ ASC G
BETOS: I1E Standard imaging - nuclear medicine
Other carrier priced
Drugs: LOCAMETZ
Coding Clinic: 2022, Q4

MISCELLANEOUS DME SUPPLIES AND SERVICES (A9900-A9999)

C **A9900** Miscellaneous DME supply, accessory, and/or service component of another HCPCS code Y
BETOS: D1E Other DME

C **A9901** DME delivery, set up, and/or dispensing service component of another HCPCS code A
BETOS: D1E Other DME

C **A9999** Miscellaneous DME supply or accessory, not otherwise specified Y
BETOS: D1F Prosthetic/Orthotic devices

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ENTERAL AND PARENTERAL THERAPY (B4034-B9999)

ENTERAL FEEDING SUPPLIES AND EQUIPMENT (B4034-B4088)

D **B4034** Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/ flushing syringe, administration set tubing, dressings, tape Y
BETOS: O1C Enteral and parenteral

D **B4035** Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/ flushing syringe, administration set tubing, dressings, tape Y
BETOS: O1C Enteral and parenteral

D **B4036** Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/ flushing syringe, administration set tubing, dressings, tape Y
BETOS: O1C Enteral and parenteral

D **B4081** Nasogastric tubing with stylet Y
BETOS: O1C Enteral and parenteral

D **B4082** Nasogastric tubing without stylet Y
BETOS: O1C Enteral and parenteral

D **B4083** Stomach tube - Levine type Y
BETOS: O1C Enteral and parenteral

C **B4087** Gastrostomy/jejunostomy tube, standard, any material, any type, each Y
BETOS: O1C Enteral and parenteral

C **B4088** Gastrostomy/jejunostomy tube, low-profile, any material, any type, each Y
BETOS: O1C Enteral and parenteral

ENTERAL FORMULAS AND ADDITIVES (B4100-B4162)

M **B4100** Food thickener, administered orally, per ounce E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **B4102** Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

D **B4103** Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

D **B4104** Additive for enteral formula (e.g., fiber) E1
BETOS: O1C Enteral and parenteral
Service not separately priced by Part B

C **B4105** In-line cartridge containing digestive enzyme(s) for enteral feeding, each Y
BETOS: O1C Enteral and parenteral

D **B4148** Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape Y
BETOS: O1C Enteral and parenteral
Coding Clinic: 2023, Q4

D **B4149** Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

D **B4150** Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

D **B4152** Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

D **B4153** Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

D **B4154** Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

D **B4155** Enteral formula, nutritionally incomplete/ modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

D **B4157** Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Y
BETOS: O1C Enteral and parenteral

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D **B4158** Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

D **B4159** Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

D **B4160** Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

D **B4161** Enteral formula, for pediatrics, hydrolyzed/ amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

D **B4162** Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit Ⓐ Y
BETOS: O1C Enteral and parenteral

PARENTERAL SOLUTIONS AND SUPPLIES (B4164-B5200)

D **B4164** Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix Y
BETOS: O1C Enteral and parenteral

D **B4168** Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - homemix Y
BETOS: O1C Enteral and parenteral

D **B4172** Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - homemix Y
BETOS: O1C Enteral and parenteral

D **B4176** Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - homemix Y
BETOS: O1C Enteral and parenteral

D **B4178** Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml = 1 unit) - homemix Y
BETOS: O1C Enteral and parenteral

D **B4180** Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml=1 unit) - homemix Y
BETOS: O1C Enteral and parenteral

D **B4185** Parenteral nutrition solution, not otherwise specified, 10 grams lipids B
BETOS: O1C Enteral and parenteral

D **B4187** Omegaven, 10 grams lipids Ⓐ B
BETOS: O1C Enteral and parenteral

D **B4189** Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix Y
BETOS: O1C Enteral and parenteral

D **B4193** Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix Y
BETOS: O1C Enteral and parenteral

D **B4197** Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix Y
BETOS: O1C Enteral and parenteral

D **B4199** Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix Y
BETOS: O1C Enteral and parenteral

D **B4216** Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes), homemix per day Y
BETOS: O1C Enteral and parenteral

D **B4220** Parenteral nutrition supply kit; premix, per day Y
BETOS: O1C Enteral and parenteral

D **B4222** Parenteral nutrition supply kit; home mix, per day Y
BETOS: O1C Enteral and parenteral

D **B4224** Parenteral nutrition administration kit, per day Y
BETOS: O1C Enteral and parenteral

D **B5000** Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-Amirosyn RF, NephrAmine, RenAmine-premix Y
BETOS: O1C Enteral and parenteral

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D **B5100** Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, HepAtamine-premix Y
BETOS: O1C Enteral and parenteral

D **B5200** Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix Y
BETOS: O1C Enteral and parenteral

NUTRITION INFUSION PUMPS AND SUPPLIES NOT OTHERWISE CLASSIFIED, NOC (B9002-B9999)

D **B9002** Enteral nutrition infusion pump, any type Y
BETOS: O1C Enteral and parenteral

D **B9004** Parenteral nutrition infusion pump, portable Y
BETOS: O1C Enteral and parenteral

D **B9006** Parenteral nutrition infusion pump, stationary Y
BETOS: O1C Enteral and parenteral

D **B9998** NOC for enteral supplies Y
BETOS: O1C Enteral and parenteral
Other carrier priced

D **B9999** NOC for parenteral supplies Y
BETOS: O1C Enteral and parenteral
Other carrier priced
Coding Clinic: 2009, Q2

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NOTES

OUTPATIENT PPS (C1052-C9901)

OTHER THERAPEUTIC PROCEDURES (C1052-C1062)

D **C1052** Hemostatic agent, gastrointestinal, topical N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)

D **C1062** Intravertebral body fracture augmentation with implant (e.g., metal, polymer) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)

SURGICAL, IMAGING DEVICES AND GRAFTS (C1600-C1606)

D **C1600** Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable) J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2024, Q1

D **C1601** Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable) J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2024, Q1

D **C1602** Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable) J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2024, Q1

D **C1603** Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter) J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2024, Q1

D **C1604** Graft, transmural transvenous arterial bypass (implantable), with all delivery system components N1 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2024, Q1

● D **C1605** Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation N1 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2024, Q3

● D **C1606** Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2024, Q3

ASSORTED DEVICES AND SUPPLIES (C1713-C1715)

D **C1713** Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2010, Q1; 2016, Q3; 2016, Q3; 2018, Q1; 2018, Q2; 2020, Q4; 2020, Q4; 2021, Q1; 2021, Q1; 2021, Q1; 2021, Q2; 2022, Q1; 2022, Q3; 2022, Q4

D **C1714** Catheter, transluminal atherectomy, directional N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3

D **C1715** Brachytherapy needle N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3

BRACHYTHERAPY SOURCES (C1716-C1719), SEE ALSO BRACHYTHERAPY SOURCES (C2616), (C2634-C2699)

D **C1716** Brachytherapy source, non-stranded, gold-198, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q2; 2004, Q4; 2007, Q2; 2016, Q3; 2016, Q3; 2016, Q3

D **C1717** Brachytherapy source, non-stranded, high dose rate iridium-192, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q2; 2004, Q4; 2007, Q2; 2016, Q3; 2016, Q3; 2016, Q3

D **C1719** Brachytherapy source, non-stranded, non-high dose rate iridium-192, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q2; 2004, Q4; 2007, Q2; 2016, Q3; 2016, Q3; 2016, Q3

CARDIOVERTER-DEFIBRILLATORS (C1721-C1722)

D **C1721** Cardioverter-defibrillator, dual chamber (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q4; 2016, Q3

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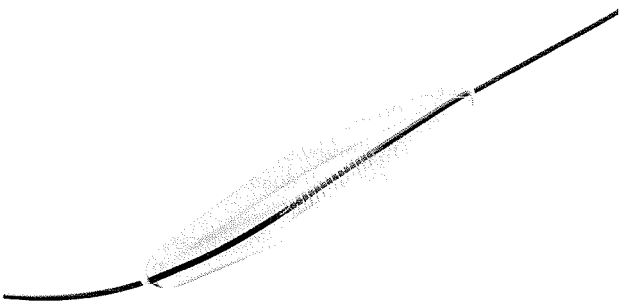
C1722 Cardioverter-defibrillator, single chamber (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q2; 2006, Q4; 2016, Q3; 2017, Q2

CATHETERS FOR MULTIPLE APPLICATIONS (C1724-C1736)

C1724 Catheter, transluminal atherectomy, rotational N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3; 2016, Q3

C1725 Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3; 2016, Q3

C1726 Catheter, balloon dilatation, non-vascular N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3



Balloon angioplasty

C1727 Catheter, balloon tissue dissector, non-vascular (insertable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3

C1728 Catheter, brachytherapy seed administration N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3

C1729 Catheter, drainage N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3

C1730 Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2004, Q4; 2016, Q3; 2016, Q3

C1731 Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2016, Q3; 2016, Q3

C1732 Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2004, Q4; 2016, Q3; 2016, Q3

C1733 Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2004, Q4; 2016, Q3; 2016, Q3

C1734 Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2020, Q1

● **C1735** Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components Ⓐ
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

● **C1736** Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components Ⓐ
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

JOINT FIXATION DEVICE (C1737)

● **C1737** Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)
BETOS: P3D Major procedure, orthopedic - other
Statute: 1833(t)

IMAGING SUPPLIES (C1738-C1749)

● **C1738** Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device
BETOS: P8I Endoscopy - other
Statute: 1833(t)

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● D **C1739** Tissue marker, imaging and non-imaging device (implantable)
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

D **C1747** Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable) J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2023, Q1; 2023, Q1; 2023, Q3

D **C1748** Endoscope, single-use (i.e. disposable), upper gi, imaging/illumination device (insertable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2020, Q2; 2023, Q3

D **C1749** Endoscope, retrograde imaging/illumination colonoscope device (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2016, Q3

CATHETERS FOR MULTIPLE APPLICATIONS (C1750-C1759)

D **C1750** Catheter, hemodialysis/peritoneal, long-term N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2012, Q4

D **C1751** Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2003, Q4; 2004, Q4; 2014, Q3; 2016, Q3; 2019, Q2

D **C1752** Catheter, hemodialysis/peritoneal, short-term N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1753** Catheter, intravascular ultrasound N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1754** Catheter, intradiscal N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1755** Catheter, intraspinal N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1756** Catheter, pacing, transesophageal N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4

D **C1757** Catheter, thrombectomy/ embolectomy N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1758** Catheter, ureteral N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1759** Catheter, intracardiac echocardiography N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2003, Q4; 2016, Q3

ASSORTED DEVICES, IMPLANTS, AND SYSTEMS (C1760-C2615)

D **C1760** Closure device, vascular (implantable/insertable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

D **C1761** Catheter, transluminal intravascular lithotripsy, coronary N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2021, Q3; 2021, Q4; 2023, Q2

D **C1762** Connective tissue, human (includes fascia lata) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q3; 2003, Q4; 2010, Q1; 2016, Q3; 2016, Q3; 2016, Q3

D **C1763** Connective tissue, non-human (includes synthetic) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q3; 2003, Q4; 2010, Q1; 2010, Q4; 2016, Q3; 2016, Q3; 2016, Q3; 2022, Q4

D **C1764** Event recorder, cardiac (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

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D **C1765** Adhesion barrier N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2016, Q3; 2016, Q3

D **C1766** Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q3; 2002, Q3; 2004, Q4; 2016, Q3

D **C1767** Generator, neurostimulator (implantable), non-rechargeable N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2006, Q1; 2006, Q4; 2007, Q1; 2016, Q3; 2021, Q1

D **C1768** Graft, vascular N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1769** Guide wire N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2003, Q4; 2007, Q2; 2014, Q3; 2016, Q3; 2016, Q3; 2019, Q2; 2019, Q3; 2022, Q1

D **C1770** Imaging coil, magnetic resonance (insertable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1771** Repair device, urinary, incontinence, with sling graft N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2003, Q4; 2008, Q3; 2016, Q3; 2016, Q3

D **C1772** Infusion pump, programmable (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2016, Q3

D **C1773** Retrieval device, insertable (used to retrieve fractured medical devices) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

D **C1776** Joint device (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2008, Q4; 2010, Q3; 2016, Q3; 2016, Q3; 2016, Q3; 2018, Q3; 2020, Q1; 2021, Q3; 2024, Q1

D **C1777** Lead, cardioverter-defibrillator, endocardial single coil (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q2; 2006, Q4; 2016, Q3; 2017, Q2

D **C1778** Lead, neurostimulator (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q1; 2002, Q3; 2006, Q4; 2007, Q1; 2011, Q4; 2016, Q3; 2019, Q1; 2021, Q1; 2022, Q4

D **C1779** Lead, pacemaker, transvenous VDD single pass N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q4; 2016, Q3; 2016, Q3

D **C1780** Lens, intraocular (new technology) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3

D **C1781** Mesh (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2010, Q1; 2012, Q2; 2016, Q3; 2016, Q3; 2019, Q1; 2022, Q4

D **C1782** Morcellator N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3

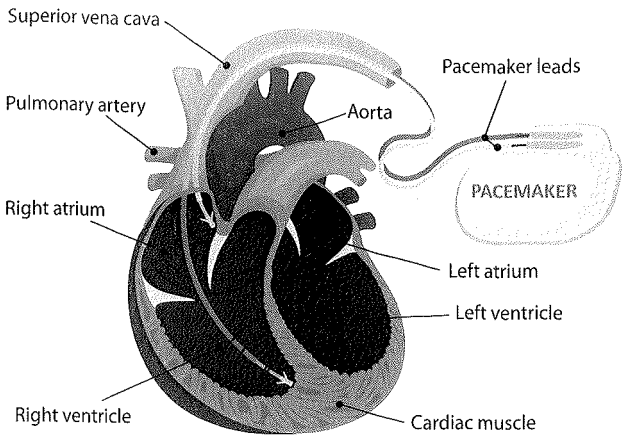
D **C1783** Ocular implant, aqueous drainage assist device N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2016, Q3; 2017, Q1

D **C1784** Ocular device, intraoperative, detached retina N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3

D **C1785** Pacemaker, dual chamber, rate-responsive (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2006, Q4; 2016, Q3

D **C1786** Pacemaker, single chamber, rate-responsive (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2006, Q4; 2016, Q3

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Pacemaker insertion

D **C1787** Patient programmer, neurostimulator N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

D **C1788** Port, indwelling (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2003, Q4; 2004, Q4; 2014, Q3; 2016, Q3; 2019, Q2

D **C1789** Prosthesis, breast (implantable) N1 Ⓐ ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1813** Prosthesis, penile, inflatable N1 ♂ ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1814** Retinal tamponade device, silicone oil N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833t
Coding Clinic: 2006, Q2; 2016, Q3; 2016, Q3

D **C1815** Prosthesis, urinary sphincter (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D **C1816** Receiver and/or transmitter, neurostimulator (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2022, Q4

D **C1817** Septal defect implant system, intracardiac N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

D **C1818** Integrated keratoprosthesis N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833T
Coding Clinic: 2016, Q3; 2016, Q3

D **C1819** Surgical tissue localization and excision device (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833T
Coding Clinic: 2004, Q1; 2016, Q3

D **C1820** Generator, neurostimulator (implantable), with rechargeable battery and charging system. N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2006, Q1; 2006, Q1; 2006, Q4; 2016, Q1; 2016, Q2; 2016, Q3

D **C1821** Interspinous process distraction device (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2007, Q1; 2009, Q2; 2016, Q3

D **C1822** Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2016, Q1; 2016, Q2; 2016, Q3

D **C1823** Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2019, Q1; 2023, Q1

D **C1824** Generator, cardiac contractility modulation (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2020, Q1

D **C1825** Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)

D **C1826** Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2023, Q1; 2023, Q1

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D C1827 Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2023, Q1; 2023, Q1

D C1830 Powered bone marrow biopsy needle N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2011, Q4; 2016, Q3

D C1831 Interbody cage, anterior, lateral or posterior, personalized (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2021, Q4; 2021, Q4; 2022, Q1; 2023, Q1

D C1832 Autograft suspension, including cell processing and application, and all system components J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2022, Q1

D C1833 Monitor, cardiac, including intracardiac lead and all system components (implantable) J7 ASC H
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2022, Q1

D C1839 Iris prosthesis N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2020, Q1

D C1840 Lens, intraocular (telescopic) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2011, Q4; 2012, Q1; 2012, Q3; 2016, Q3

D C1874 Stent, coated/covered, with delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2002, Q3; 2003, Q4; 2004, Q3; 2004, Q4; 2016, Q3; 2016, Q3; 2023, Q2; 2023, Q2

D C1875 Stent, coated/covered, without delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3; 2016, Q3; 2020, Q2; 2023, Q2

D C1876 Stent, non-coated/non-covered, with delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3; 2016, Q3

D C1877 Stent, non-coated/non-covered, without delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3

D C1878 Material for vocal cord medialization, synthetic (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3

D C1880 Vena cava filter N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D C1881 Dialysis access system (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D C1882 Cardioverter-defibrillator, other than single or dual chamber (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q2; 2006, Q4; 2012, Q2; 2016, Q3; 2016, Q3

D C1883 Adaptor/extension, pacing lead or neurostimulator lead (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q1; 2002, Q3; 2007, Q1; 2016, Q3; 2016, Q3

D C1884 Embolization protective system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833T
Coding Clinic: 2014, Q3; 2016, Q3; 2016, Q3

D C1885 Catheter, transluminal angioplasty, laser N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q1; 2016, Q3; 2016, Q3

D C1886 Catheter, extravascular tissue ablation, any modality (insertable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2016, Q3

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D **C1887** Catheter, guiding (may include infusion/perfusion capability) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2004, Q4; 2016, Q3

D **C1888** Catheter, ablation, non-cardiac, endovascular (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2016, Q3; 2016, Q3

D **C1889** Implantable/insertable device, not otherwise classified N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)

D **C1890** No implantable/insertable device used with device-intensive procedures J7 ASC E1
BETOS: D1E Other DME
Statute: 1833(t)
Coding Clinic: 2019, Q1

D **C1891** Infusion pump, non-programmable, permanent (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3

D **C1892** Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2016, Q3; 2016, Q3

D **C1893** Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2004, Q4; 2016, Q3

D **C1894** Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3; 2016, Q3; 2019, Q2

D **C1895** Lead, cardioverter-defibrillator, endocardial dual coil (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q2; 2006, Q4; 2016, Q3

D **C1896** Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q2; 2006, Q4; 2016, Q3

D **C1897** Lead, neurostimulator test kit (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q1; 2002, Q3; 2006, Q4; 2007, Q1; 2016, Q3

D **C1898** Lead, pacemaker, other than transvenous VDD single pass N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2002, Q3; 2006, Q4; 2016, Q3

D **C1899** Lead, pacemaker/cardioverter-defibrillator combination (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2006, Q4; 2016, Q3

D **C1900** Lead, left ventricular coronary venous system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2004, Q4; 2006, Q4; 2016, Q3; 2016, Q3

D **C1982** Catheter, pressure-generating, one-way valve, intermittently occlusive N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2020, Q1

D **C2596** Probe, image-guided, robotic, waterjet ablation N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2020, Q1

D **C2613** Lung biopsy plug with delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2016, Q3

D **C2614** Probe, percutaneous lumbar discectomy N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2016, Q3

D **C2615** Sealant, pulmonary, liquid N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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BRACHYTHERAPY SOURCES (C2616), SEE ALSO BRACHYTHERAPY SOURCES (C1716-C1719); BRACHYTHERAPY SOURCES (C2634-C2699)

D C2616 Brachytherapy source, non-stranded, yttrium-90, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2002, Q3; 2003, Q3; 2004, Q2; 2004, Q4; 2007, Q2; 2016, Q3; 2016, Q3; 2016, Q3

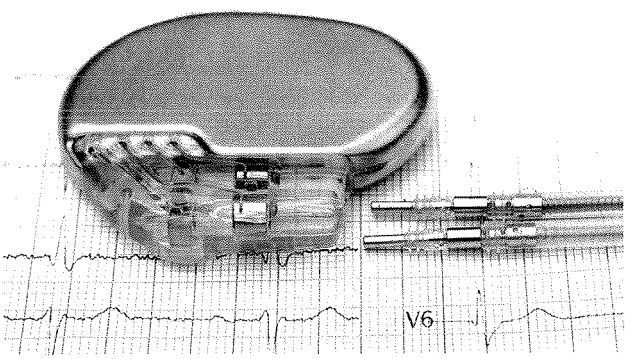
ASSORTED CARDIOVASCULAR AND GENITOURINARY DEVICES (C2617-C2631)

D C2617 Stent, non-coronary, temporary, without delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3; 2016, Q3; 2016, Q3; 2018, Q1

D C2618 Probe/needle, cryoablation N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3

D C2619 Pacemaker, dual chamber, non rate-responsive (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2001, Q3; 2002, Q3; 2006, Q4; 2016, Q3

D C2620 Pacemaker, single chamber, non rate-responsive (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2006, Q4; 2016, Q3



Pacemaker

D C2621 Pacemaker, other than single or dual chamber (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2002, Q3; 2003, Q4; 2006, Q4; 2016, Q3; 2016, Q3

D C2622 Prosthesis, penile, non-inflatable N1 ♂ ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

D C2623 Catheter, transluminal angioplasty, drug-coated, non-laser N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2016, Q3

D C2624 Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2016, Q3

D C2625 Stent, non-coronary, temporary, with delivery system N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3; 2016, Q3

D C2626 Infusion pump, non-programmable, temporary (implantable) N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2004, Q4; 2016, Q3; 2016, Q3

D C2627 Catheter, suprapubic/cystoscopic N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

D C2628 Catheter, occlusion N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2004, Q4; 2016, Q3

D C2629 Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2016, Q3

D C2630 Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2009, Q2; 2016, Q3; 2016, Q3

D C2631 Repair device, urinary, incontinence, without sling graft N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3; 2016, Q3

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BRACHYTHERAPY SOURCES (C2634-C2699), SEE ALSO BRACHYTHERAPY SOURCES (C1716-C1719), (C2616)

D **C2634** Brachytherapy source, non-stranded, high activity, iodine-125, greater than 1.01 mCi (NIST), per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2004, Q4; 2005, Q2; 2007, Q2; 2009, Q2; 2016, Q3; 2016, Q3

D **C2635** Brachytherapy source, non-stranded, high activity, palladium-103, greater than 2.2 mCi (NIST), per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2004, Q4; 2005, Q2; 2007, Q2; 2016, Q3; 2016, Q3

D **C2636** Brachytherapy linear source, non-stranded, palladium-103, per 1 mm H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2004, Q4; 2007, Q2; 2016, Q3; 2016, Q3

D **C2637** Brachytherapy source, non-stranded, ytterbium-169, per source B
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2005, Q3; 2007, Q2; 2016, Q3; 2016, Q3

D **C2638** Brachytherapy source, stranded, iodine-125, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

D **C2639** Brachytherapy source, non-stranded, iodine-125, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

D **C2640** Brachytherapy source, stranded, palladium-103, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

D **C2641** Brachytherapy source, non-stranded, palladium-103, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

D **C2642** Brachytherapy source, stranded, cesium-131, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

D **C2643** Brachytherapy source, non-stranded, cesium-131, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2016, Q3; 2016, Q3

D **C2644** Brachytherapy source, cesium-131 chloride solution, per millicurie K5 ASC E2
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)
Coding Clinic: 2016, Q3; 2016, Q3

D **C2645** Brachytherapy planar source, Palladium-103, per square millimeter H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2016, Q3; 2016, Q3

D **C2698** Brachytherapy source, stranded, not otherwise specified, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2007, Q3; 2016, Q3; 2016, Q3

D **C2699** Brachytherapy source, non-stranded, not otherwise specified, per source H2 ASC U
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)(2)
Coding Clinic: 2007, Q2; 2007, Q3; 2009, Q2; 2016, Q3; 2016, Q3

SKIN SUBSTITUTE GRAFT APPLICATION (C5271-C5278)

D **C5271** Application of low cost 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 G2 ASC T
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

D **C5272** Application of low cost 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) N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

D **C5273** Application of low cost 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 G2 ASC T
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

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D **C5274** Application of low cost 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) N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

D **C5275** Application of low cost 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; first 25 sq cm or less wound surface area G2 ASC T
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

D **C5276** Application of low cost 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) N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

D **C5277** Application of low cost 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 G2 ASC T
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

D **C5278** Application of low cost 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) N1 ASC N
BETOS: P5A Ambulatory procedures - skin
Statute: 1833(t)
Coding Clinic: 2013, Q4

MISCELLANEOUS SURGICAL PROCEDURES (C7500-C7565)

C **C7500** Debridement, bone including epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed, first 20 sq cm or less with manual preparation and insertion of deep (eg, subfacial) drug-delivery device(s) G2 ASC E1
BETOS: P5A Ambulatory procedures - skin
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7501** Percutaneous breast biopsies using stereotactic guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral and bilateral (for single lesion biopsy, use appropriate code) G2 ASC E1
BETOS: P1A Major procedure - breast
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7502** Percutaneous breast biopsies using magnetic resonance guidance, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, all lesions unilateral or bilateral (for single lesion biopsy, use appropriate code) G2 ASC E1
BETOS: P1A Major procedure - breast
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7503** Open biopsy or excision of deep cervical node(s) with intraoperative identification (eg, mapping) of sentinel lymph node(s) including injection of non-radioactive dye when performed G2 ASC E1
BETOS: P5E Ambulatory procedures - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7504** Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance G2 ASC E1
BETOS: P3D Major procedure, orthopedic - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7505** Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance G2 ASC E1
BETOS: P3D Major procedure, orthopedic - other
Price established using national RVUs
Coding Clinic: 2023, Q1

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C7506 Arthrodesis, interphalangeal joints, with or without internal fixation G2 ASC E1
BETOS: P5B Ambulatory procedures - musculoskeletal
Price established using national RVUs
Coding Clinic: 2023, Q1

C7507 Percutaneous vertebral augmentations, first thoracic and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance G2 ASC E1
BETOS: P3D Major procedure, orthopedic - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C7508 Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (eg, kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance G2 ASC E1
BETOS: P3D Major procedure, orthopedic - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C7509 Bronchoscopy, rigid or flexible, diagnostic with cell washing(s) when performed, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed G2 ASC E1
BETOS: P8F Endoscopy - bronchoscopy
Price established using national RVUs
Coding Clinic: 2023, Q1

C7510 Bronchoscopy, rigid or flexible, with bronchial alveolar lavage(s), with computer-assisted image-guided navigation, including fluoroscopic guidance when performed G2 ASC E1
BETOS: P8F Endoscopy - bronchoscopy
Price established using national RVUs
Coding Clinic: 2023, Q1

C7511 Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with computer-assisted image-guided navigation, including fluoroscopic guidance when performed G2 ASC E1
BETOS: P8F Endoscopy - bronchoscopy
Price established using national RVUs
Coding Clinic: 2023, Q1

C7512 Bronchoscopy, rigid or flexible, with single or multiple bronchial or endobronchial biopsy(ies), single or multiple sites, with transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance when performed G2 ASC E1
BETOS: P8F Endoscopy - bronchoscopy
Price established using national RVUs
Coding Clinic: 2023, Q1

C7513 Dialysis circuit, introduction of needle(s) and/or catheter(s), with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, with transluminal balloon angioplasty of central dialysis segment, performed through dialysis circuit, including all required imaging, radiological supervision and interpretation, image documentation and report G2 ASC E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2023, Q1; 2024, Q2

C7514 Dialysis circuit, introduction of needle(s) and/or catheter(s), with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, with all angioplasty in the central dialysis segment, and transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all required imaging, radiological supervision and interpretation, image documentation and report G2 ASC E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2023, Q1

C7515 Dialysis circuit, introduction of needle(s) and/or catheter(s), with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, with dialysis circuit permanent endovascular embolization or occlusion of main circuit or any accessory veins, including all required imaging, radiological supervision and interpretation, image documentation and report G2 ASC E1

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BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7516** Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7517** Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and radiologic supervision and interpretation G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7518** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging, supervision, interpretation and report E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7519** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7520** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) includes intraprocedural injection(s) for bypass graft angiography with iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and radiologic supervision and interpretation G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7521** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography with right heart catheterization with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7522** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right heart catheterization, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

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C **C7523** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7524** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7525** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7526** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7527** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (ivus) or optical coherence tomography (oct) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7528** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7529** Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or

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graft) during coronary angiography including pharmacologically induced stress G2 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7530** Dialysis circuit, introduction of needle(s) and/or catheter(s), with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty and all angioplasty in the central dialysis segment, with transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging, radiological supervision and interpretation, documentation and report G2 ASC E1

BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7531** Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal angioplasty with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation J8 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7532** Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), initial artery, open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation J8 ASC E1

BETOS: P1G Major procedure - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7533** Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy J8 ASC E1

BETOS: P2D Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7534** Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with atherectomy, includes angioplasty within the same vessel, when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7535** Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal stent placement(s), includes angioplasty within the same vessel, when performed, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation J8 ASC E1

BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7537** Insertion of new or replacement of permanent pacemaker with atrial transvenous electrode(s), with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable debribrillator or pacemake pulse generator (eg, for upgrade to dual chamber system) J8 ASC E1

BETOS: P2E Major procedure, cardiovascular-Pacemaker insertion
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7538** Insertion of new or replacement of permanent pacemaker with ventricular transvenous electrode(s), with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defribrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) J8 ASC E1

BETOS: P2E Major procedure, cardiovascular-Pacemaker insertion
Price established using national RVUs
Coding Clinic: 2023, Q1

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D **C7539** Insertion of new or replacement of permanent pacemaker with atrial and ventricular transvenous electrode(s), with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) J8 ASC E1

BETOS: P2E Major procedure, cardiovascular-Pacemaker insertion
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7540** Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator, dual lead system, with insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (eg, for upgrade to dual chamber system) J8 ASC E1

BETOS: P2E Major procedure, cardiovascular-Pacemaker insertion
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7541** Diagnostic endoscopic retrograde cholangiopancreatography (ercp), including collection of specimen(s) by brushing or washing, when performed, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s) E1

BETOS: P8B Endoscopy - upper gastrointestinal
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7542** Endoscopic retrograde cholangiopancreatography (ercp) with biopsy, single or multiple, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s) E1

BETOS: P8B Endoscopy - upper gastrointestinal
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7543** Endoscopic retrograde cholangiopancreatography (ercp) with sphincterotomy/papillotomy, with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s) E1

BETOS: P8B Endoscopy - upper gastrointestinal
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7544** Endoscopic retrograde cholangiopancreatography (ercp) with removal of calculi/debris from biliary/pancreatic duct(s), with endoscopic cannulation of papilla with direct visualization of pancreatic/common bile ducts(s) E1

BETOS: P8B Endoscopy - upper gastrointestinal
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7545** Percutaneous exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), with removal of calculi/debris from biliary duct(s) and/or gallbladder, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, including diagnostic cholangiography(ies) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation G2 ASC E1

BETOS: P1G Major procedure - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7546** Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, with ureteral stricture balloon dilation, including imaging guidance and all associated radiological supervision and interpretation E1

BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7547** Convert nephrostomy catheter to nephroureteral catheter, percutaneous via pre-existing nephrostomy tract, with ureteral stricture balloon dialation, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation G2 ASC E1

BETOS: P5E Ambulatory procedures - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7548** Exchange nephrostomy catheter, percutaneous, with ureteral stricture balloon dilation, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation G2 ASC E1

BETOS: P5E Ambulatory procedures - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7549** Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit with ureteral stricture balloon dilation, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation E1

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BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7550** Cystourethroscopy, with biopsy(ies) with adjuctive blue light cystoscopy with fluorescent imaging agent G2 ASC E1
BETOS: P8E Endoscopy - cystoscopy
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7551** Excision of major peripheral nerve neuroma, except sciatic, with implantation of nerve end into bone or muscle G2 ASC E1
BETOS: P5E Ambulatory procedures - other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7552** Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, initial vessel E1
BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7553** Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed E1
BETOS: P2F Major procedure, cardiovascular-Other
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7554** Cystourethroscopy with adjunctive blue light cystoscopy with fluorescent imaging agent G2 ASC E1
BETOS: P8E Endoscopy - cystoscopy
Price established using national RVUs
Coding Clinic: 2023, Q1

C **C7555** Thyroidectomy, total or complete with parathyroid autotransplantation E1
BETOS: P1G Major procedure - other
Price established using national RVUs
Coding Clinic: 2023, Q1

D **C7556** Bronchoscopy, rigid or flexible, with bronchial alveolar lavage and transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance, when performed G2 ASC E1
BETOS: P8F Endoscopy - bronchoscopy
Value not established
Coding Clinic: 2024, Q1

D **C7557** Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed and intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention G2 ASC E1
BETOS: P2F Major procedure, cardiovascular-Other
Value not established
Coding Clinic: 2024, Q1

D **C7560** Endoscopic retrograde cholangiopancreatography (ercp) with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s) and endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) G2 ASC E1
BETOS: P8B Endoscopy - upper gastrointestinal
Value not established
Coding Clinic: 2024, Q1

● D **C7562** Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed with intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for

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the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
BETOS: P2F Major procedure, cardiovascular-Other
Value not established
Statute: 1833(t)

C7563 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, initial artery and all additional arteries
BETOS: P2F Major procedure, cardiovascular-Other
Value not established
Statute: 1833(t)

C7564 Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance with intravascular ultrasound (noncoronary vessel(s)) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation
BETOS: P1G Major procedure - other
Value not established
Statute: 1833(t)

C7565 Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s) less than 3 cm, reducible with removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair
BETOS: P1G Major procedure - other
Value not established
Statute: 1833(t)

MENTAL HEALTH EVALUATION AND MANAGEMENT SERVICES (C7900-C7903)

C7900 Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service S
BETOS: M2A Hospital visit - initial
Service not separately priced by Part B
Coding Clinic: 2023, Q1

C7901 Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 30-60 minutes, provided remotely by hospital staff who are licensed to provided mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service S
BETOS: M2A Hospital visit - initial
Service not separately priced by Part B
Coding Clinic: 2023, Q1

C7902 Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service (list separately in addition to code for primary service) N
BETOS: M2B Hospital visit - subsequent
Service not separately priced by Part B
Coding Clinic: 2023, Q1

C7903 Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service S
BETOS: M2A Hospital visit - initial
Statute: 1833(T)
Coding Clinic: 2024, Q1

IMPLANTABLE SUPPORT DEVICE FOR AV FISTULA (C8000)

C8000 Support device, extravascular, for arteriovenous fistula (implantable) J7 ASC H
BETOS: P1G Major procedure - other
Statute: 1833(t)

3D IMAGING FOR PREOPERATIVE PLANNING (C8001)

C8001 3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy
BETOS: I4B Imaging/procedure - other
Price established by carriers

PREPARATION OF SKIN CELL AUTOGRAFT (C8002)

C8002 Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)
BETOS: P1G Major procedure - other
Price established using national RVUs

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EXTRAARTICULAR KNEE IMPLANTS (C8003)

● C **C8003** Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (eg, fluoroscopy)
BETOS: P3D Major procedure, orthopedic - other
Price established using national RVUs

MAGNETIC RESONANCE ANGIOGRAPHY, TRUNK AND LOWER EXTREMITIES (C8900-C8920)

D **C8900** Magnetic resonance angiography with contrast, abdomen Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)
Coding Clinic: 2009, Q2
Pub: 100-4, Chapter-13, 40.1.2

D **C8901** Magnetic resonance angiography without contrast, abdomen Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8902** Magnetic resonance angiography without contrast followed by with contrast, abdomen Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)
Pub: 100-4, Chapter-13, 40.1.2

D **C8903** Magnetic resonance imaging with contrast, breast; unilateral Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8905** Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8906** Magnetic resonance imaging with contrast, breast; bilateral Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8908** Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8909** Magnetic resonance angiography with contrast, chest (excluding myocardium) Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)
Pub: 100-4, Chapter-13, 40.1.2

D **C8910** Magnetic resonance angiography without contrast, chest (excluding myocardium) Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8911** Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium) Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)
Pub: 100-4, Chapter-13, 40.1.2

D **C8912** Magnetic resonance angiography with contrast, lower extremity Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)
Pub: 100-4, Chapter-13, 40.1.2

D **C8913** Magnetic resonance angiography without contrast, lower extremity Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)

D **C8914** Magnetic resonance angiography without contrast followed by with contrast, lower extremity Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)(2)
Pub: 100-4, Chapter-13, 40.1.2

D **C8918** Magnetic resonance angiography with contrast, pelvis Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 430 BIPA
Pub: 100-4, Chapter-13, 40.1.2

D **C8919** Magnetic resonance angiography without contrast, pelvis Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 430 BIPA

D **C8920** Magnetic resonance angiography without contrast followed by with contrast, pelvis Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 430 BIPA
Coding Clinic: 2009, Q2
Pub: 100-4, Chapter-13, 40.1.2

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TRANSESOPHAGEAL/TRANSTHORACIC ECHOCARDIOGRAPHY (C8921-C8930)

D **C8921** Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2; 2009, Q2; 2012, Q3
Pub: 100-4, Chapter-4, 200.7.2

D **C8922** Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8923** Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color doppler echocardiography S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8924** Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8925** Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8926** Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8927** Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8928** Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2007, Q4; 2008, Q2
Pub: 100-4, Chapter-4, 200.7.2

D **C8929** Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2008, Q4
Pub: 100-4, Chapter-4, 200.7.2

D **C8930** Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision S
BETOS: I3C Echography/ultrasonography - heart
Statute: 1833(t)(2)
Coding Clinic: 2008, Q4; 2012, Q3
Pub: 100-4, Chapter-4, 200.7.2

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MAGNETIC RESONANCE ANGIOGRAPHY, SPINE AND UPPER EXTREMITIES (C8931-C8936)

D C8931 Magnetic resonance angiography with contrast, spinal canal and contents Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

D C8932 Magnetic resonance angiography without contrast, spinal canal and contents Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

D C8933 Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

D C8934 Magnetic resonance angiography with contrast, upper extremity Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

D C8935 Magnetic resonance angiography without contrast, upper extremity Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

D C8936 Magnetic resonance angiography without contrast followed by with contrast, upper extremity Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

BREAST MRI - COMPUTER AIDED DETECTION (C8937)

D C8937 Computer-aided detection, including computer algorithm analysis of breast mri image data for lesion detection/ characterization, pharmacokinetic analysis, with further physician review for interpretation (list separately in addition to code for primary procedure) N
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)

MISCELLANEOUS DRUGS, BIOLOGICALS, AND SUPPLIES (C8957-C9488)

D C8957 Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump S
BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Value not established
Statute: 1833(t)
Coding Clinic: 2005, Q4; 2006, Q4; 2008, Q3
Pub: 100-4, Chapter-4, 230.2

D C9046 Cocaine hydrochloride nasal solution (goprelto), 1 mg N1 ASC N
BETOS: O1E Other drugs
Statute: 1833(t)
Coding Clinic: 2019, Q2; 2019, Q2; 2023, Q1

D C9047 Injection, caplacizumab-yhdp, 1 mg K2 ASC K
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: CABLIVI
Coding Clinic: 2019, Q3

D C9067 Gallium ga-68, dotatoc, diagnostic, 0.01 mci N1 ⓐ ASC N
BETOS: O1E Other drugs
Statute: 1833(t)
Coding Clinic: 2020, Q4

D C9088 Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg K2 ASC G
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: ZYNRELEF
Coding Clinic: 2022, Q1

D C9089 Bupivacaine, collagen-matrix implant, 1 mg K2 ASC N
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: XARACOLL
Coding Clinic: 2022, Q1

D C9101 Injection, oliceridine, 0.1 mg K2 ⓐ ASC G
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Drugs: OLINVYK
Coding Clinic: 2022, Q4

D C9143 Cocaine hydrochloride nasal solution (numbrino), 1 mg N1 ASC N
BETOS: O1E Other drugs
Statute: 1833(t)
Coding Clinic: 2023, Q1

D C9144 Injection, bupivacaine (posimir), 1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: POSIMIR
Coding Clinic: 2023, Q1

D C9145 Injection, aprepitant, (aponvie), 1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: APONVIE
Coding Clinic: 2023, Q2

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● D **C9173** Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram
BETOS: O1E Other drugs
Statute: 1833(t)

D **C9248** Injection, clevidipine butyrate, 1 mg N1 ASC N
BETOS: O1E Other drugs
Statute: 1833(t)
Coding Clinic: 2008, Q4; 2009, Q1

D **C9250** Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml K2 ASC K
BETOS: O1E Other drugs
Statute: 621MMA
Drugs: ARTISS
Coding Clinic: 2009, Q3

D **C9254** Injection, lacosamide, 1 mg N1 ASC N
BETOS: O1E Other drugs
Statute: 621MMA

D **C9257** Injection, bevacizumab, 0.25 mg K2 ASC K
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: AVASTIN
Coding Clinic: 2013, Q3

D **C9285** Lidocaine 70 mg/tetracaine 70 mg, per patch N1 ASC N
BETOS: O1E Other drugs
Statute: 1833(t)

D **C9293** Injection, glucarpidase, 10 units K5 ASC E2
BETOS: O1E Other drugs
Statute: 1833(t)

D **C9352** Microporous collagen implantable tube (NeuraGen Nerve Guide), per centimeter length N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2008, Q1

D **C9353** Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per centimeter length N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2008, Q1

D **C9354** Acellular pericardial tissue matrix of non-human origin (Veritas), per square centimeter N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2008, Q1

D **C9355** Collagen nerve cuff (NeuroMatrix), per 0.5 centimeter length N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2008, Q1

D **C9356** Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621 MMA
Coding Clinic: 2008, Q3

D **C9358** Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621 MMA
Coding Clinic: 2008, Q3; 2009, Q3; 2012, Q2; 2024, Q1

D **C9359** Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra Os Osteoconductive Scaffold Putty), per 0.5 cc N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 1833(T)
Coding Clinic: 2009, Q3

D **C9360** Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2009, Q3; 2012, Q2; 2024, Q1

D **C9361** Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2009, Q3

D **C9362** Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2009, Q3; 2010, Q1

D **C9363** Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2009, Q3; 2010, Q1; 2012, Q2

D **C9364** Porcine implant, Permacol, per square centimeter N1 ASC N
BETOS: D1A Medical/surgical supplies
Statute: 621MMA
Coding Clinic: 2009, Q3

D **C9399** Unclassified drugs or biologicals K7 ASC A
BETOS: O1E Other drugs
Statute: 621MMA
Coding Clinic: 2004, Q4; 2005, Q4; 2008, Q1; 2009, Q1; 2009, Q3; 2010, Q3; 2011, Q4; 2013, Q1; 2014, Q2; 2014, Q4; 2016, Q4; 2017, Q1; 2017, Q1; 2023, Q3
Pub: 100-4, Chapter-17, 90.3

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C9460 Injection, cangrelor, 1 mg K2 ASC K
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: KENGREAL
Coding Clinic: 2016, Q1

C9462 Injection, delafloxacin, 1 mg K5 ⓐ ASC E2
BETOS: O1E Other drugs
Statute: 1833(t)
Coding Clinic: 2018, Q2

C9482 Injection, sotalol hydrochloride, 1 mg K2 ASC K
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: SOTALOL
Coding Clinic: 2016, Q4

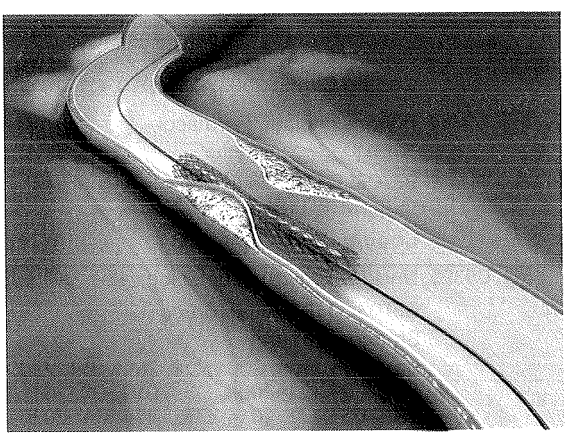
C9488 Injection, conivaptan hydrochloride, 1 mg K2 ASC K
BETOS: O1E Other drugs
Statute: 1833(t)
Drugs: VAPRISOL

FRESH FROZEN PLASMA-COVID-19 (C9507)

C9507 Fresh frozen plasma, high titer COVID-19 convalescent, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Statute: 1833(t)
Coding Clinic: 2022, Q2

PERCUTANEOUS TRANSCATHETER/TRANSLUMINAL CORONARY PROCEDURES (C9600-C9610)

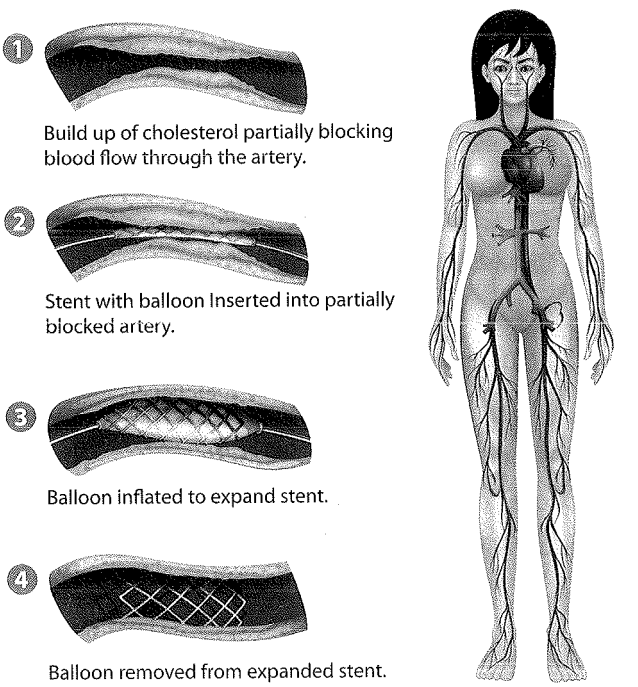
C9600 Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch J8 ASC J1 MIPS
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2021, Q4; 2023, Q2; 2024, Q1



Coronary angioplasty

C9601 Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure) N1 ASC N
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2023, Q2; 2024, Q1

C9602 Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch J1 MIPS
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2021, Q4; 2023, Q2; 2024, Q1



Stent angioplasty

C9603 Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure) N
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2023, Q2; 2024, Q1

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D C9604 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel J1 MIPS

BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2023, Q2; 2024, Q1

D **C9605** Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure) N

BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2023, Q2; 2024, Q1

D **C9606** Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel C MIPS

BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2012, Q4; 2019, Q1; 2023, Q2; 2024, Q1

D **C9607** Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel J1 MIPS

BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2021, Q4; 2023, Q2; 2024, Q1

D **C9608** Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure) N

BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2023, Q2; 2024, Q1

● D **C9610** Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)

BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)

OTHER THERAPEUTIC SERVICES AND SUPPLIES (C9725-C9901)

D **C9725** Placement of endorectal intracavitary applicator for high intensity brachytherapy G2 ASC T

BETOS: P7A Oncology - radiation therapy
Statute: 1833(T)
Coding Clinic: 2005, Q3

D **C9726** Placement and removal (if performed) of applicator into breast for intraoperative radiation therapy, add-on to primary breast procedure N1 ♀ ASC N

BETOS: P7A Oncology - radiation therapy
Statute: 1833(T)
Coding Clinic: 2006, Q1; 2007, Q2

D **C9727** Insertion of implants into the soft palate; minimum of three implants G2 ASC J1

BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Statute: 1833(T)

D **C9728** Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple G2 ASC S

BETOS: P5E Ambulatory procedures - other
Statute: 1833(T)
Coding Clinic: 2007, Q2; 2018, Q2

D **C9733** Non-ophthalmic fluorescent vascular angiography Q2

BETOS: I4B Imaging/procedure - other
Statute: 1833(t)
Coding Clinic: 2023, Q1

D **C9738** Adjunctive blue light cystoscopy with fluorescent imaging agent (list separately in addition to code for primary procedure) N1 ASC N

BETOS: I1F Standard imaging - other
Statute: 1833(t)

D **C9739** Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants J8 ♂ ASC J1

BETOS: P5E Ambulatory procedures - other
Statute: 1833(t)
Coding Clinic: 2014, Q2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **C9740** Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants J8 ♂ ASC J1
BETOS: P5E Ambulatory procedures - other
Statute: 1833(t)
Coding Clinic: 2014, Q2

D **C9751** Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-d rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s) T
BETOS: P8F Endoscopy - bronchoscopy
Statute: 1833(t)
Coding Clinic: 2019, Q1

D **C9756** Intraoperative near-infrared fluorescence lymphatic mapping of lymph node(s) (sentinel or tumor draining) with administration of indocyanine green (ICG) (List separately in addition to code for primary procedure) N
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)
Coding Clinic: 2019, Q3; 2021, Q1

D **C9757** Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar G2 ASC J1
BETOS: P6B Minor procedures - musculoskeletal
Statute: 1833(T)
Coding Clinic: 2020, Q1

D **C9758** Blinded procedure for nyha class III/IV heart failure; transcatheter implantation of interatrial shunt or placebo control, including right heart catheterization, trans-esophageal echocardiography (tee)/ intracardiac echocardiography (ice), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study T
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(T)

D **C9759** Transcatheter intraoperative blood vessel microinfusion(s) (e.g., intraluminal, vascular wall and/or perivascular) therapy, any vessel, including radiological supervision and interpretation, when performed N1 ASC N
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2020, Q2

D **C9760** Non-randomized, non-blinded procedure for NYHA class II, III, IV heart failure; transcatheter implantation of interatrial shunt, including right and left heart catheterization, transeptal puncture, trans-esophageal echocardiography (tee)/intracardiac echocardiography (ice), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study T
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2020, Q2

D **C9761** Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable (must use a steerable ureteral catheter) G2 ASC J1
BETOS: P5E Ambulatory procedures - other
Statute: 1833(t)
Coding Clinic: 2020, Q4; 2021, Q2; 2023, Q1; 2023, Q1

D **C9762** Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)
Coding Clinic: 2020, Q2

D **C9763** Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Z2 ASC Q3
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)
Coding Clinic: 2020, Q2

D **C9764** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2020, Q2

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C9765 Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2020, Q2

C9766 Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2020, Q2

C9767 Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2020, Q2

C9768 Endoscopic ultrasound-guided direct measurement of hepatic portosystemic pressure gradient by any method (list separately in addition to code for primary procedure) N
BETOS: P8B Endoscopy - upper gastrointestinal
Statute: 1833(t)
Coding Clinic: 2020, Q4; 2023, Q2

C9772 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(T)
Coding Clinic: 2021, Q1

C9773 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(T)
Coding Clinic: 2021, Q1

C9774 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(T)
Coding Clinic: 2021, Q1

C9775 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed J8 ASC J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(T)
Coding Clinic: 2021, Q1

C9776 Intraoperative near-infrared fluorescence imaging of major extra-hepatic bile duct(s) (e.g., cystic duct, common bile duct and common hepatic duct) with intravenous administration of indocyanine green (icg) (list separately in addition to code for primary procedure) N1 ASC N
BETOS: I4B Imaging/procedure - other
Statute: 1833(t)
Coding Clinic: 2021, Q2; 2022, Q1

C9777 Esophageal mucosal integrity testing by electrical impedance, transoral, includes esophagoscopy or esophagogastroduodenoscopy J8 ASC J1
BETOS: P8B Endoscopy - upper gastrointestinal
Statute: 1833(t)
Coding Clinic: 2021, Q2

C9778 Colpopexy, vaginal; minimally invasive extra-peritoneal approach (sacrospinous) J8 ♀ ASC J1
BETOS: P5E Ambulatory procedures - other
Statute: 1833(t)
Coding Clinic: 2021, Q3

C9779 Endoscopic submucosal dissection (esd), including endoscopy or colonoscopy, mucosal closure, when performed J1
BETOS: P8D Endoscopy - colonoscopy
Statute: 1833(t)
Coding Clinic: 2021, Q4; 2023, Q3

C9780 Insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance S
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)
Coding Clinic: 2021, Q4

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D **C9781** Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed J8 ASC J1
BETOS: P8A Endoscopy - arthroscopy
Statute: 1833(t)
Coding Clinic: 2022, Q2

D **C9782** Blinded procedure for new york heart association (nyha) class ii or iii heart failure, or canadian cardiovascular society (ccs) class iii or iv chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study T
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2022, Q2

D **C9783** Blinded procedure for transcatheter implantation of coronary sinus reduction device or placebo control, including vascular access and closure, right heart catherization, venous and coronary sinus angiography, imaging guidance and supervision and interpretation when performed in an approved investigational device exemption (ide) study J1
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2022, Q2

D **C9784** Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components J1
BETOS: P1G Major procedure - other
Statute: 1833(t)
Coding Clinic: 2023, Q3

D **C9785** Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components J1
BETOS: P1G Major procedure - other
Statute: 1833(t)
Coding Clinic: 2023, Q3

D **C9789** Instillation of anti-neoplastic pharmacologic/ biologic agent into renal pelvis, any method, including all imaging guidance, including volumetric measurement if performed G2 ASC T
BETOS: P5E Ambulatory procedures - other
Statute: 1833(t)
Coding Clinic: 2023, Q4

D **C9791** Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent A T
BETOS: I2D Advanced imaging - MRI/MRA: other
Statute: 1833(t)
Coding Clinic: 2023, Q4

D **C9792** Blinded or nonblinded procedure for symptomatic new york heart association (nyha) class ii, iii, iva heart failure; transcatheter implantation of left atrial to coronary sinus shunt using jugular vein access, including all imaging necessary to intra procedurally map the coronary sinus for optimal shunt placement (e.g., tee or ice ultrasound, fluoroscopy), performed under general anesthesia in an approved investigational device exemption (ide) study) S
BETOS: P2F Major procedure, cardiovascular-Other
Statute: 1833(t)
Coding Clinic: 2023, Q4

D **C9793** 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report S
BETOS: I4B Imaging/procedure - other
Statute: 1833(T)
Coding Clinic: 2024, Q1

● D **C9796** Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [sis]) J8 ASC J1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Statute: 1833(t)
Coding Clinic: 2024, Q1

● D **C9797** Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction J8 ASC J1
BETOS: P1G Major procedure - other
Statute: 1833(t)
Coding Clinic: 2024, Q1

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● D **C9804** Elastomeric infusion pump (e.g., on-q* pump with bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023) Ⓐ
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

● D **C9806** Rotary peristaltic infusion pump (e.g., ambit pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

● D **C9807** Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

● D **C9808** Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023) Ⓐ
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

● D **C9809** Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
BETOS: D1A Medical/surgical supplies
Statute: 1833(t)

D **C9898** Radiolabeled product provided during a hospital inpatient stay N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: NA

D **C9899** Implanted prosthetic device, payable only for inpatients who do not have inpatient coverage A
BETOS: Z2 Undefined codes
Statute: 1833(t)
Coding Clinic: 2008, Q4

● D **C9901** Endoscopic defect closure within the entire gastrointestinal tract, including upper endoscopy (including diagnostic, if performed) or colonoscopy (including diagnostic, if performed), with all system and tissue anchoring components J1
BETOS: P1G Major procedure - other
Statute: 1033(t)
Coding Clinic: 2024, Q3

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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NOTES

DURABLE MEDICAL EQUIPMENT (E0100-E8002)

WALKING AIDS AND ATTACHMENTS (E0100-E0159)

D E0100 Cane, includes canes of all materials, adjustable or fixed, with tip DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2009, Q2

D E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D E0110 Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D E0111 Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D E0112 Crutches underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D E0113 Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D E0114 Crutches underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2002, Q2

D E0116 Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D E0117 Crutch, underarm, articulating, spring assisted, each DME Y
BETOS: D1E Other DME
DME Modifier: RR

C E0118 Crutch substitute, lower leg platform, with or without wheels, each E1
BETOS: D1E Other DME

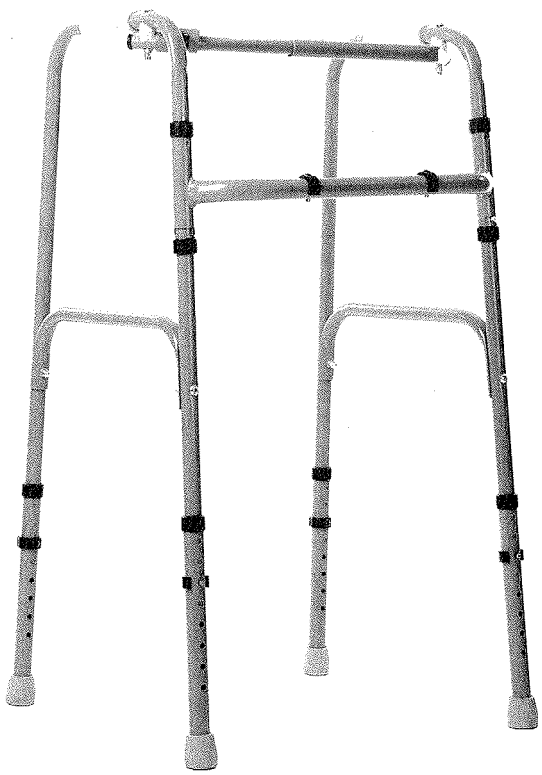
D E0130 Walker, rigid (pickup), adjustable or fixed height DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

D E0135 Walker, folding (pickup), adjustable or fixed height DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

D E0140 Walker, with trunk support, adjustable or fixed height, any type DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR
Pub: 100-4, Chapter-36, 50.15

D E0141 Walker, rigid, wheeled, adjustable or fixed height DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

D E0143 Walker, folding, wheeled, adjustable or fixed height DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15



Walker

D E0144 Walker, enclosed, four sided framed, rigid or folding, wheeled with posterior seat DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR
Pub: 100-4, Chapter-36, 50.15

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **E0147** Walker, heavy duty, multiple braking system, variable wheel resistance DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

C **E0148** Walker, heavy duty, without wheels, rigid or folding, any type, each DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

C **E0149** Walker, heavy duty, wheeled, rigid or folding, any type DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR
Pub: 100-4, Chapter-36, 50.15

● I **E0152** Walker, battery powered, wheeled, folding, adjustable or fixed height E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q2

C **E0153** Platform attachment, forearm crutch, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0154** Platform attachment, walker, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14; 100-4, Chapter-36, 50.15

C **E0155** Wheel attachment, rigid pick-up walker, per pair DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

C **E0156** Seat attachment, walker DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14; 100-4, Chapter-36, 50.15

C **E0157** Crutch attachment, walker, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15; 100-4, Chapter-36, 50.14

C **E0158** Leg extensions for walker, per set of four (4) DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14; 100-4, Chapter-36, 50.15

C **E0159** Brake attachment for wheeled walker, replacement, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.15

SITZ BATH/EQUIPMENT (E0160-E0162)

D **E0160** Sitz type bath or equipment, portable, used with or without commode DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0161** Sitz type bath or equipment, portable, used with or without commode, with faucet attachment/s DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2009, Q2

D **E0162** Sitz bath chair DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

COMMODE CHAIR AND SUPPLIES (E0163-E0175)

D **E0163** Commode chair, mobile or stationary, with fixed arms DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0165** Commode chair, mobile or stationary, with detachable arms DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

D **E0167** Pail or pan for use with commode chair, replacement only DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0168** Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0170** Commode chair with integrated seat lift mechanism, electric, any type DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

C **E0171** Commode chair with integrated seat lift mechanism, non-electric, any type DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

S **E0172** Seat lift mechanism placed over or on top of toilet, any type E1
BETOS: D1E Other DME
Service not separately priced by Part B
Statute: 1861SSA

C **E0175** Foot rest, for use with commode chair, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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PRESSURE MATTRESSES, PADS, AND OTHER SUPPLIES (E0181-E0199)

D **E0181** Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0182** Pump for alternating pressure pad; for replacement only DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0183** Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0184** Dry pressure mattress DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0185** Gel or gel-like pressure pad for mattress, standard mattress length and width DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0186** Air pressure mattress DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0187** Water pressure mattress DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0188** Synthetic sheepskin pad DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0189** Lambswool sheepskin pad, any size DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0190** Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0191** Heel or elbow protector, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0193** Powered air flotation bed (low air loss therapy) DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0194** Air fluidized bed DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0196** Gel pressure mattress DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0197** Air pressure pad for mattress, standard mattress length and width DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0198** Water pressure pad for mattress, standard mattress length and width DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0199** Dry pressure pad for mattress, standard mattress length and width DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

HEAT, COLD, AND LIGHT THERAPIES (E0200-E0239), SEE ALSO ULTRAVIOLET LIGHT THERAPY SYSTEMS (E0691-E0694)

D **E0200** Heat lamp, without stand (table model), includes bulb, or infrared element DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0202** Phototherapy (bilirubin) light with photometer DME Y
BETOS: D1E Other DME
DME Modifier: RR

M **E0203** Therapeutic lightbox, minimum 10, 000 lux, table top model E1
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0205** Heat lamp, with stand, includes bulb, or infrared element DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0210** Electric heat pad, standard DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0215** Electric heat pad, moist DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0217** Water circulating heat pad with pump DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0218** Fluid circulating cold pad with pump, any type Y
BETOS: D1E Other DME

C **E0221** Infrared heating pad system Y
BETOS: D1E Other DME
Service not separately priced by Part B
Coding Clinic: 2002, Q1
Pub: 100-4, Chapter-5, 20.4

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D **E0225** Hydrocollator unit, includes pads DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

M **E0231** Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover E1
BETOS: D1E Other DME
Service not separately priced by Part B
Coding Clinic: 2002, Q1

M **E0232** Warming card for use with the non contact wound warming device and non contact wound warming wound cover E1
BETOS: D1E Other DME
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **E0235** Paraffin bath unit, portable (see medical supply code A4265 for paraffin) DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0236** Pump for water circulating pad DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0239** Hydrocollator unit, portable DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

BATHING SUPPLIES (E0240-E0249)

M **E0240** Bath/shower chair, with or without wheels, any size E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0241** Bath tub wall rail, each E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0242** Bath tub rail, floor base E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0243** Toilet rail, each E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0244** Raised toilet seat E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0245** Tub stool or bench E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0246** Transfer tub rail attachment E1
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0247** Transfer bench for tub or toilet with or without commode opening E1
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0248** Transfer bench, heavy duty, for tub or toilet with or without commode opening E1
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0249** Pad for water circulating heat unit, for replacement only DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

HOSPITAL BEDS AND ASSOCIATED SUPPLIES (E0250-E0373)

D **E0250** Hospital bed, fixed height, with any type side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0251** Hospital bed, fixed height, with any type side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0255** Hospital bed, variable height, hi-lo, with any type side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0256** Hospital bed, variable height, hi-lo, with any type side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0260** Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0261** Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0265** Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0266** Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

M **E0270** Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress E1 MIPS
BETOS: D1B Hospital beds
Service not separately priced by Part B

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D **E0271** Mattress, innerspring DME Y
BETOS: D1B Hospital beds
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

D **E0272** Mattress, foam rubber DME Y
BETOS: D1B Hospital beds
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

M **E0273** Bed board E1
BETOS: D1B Hospital beds
Service not separately priced by Part B

M **E0274** Over-bed table E1
BETOS: D1B Hospital beds
Service not separately priced by Part B

D **E0275** Bed pan, standard, metal or plastic DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0276** Bed pan, fracture, metal or plastic DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0277** Powered pressure-reducing air mattress DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0280** Bed cradle, any type DME Y
BETOS: D1B Hospital beds
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

D **E0290** Hospital bed, fixed height, without side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0291** Hospital bed, fixed height, without side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0292** Hospital bed, variable height, hi-lo, without side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0293** Hospital bed, variable height, hi-lo, without side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0294** Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0295** Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0296** Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0297** Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

C **E0300** Pediatric crib, hospital grade, fully enclosed, with or without top enclosure DME A Y
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0301** Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0302** Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0303** Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0304** Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0305** Bed side rails, half length DME Y
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0310** Bed side rails, full length DME Y
BETOS: D1B Hospital beds
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

M **E0315** Bed accessory: board, table, or support device, any type E1
BETOS: D1B Hospital beds
Service not separately priced by Part B

C **E0316** Safety enclosure frame/canopy for use with hospital bed, any type DME Y
BETOS: D1B Hospital beds
DME Modifier: RR
Coding Clinic: 2002, Q1

♂ Male only ♀ Female only A Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **E0325** Urinal; male, jug-type, any material ♂ DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0326** Urinal; female, jug-type, any material ♀ DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0328** Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress Ⓐ Y
BETOS: D1B Hospital beds

C **E0329** Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress Ⓐ Y
BETOS: D1B Hospital beds

C **E0350** Control unit for electronic bowel irrigation/evacuation system E1
BETOS: Z2 Undefined codes
Other carrier priced

C **E0352** Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system E1
BETOS: Z2 Undefined codes
Other carrier priced

C **E0370** Air pressure elevator for heel E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0371** Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0372** Powered air overlay for mattress, standard mattress length and width DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0373** Nonpowered advanced pressure reducing mattress DME Y
BETOS: D1E Other DME
DME Modifier: RR

OXYGEN DELIVERY SYSTEMS AND RELATED SUPPLIES (E0424-E0493)

D **E0424** Stationary compressed gaseous oxygen system, rental; includes container, contents regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing DME Y MIPS
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

D **E0425** Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing E1 MIPS
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **E0430** Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing E1 MIPS
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **E0431** Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing DME Y MIPS
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

C **E0433** Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge DME Y MIPS
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

D **E0434** Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing DME Y MIPS
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

D **E0435** Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor E1 MIPS
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **E0439** Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing DME Y MIPS
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

D **E0440** Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing E1 MIPS
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **E0441** Stationary oxygen contents, gaseous, 1 month's supply = 1 unit DME Y MIPS
BETOS: D1C Oxygen and supplies

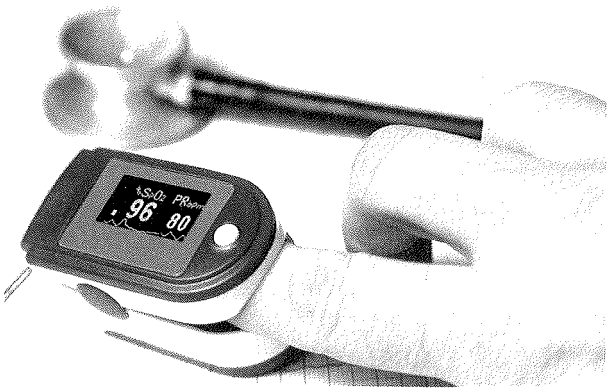
D **E0442** Stationary oxygen contents, liquid, 1 month's supply = 1 unit DME Y MIPS
BETOS: D1C Oxygen and supplies

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D **E0443** Portable oxygen contents, gaseous, 1 month's supply = 1 unit DME Y MIPS
BETOS: D1C Oxygen and supplies

D **E0444** Portable oxygen contents, liquid, 1 month's supply = 1 unit DME Y MIPS
BETOS: D1C Oxygen and supplies

C **E0445** Oximeter device for measuring blood oxygen levels non-invasively N
BETOS: Z2 Undefined codes
Service not separately priced by Part B



Pulse oximeter

C **E0446** Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories A
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0447** Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm) DME Y
BETOS: D1C Oxygen and supplies

D **E0455** Oxygen tent, excluding croup or pediatric tents Ⓐ Y
BETOS: D1C Oxygen and supplies

I **E0457** Chest shell (cuirass) E1
BETOS: D1E Other DME
Service not separately priced by Part B

I **E0459** Chest wrap E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0462** Rocking bed with or without side rails DME Y MIPS
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0465** Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube) DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

D **E0466** Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell) DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

D **E0467** Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions DME Y
BETOS: D1E Other DME
DME Modifier: RR

• D **E0468** Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2024, Q2

• C **E0469** Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device DME
BETOS: D1E Other DME
DME Modifier: RR

D **E0470** Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

D **E0471** Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

D **E0472** Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) DME Y MIPS
BETOS: D1E Other DME
DME Modifier: RR

D **E0480** Percussor, electric or pneumatic, home model DME Y
BETOS: D1E Other DME
DME Modifier: RR

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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M **E0481** Intrapulmonary percussive ventilation system and related accessories E1
BETOS: D1E Other DME
Service not separately priced by Part B
Coding Clinic: 2002, Q1

C **E0482** Cough stimulating device, alternating positive and negative airway pressure DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

C **E0483** High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2022, Q4

C **E0484** Oscillatory positive expiratory pressure device, non-electric, any type, each DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0485** Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0486** Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0487** Spirometer, electronic, includes all accessories N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **E0490** Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation .. of the tongue muscle, controlled by hardware remote DME ▲ E1
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2023, Q4

C **E0491** Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply DME ▲ E1
BETOS: D1E Other DME
Coding Clinic: 2023, Q4

S **E0492** Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

S **E0493** Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

INTERMITTENT POSITIVE PRESSURE BREATHING DEVICES (E0500), SEE ALSO BREATHING AIDS (A7000-A7049); OTHER BREATHING AIDS (E0605, E0606); ASSISTED BREATHING SUPPLIES (S8096-S8210)

D **E0500** IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source DME Y
BETOS: D1E Other DME
DME Modifier: RR

ELECTRONIC POSITIONAL OBSTRUCTIVE SLEEP APNEA TREATMENT (E0530)

C **E0530** Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type DME Y
BETOS: D1E Other DME
DME Modifier: RR

HUMIDIFIERS AND NEBULIZERS WITH RELATED EQUIPMENT (E0550-E0601)

D **E0550** Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0555** Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter Y
BETOS: D1C Oxygen and supplies

D **E0560** Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0561** Humidifier, non-heated, used with positive airway pressure device DME Y MPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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C **E0562** Humidifier, heated, used with positive airway pressure device DME Y MIPS
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Pub: 100-4, Chapter-36, 50.14

C **E0565** Compressor, air power source for equipment which is not self- contained or cylinder driven DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0570** Nebulizer, with compressor DME Y
BETOS: D1E Other DME
DME Modifier: RR

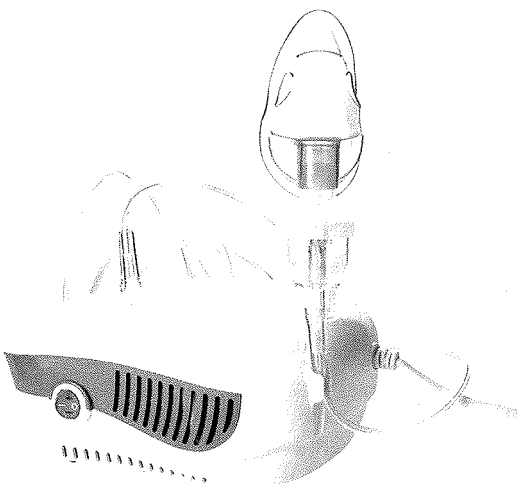
C **E0572** Aerosol compressor, adjustable pressure, light duty for intermittent use DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0574** Ultrasonic/electronic aerosol generator with small volume nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0575** Nebulizer, ultrasonic, large volume DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0580** Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0585** Nebulizer, with compressor and heater DME Y
BETOS: D1E Other DME
DME Modifier: RR



Nebulizer

D **E0600** Respiratory suction pump, home model, portable or stationary, electric DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0601** Continuous positive airway pressure (CPAP) device DME Y
BETOS: D1E Other DME
DME Modifier: RR

BREAST PUMPS (E0602-E0604)

C **E0602** Breast pump, manual, any type ♀ DME Ⓐ Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0603** Breast pump, electric (AC and/or DC), any type ♀ Ⓐ N
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

C **E0604** Breast pump, hospital grade, electric (AC and / or DC), any type ♀ Ⓐ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

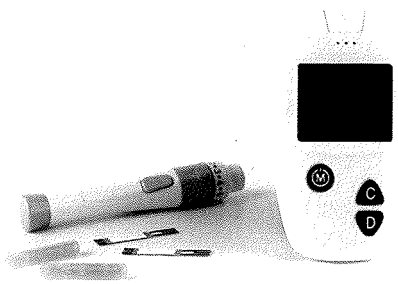
OTHER BREATHING AIDS (E0605, E0606), SEE ALSO BREATHING AIDS (A7000-A7049); INTERMITTENT POSITIVE PRESSURE BREATHING DEVICES (E0500); ASSISTED BREATHING SUPPLIES (S8096-S8210)

D **E0605** Vaporizer, room type DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0606** Postural drainage board DME Y
BETOS: D1E Other DME
DME Modifier: RR

MONITORING EQUIPMENT (E0607-E0620)

D **E0607** Home blood glucose monitor DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE



Glucose monitor

D **E0610** Pacemaker monitor, self-contained, (checks battery depletion, includes audible and visible check systems) DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **E0615** Pacemaker monitor, self contained, checks battery depletion and other pacemaker components, includes digital/visible check systems DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0616** Implantable cardiac event recorder with memory, activator and programmer N
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0617** External defibrillator with integrated electrocardiogram analysis DME Y
BETOS: D1E Other DME
DME Modifier: KF, RR

C **E0618** Apnea monitor, without recording feature DME Y
BETOS: D1E Other DME
Service not separately priced by Part B
DME Modifier: RR

C **E0619** Apnea monitor, with recording feature DME Y
BETOS: D1E Other DME
Service not separately priced by Part B
DME Modifier: RR

C **E0620** Skin piercing device for collection of capillary blood, laser, each DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

PATIENT LIFTS AND SUPPORT SYSTEMS (E0621-E0642)

D **E0621** Sling or seat, patient lift, canvas or nylon DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

M **E0625** Patient lift, bathroom or toilet, not otherwise classified E1
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0627** Seat lift mechanism, electric, any type DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0629** Seat lift mechanism, non-electric, any type DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0630** Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s) DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0635** Patient lift, electric with seat or sling DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0636** Multipositional patient support system, with integrated lift, patient accessible controls DME Y
BETOS: D1E Other DME
DME Modifier: RR

M **E0637** Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels A E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0638** Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels A E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0639** Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories DME E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B
DME Modifier: RR

C **E0640** Patient lift, fixed system, includes all components/accessories DME E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B
DME Modifier: RR

M **E0641** Standing frame/table system, multi-position (e.g., 3-way stander), any size including pediatric, with or without wheels A E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E0642** Standing frame/table system, mobile (dynamic stander), any size including pediatric A E1
BETOS: D1E Other DME
Service not separately priced by Part B

PNEUMATIC COMPRESSORS AND APPLIANCES (E0650-E0683)

D **E0650** Pneumatic compressor, non-segmental home model DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0651** Pneumatic compressor, segmental home model without calibrated gradient pressure DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0652** Pneumatic compressor, segmental home model with calibrated gradient pressure DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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D **E0655** Non-segmental pneumatic appliance for use with pneumatic compressor, half arm DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0656** Segmental pneumatic appliance for use with pneumatic compressor, trunk DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2008, Q4

D **E0657** Segmental pneumatic appliance for use with pneumatic compressor, chest DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2008, Q4

D **E0660** Non-segmental pneumatic appliance for use with pneumatic compressor, full leg DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0665** Non-segmental pneumatic appliance for use with pneumatic compressor, full arm DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0666** Non-segmental pneumatic appliance for use with pneumatic compressor, half leg DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0667** Segmental pneumatic appliance for use with pneumatic compressor, full leg DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0668** Segmental pneumatic appliance for use with pneumatic compressor, full arm DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0669** Segmental pneumatic appliance for use with pneumatic compressor, half leg DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0670** Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0671** Segmental gradient pressure pneumatic appliance, full leg DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0672** Segmental gradient pressure pneumatic appliance, full arm DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0673** Segmental gradient pressure pneumatic appliance, half leg DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0675** Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0676** Intermittent limb compression device (includes all accessories), not otherwise specified Y
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **E0677** Non-pneumatic sequential compression garment, trunk DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2023, Q2

C **E0678** Non-pneumatic sequential compression garment, full leg DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0679** Non-pneumatic sequential compression garment, half leg DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0680** Non-pneumatic compression controller with sequential calibrated gradient pressure DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0681** Non-pneumatic compression controller without calibrated gradient pressure DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0682** Non-pneumatic sequential compression garment, full arm DME Y
BETOS: D1E Other DME
DME Modifier: RR

• C **E0683** Non-pneumatic, non-sequential, peristaltic wave compression pump DME
BETOS: D1E Other DME
DME Modifier: RR

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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ULTRAVIOLET LIGHT THERAPY SYSTEMS (E0691-E0694), SEE ALSO HEAT, COLD, AND LIGHT THERAPIES (E0200-E0239)

C E0691 Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C E0692 Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C E0693 Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C E0694 Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

SAFETY DEVICES (E0700-E0711)

C E0700 Safety equipment, device or accessory, any type E1
BETOS: D1E Other DME
Service not separately priced by Part B

D E0705 Transfer device, any type, each DME B
BETOS: D1E Other DME
DME Modifier: KU, NU, RR, UE

C E0710 Restraints, any type (body, chest, wrist or ankle) E1
BETOS: Z2 Undefined codes
Other carrier priced

C E0711 Upper extremity medical tubing/lines enclosure or covering device, restricts elbow range of motion E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q2

INTRAVAGINAL DEVICE AND SUPPLIES FOR PELVIC FLOOR MUSCLES STRENGTHENING (E0715-E0716)

● **S E0715** Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

● **S E0716** Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

STIMULATION DEVICES (E0720-E0770)

D E0720 Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation DME Y
BETOS: D1E Other DME
DME Modifier: NU

● **C E0721** Transcutaneous electrical nerve stimulator for nerves in the auricular region
BETOS: D1E Other DME

D E0730 Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation DME Y
BETOS: D1E Other DME
DME Modifier: NU

D E0731 Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric) DME Y
BETOS: D1E Other DME
DME Modifier: NU

C E0732 Cranial electrotherapy stimulation (ces) system, any type DME Y
BETOS: D1E Other DME
DME Modifier: RR

C E0733 Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve DME A Y
BETOS: D1E Other DME
DME Modifier: RR

C E0734 External upper limb tremor stimulator of the peripheral nerves of the wrist DME A Y
BETOS: D1E Other DME
DME Modifier: RR

C E0735 Non-invasive vagus nerve stimulator DME A Y
BETOS: D1E Other DME
DME Modifier: RR

● **C E0736** Transcutaneous tibial nerve stimulator DME A
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2024, Q2

● **S E0737** Transcutaneous tibial nerve stimulator, controlled by phone application
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)

● **C E0738** Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories DME A
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2024, Q2

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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▲ C **E0739** Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors DME A
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2024, Q2

D **E0740** Non-implanted pelvic floor electrical stimulator, complete system DME Y
BETOS: D1E Other DME
DME Modifier: RR

● C **E0743** External lower extremity nerve stimulator for restless legs syndrome, each DME
BETOS: D1E Other DME
DME Modifier: RR

C **E0744** Neuromuscular stimulator for scoliosis DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0745** Neuromuscular stimulator, electronic shock unit DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0746** Electromyography (EMG), biofeedback device N
BETOS: D1E Other DME
Reasonable charge

D **E0747** Osteogenesis stimulator, electrical, non-invasive, other than spinal applications DME Y
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

D **E0748** Osteogenesis stimulator, electrical, non-invasive, spinal applications DME Y
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

D **E0749** Osteogenesis stimulator, electrical, surgically implanted DME N
BETOS: D1E Other DME
DME Modifier: KF, RR

C **E0755** Electronic salivary reflex stimulator (intra-oral/non-invasive) E1
BETOS: Z2 Undefined codes
Reasonable charge

C **E0760** Osteogenesis stimulator, low intensity ultrasound, non-invasive DME Y
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE
Pub: 100-4, Chapter-32, 110.5

D **E0761** Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device E1
BETOS: D1E Other DME
Service not separately priced by Part B

C **E0762** Transcutaneous electrical joint stimulation device system, includes all accessories DME B
BETOS: D1E Other DME
DME Modifier: RR

D **E0764** Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program DME Y
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KF, RR

C **E0765** FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0766** Electrical stimulation device used for cancer treatment, includes all accessories, any type DME Y
BETOS: D1E Other DME
DME Modifier: KF, RR

● C **E0767** Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories
BETOS: D1E Other DME

D **E0769** Electrical stimulation or electromagnetic wound treatment device, not otherwise classified B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **E0770** Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified Y
BETOS: D1E Other DME
Coding Clinic: 2008, Q4

INFUSION PUMPS AND SUPPLIES (E0776-E0791)

C **E0776** IV pole DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0779** Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0780** Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours DME Y
BETOS: D1E Other DME
DME Modifier: NU

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D **E0781** Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0782** Infusion pump, implantable, non-programmable (includes all components, e.g., pump, catheter, connectors, etc.) DME N
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

D **E0783** Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.) DME N
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

D **E0784** External ambulatory infusion pump, insulin DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0785** Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement DME N
BETOS: D1E Other DME
DME Modifier: KF

D **E0786** Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter) DME N
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

I **E0787** External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **E0791** Parenteral infusion pump, stationary, single or multi-channel DME Y
BETOS: D1E Other DME
DME Modifier: RR

TRACTION AND OTHER ORTHOPEDIC DEVICES (E0830-E0948)

D **E0830** Ambulatory traction device, all types, each N
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0840** Traction frame, attached to headboard, cervical traction DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0849** Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0850** Traction stand, free standing, cervical traction DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0855** Cervical traction equipment not requiring additional stand or frame DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0856** Cervical traction device, with inflatable air bladder(s) DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0860** Traction equipment, overdoor, cervical DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0870** Traction frame, attached to footboard, extremity traction, (e.g., Buck's) DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0880** Traction stand, free standing, extremity traction DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0890** Traction frame, attached to footboard, pelvic traction DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0900** Traction stand, free standing, pelvic traction, (e.g., Buck's) DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0910** Trapeze bars, also known as Patient Helper, attached to bed, with grab bar DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0911** Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar DME Y
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0912** Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar DME Y
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0920** Fracture frame, attached to bed, includes weights DME Y
BETOS: D1E Other DME
DME Modifier: RR

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D **E0930** Fracture frame, free standing, includes weights DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0935** Continuous passive motion exercise device for use on knee only DME Y
BETOS: D1E Other DME
DME Modifier: RR

M **E0936** Continuous passive motion exercise device for use other than knee E1
BETOS: D1E Other DME
Service not separately priced by Part B

D **E0940** Trapeze bar, free standing, complete with grab bar DME Y
BETOS: D1B Hospital beds
DME Modifier: RR

D **E0941** Gravity assisted traction device, any type DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E0942** Cervical head harness/halter DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0944** Pelvic belt/harness/boot DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E0945** Extremity belt/harness DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0946** Fracture, frame, dual with cross bars, attached to bed, (e.g., balken, 4 poster) DME Y
BETOS: D1E Other DME
DME Modifier: RR

D **E0947** Fracture frame, attachments for complex pelvic traction DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E0948** Fracture frame, attachments for complex cervical traction DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

WHEELCHAIR ACCESSORIES (E0950-E1036)

D **E0950** Wheelchair accessory, tray, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0951** Heel loop/holder, any type, with or without ankle strap, each DME Y
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KE, KU, NU, RR, UE

D **E0952** Toe loop/holder, any type, each DME Y
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KE, KU, NU, RR, UE

C **E0953** Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0954** Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0955** Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E0956** Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0957** Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E0958** Manual wheelchair accessory, one-arm drive attachment, each DME Y
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, RR

C **E0959** Manual wheelchair accessory, adapter for amputee, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, NU, RR, UE

C **E0960** Wheelchair accessory, shoulder harness/ straps or chest strap, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0961** Manual wheelchair accessory, wheel lock brake extension (handle), each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, NU, RR, UE

C **E0966** Manual wheelchair accessory, headrest extension, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, NU, RR, UE

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D **E0967** Manual wheelchair accessory, hand rim with projections, any type, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

D **E0968** Commode seat, wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E0969** Narrowing device, wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

I **E0970** No. 2 footplates, except for elevating leg rest E1
BETOS: D1D Wheelchairs
Service not separately priced by Part B

C **E0971** Manual wheelchair accessory, anti-tipping device, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, NU, RR, UE

D **E0973** Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KE, KU, NU, RR, UE

D **E0974** Manual wheelchair accessory, anti-rollback device, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, NU, RR, UE

C **E0978** Wheelchair accessory, positioning belt/safety belt/pelvic strap, each DME B
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0980** Safety vest, wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E0981** Wheelchair accessory, seat upholstery, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0982** Wheelchair accessory, back upholstery, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E0983** Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E0984** Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E0985** Wheelchair accessory, seat lift mechanism DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, RR

C **E0986** Manual wheelchair accessory, push-rim activated power assist system DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E0988** Manual wheelchair accessory, lever-activated, wheel drive, pair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E0990** Wheelchair accessory, elevating leg rest, complete assembly, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KE, KU, NU, RR, UE

C **E0992** Manual wheelchair accessory, solid seat insert DME B
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

D **E0994** Arm rest, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E0995** Wheelchair accessory, calf rest/pad, replacement only, each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KE, KU, NU, RR, UE

C **E1002** Wheelchair accessory, power seating system, tilt only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1003** Wheelchair accessory, power seating system, recline only, without shear reduction DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1004** Wheelchair accessory, power seating system, recline only, with mechanical shear reduction DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1005** Wheelchair accessory, power seating system, recline only, with power shear reduction DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

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C **E1006** Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1007** Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1008** Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1009** Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E1010** Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

D **E1011** Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair) DME A Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E1012** Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, RR

D **E1014** Reclining back, addition to pediatric size wheelchair DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E1015** Shock absorber for manual wheelchair, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

D **E1016** Shock absorber for power wheelchair, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E1017** Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D **E1018** Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D **E1020** Residual limb support system for wheelchair, any type DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1028** Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1029** Wheelchair accessory, ventilator tray, fixed DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E1030** Wheelchair accessory, ventilator tray, gimbaled DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

D **E1031** Rollabout chair, any and all types with castors 5 inch or greater DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E1035** Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E1036** Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

TRANSPORT CHAIRS (E1037-E1039)

D **E1037** Transport chair, pediatric size DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E1038** Transport chair, adult size, patient weight capacity up to and including 300 pounds DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E1039** Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

♂ Male only ♀ Female only A Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
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FULLY RECLINING WHEELCHAIRS (E1050-E1070)

D E1050 Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1060 Fully-reclining wheelchair, detachable arms, desk or full length, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1070 Fully-reclining wheelchair, detachable arms (desk or full length) swing away detachable footrest DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

HEMI-WHEELCHAIRS (E1083-E1086)

D E1083 Hemi-wheelchair, fixed full length arms, swing away detachable elevating legrest DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1084 Hemi-wheelchair, detachable arms desk or full length arms, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

I E1085 Hemi-wheelchair, fixed full length arms, swing away detachable footrests E1
BETOS: D1D Wheelchairs
Service not separately priced by Part B

I E1086 Hemi-wheelchair detachable arms desk or full length, swing away detachable footrests E1
BETOS: D1D Wheelchairs
Service not separately priced by Part B

LIGHTWEIGHT, HIGH-STRENGTH WHEELCHAIRS (E1087-E1090)

D E1087 High strength lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1088 High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

I E1089 High strength lightweight wheelchair, fixed length arms, swing away detachable footrest E1
BETOS: D1D Wheelchairs
Service not separately priced by Part B

I E1090 High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable footrests E1
BETOS: D1D Wheelchairs
Service not separately priced by Part B

HEAVY DUTY, WIDE WHEELCHAIRS (E1092, E1093)

D E1092 Wide heavy duty wheel chair, detachable arms (desk or full length), swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1093 Wide heavy duty wheelchair, detachable arms desk or full length arms, swing away detachable footrests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

SEMI-RECLINING WHEELCHAIRS (E1100, E1110)

D E1100 Semi-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1110 Semi-reclining wheelchair, detachable arms (desk or full length) elevating legrest DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

STANDARD WHEELCHAIRS (E1130-E1161)

I E1130 Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests E1 MIPS
BETOS: D1D Wheelchairs
Service not separately priced by Part B

I E1140 Wheelchair, detachable arms, desk or full length, swing away detachable footrests E1 MIPS
BETOS: D1D Wheelchairs
Service not separately priced by Part B

D E1150 Wheelchair, detachable arms, desk or full length swing away detachable elevating leg rests DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1160 Wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

C E1161 Manual adult size wheelchair, includes tilt in space DME A Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

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AMPUTEE WHEELCHAIRS (E1170-E1200)

D E1170 Amputee wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1171 Amputee wheelchair, fixed full length arms, without footrests or legrest DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1172 Amputee wheelchair, detachable arms (desk or full length) without footrests or legrest DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1180 Amputee wheelchair, detachable arms (desk or full length) swing away detachable footrests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1190 Amputee wheelchair, detachable arms (desk or full length) swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1195 Heavy duty wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1200 Amputee wheelchair, fixed full length arms, swing away detachable footrest DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

OTHER WHEELCHAIRS AND ACCESSORIES (E1220-E1228)

D E1220 Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification Y
BETOS: D1D Wheelchairs

D E1221 Wheelchair with fixed arm, footrests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1222 Wheelchair with fixed arm, elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1223 Wheelchair with detachable arms, footrests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1224 Wheelchair with detachable arms, elevating leg rests DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1225 Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, RR

D E1226 Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each DME B
BETOS: D1D Wheelchairs
Service not separately priced by Part B
DME Modifier: KU, NU, RR, UE

D E1227 Special height arms for wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D E1228 Special back height for wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

PEDIATRIC WHEELCHAIRS (E1229-E1239)

C E1229 Wheelchair, pediatric size, not otherwise specified Ⓐ Y
BETOS: D1D Wheelchairs

D E1230 Power operated vehicle (three or four wheel nonhighway) specify brand name and model number DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D E1231 Wheelchair, pediatric size, tilt-in-space, rigid adjustable, with seating system DME Ⓐ Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D E1232 Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system DME Ⓐ Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1233 Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system DME Ⓐ Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1234 Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system DME Ⓐ Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D E1235 Wheelchair, pediatric size, rigid, adjustable, with seating system DME Ⓐ Y
BETOS: D1D Wheelchairs
DME Modifier: RR

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D **E1236** Wheelchair, pediatric size, folding, adjustable, with seating system DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E1237** Wheelchair, pediatric size, rigid, adjustable, without seating system DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E1238** Wheelchair, pediatric size, folding, adjustable, without seating system DME A Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E1239** Power wheelchair, pediatric size, not otherwise specified A Y
BETOS: D1D Wheelchairs
Coding Clinic: 2006, Q1

LIGHTWEIGHT WHEELCHAIRS (E1240-E1270)

D **E1240** Lightweight wheelchair, detachable arms, (desk or full length) swing away detachable, elevating legrest DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

I **E1250** Lightweight wheelchair, fixed full length arms, swing away detachable footrest E1 MIPS
BETOS: D1D Wheelchairs
Service not separately priced by Part B

I **E1260** Lightweight wheelchair, detachable arms (desk or full length) swing away detachable footrest E1 MIPS
BETOS: D1D Wheelchairs
Service not separately priced by Part B

D **E1270** Lightweight wheelchair, fixed full length arms, swing away detachable elevating leg rests DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

HEAVY DUTY AND SPECIAL WHEELCHAIRS (E1280-E1298)

D **E1280** Heavy duty wheelchair, detachable arms (desk or full length) elevating leg rests DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

I **E1285** Heavy duty wheelchair, fixed full length arms, swing away detachable footrest E1 MIPS
BETOS: D1D Wheelchairs
Service not separately priced by Part B

I **E1290** Heavy duty wheelchair, detachable arms (desk or full length) swing away detachable footrest E1 MIPS
BETOS: D1D Wheelchairs
Service not separately priced by Part B

D **E1295** Heavy duty wheelchair, fixed full length arms, elevating legrest DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: RR

D **E1296** Special wheelchair seat height from floor DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D **E1297** Special wheelchair seat depth, by upholstery DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

D **E1298** Special wheelchair seat depth and/or width, by construction DME Y MIPS
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

WHIRLPOOL BATHS (E1300-E1310)

M **E1300** Whirlpool, portable (overtub type) E1
BETOS: D1E Other DME
Service not separately priced by Part B

M **E1301** Whirlpool tub, walk-in, portable E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

D **E1310** Whirlpool, non-portable (built-in type) DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

ACCESSORIES FOR OXYGEN DELIVERY DEVICES (E1352-E1406)

C **E1352** Oxygen accessory, flow regulator capable of positive inspiratory pressure Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

D **E1353** Regulator DME Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

C **E1354** Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B
Coding Clinic: 2008, Q4

D **E1355** Stand/rack DME Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

C **E1356** Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B
Coding Clinic: 2008, Q4

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C **E1357** Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B
Coding Clinic: 2008, Q4

D **E1358** Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each Y
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B
Coding Clinic: 2008, Q4

D **E1372** Immersion external heater for nebulizer DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E1390** Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate DME Y
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

D **E1391** Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each DME Y
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

D **E1392** Portable oxygen concentrator, rental DME Y
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

C **E1399** Durable medical equipment, miscellaneous Y
BETOS: D1E Other DME
Pub: 100-4, Chapter-32, 110.5

D **E1405** Oxygen and water vapor enriching system with heated delivery DME Y
BETOS: D1C Oxygen and supplies
DME Modifier: RR

D **E1406** Oxygen and water vapor enriching system without heated delivery DME Y
BETOS: D1C Oxygen and supplies
DME Modifier: RR

DIALYSIS SYSTEMS AND ACCESSORIES (E1500-E1699)

D **E1500** Centrifuge, for dialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **E1510** Kidney, dialysate delivery system, kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1520** Heparin infusion pump for hemodialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1530** Air bubble detector for hemodialysis, each, replacement A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1540** Pressure alarm for hemodialysis, each, replacement A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1550** Bath conductivity meter for hemodialysis, each A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

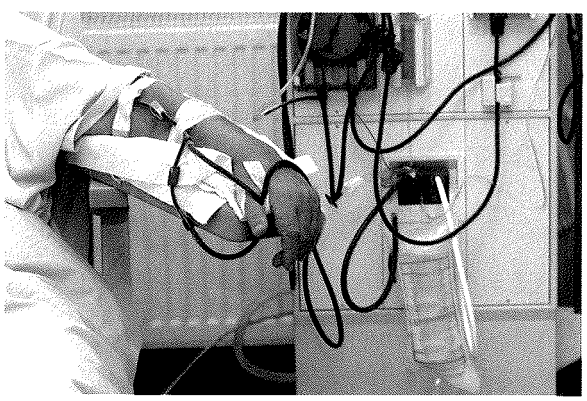
D **E1560** Blood leak detector for hemodialysis, each, replacement A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1570** Adjustable chair, for ESRD patients A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1575** Transducer protectors/fluid barriers, for hemodialysis, any size, per 10 A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1580** Unipuncture control system for hemodialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1590** Hemodialysis machine A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B



Dialysis medical device

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **E1592** Automatic intermittent peritoneal dialysis system A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1594** Cycler dialysis machine for peritoneal dialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1600** Delivery and/or installation charges for hemodialysis equipment A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1610** Reverse osmosis water purification system, for hemodialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1615** Deionizer water purification system, for hemodialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1620** Blood pump for hemodialysis, replacement A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1625** Water softening system, for hemodialysis A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

C **E1629** Tablo hemodialysis system for the billable dialysis service A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

C **E1630** Reciprocating peritoneal dialysis system A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1632** Wearable artificial kidney, each A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1634** Peritoneal dialysis clamps, each B
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1635** Compact (portable) travel hemodialyzer system A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1636** Sorbent cartridges, for hemodialysis, per 10 A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

D **E1637** Hemostats, each A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **E1639** Scale, each A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1

D **E1699** Dialysis equipment, not otherwise specified A
BETOS: P9B Dialysis services (Non-Medicare fee schedule)
Service not separately priced by Part B

JAW MOTION REHABILITATION SYSTEMS (E1700-E1702)

C **E1700** Jaw motion rehabilitation system DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E1701** Replacement cushions for jaw motion rehabilitation system, pkg. of 6 DME Y
BETOS: D1E Other DME

C **E1702** Replacement measuring scales for jaw motion rehabilitation system, pkg. of 200 DME Y
BETOS: D1E Other DME

EXTENSION/FLEXION REHABILITATION DEVICES (E1800-E1841)

▲ C **E1800** Dynamic adjustable elbow extension and flexion device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E1801** Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

C **E1802** Dynamic adjustable forearm pronation/supination device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

● C **E1803** Dynamic adjustable elbow extension only device, includes soft interface material
BETOS: D1E Other DME

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● C **E1804** Dynamic adjustable elbow flexion only device, includes soft interface material
BETOS: D1E Other DME

▲ C **E1805** Dynamic adjustable wrist extension and flexion device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E1806** Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

● C **E1807** Dynamic adjustable wrist extension only device, includes soft interface material
BETOS: D1E Other DME

● C **E1808** Dynamic adjustable wrist flexion only device, includes soft interface material
BETOS: D1E Other DME

▲ C **E1810** Dynamic adjustable knee extension and flexion device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E1811** Static progressive stretch knee device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

C **E1812** Dynamic knee, extension/flexion device with active resistance control DME Y
BETOS: D1E Other DME
DME Modifier: RR

● C **E1813** Dynamic adjustable knee extension only device, includes soft interface material
BETOS: D1E Other DME

● C **E1814** Dynamic adjustable knee flexion only device, includes soft interface material
BETOS: D1E Other DME

▲ C **E1815** Dynamic adjustable ankle extension and flexion device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E1816** Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

C **E1818** Static progressive stretch forearm pronation / supination device, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

C **E1820** Replacement soft interface material, dynamic adjustable extension/flexion device DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

C **E1821** Replacement soft interface material/ cuffs for bi-directional static progressive stretch device DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2002, Q1

● C **E1822** Dynamic adjustable ankle extension only device, includes soft interface material
BETOS: D1E Other DME

● C **E1823** Dynamic adjustable ankle flexion only device, includes soft interface material
BETOS: D1E Other DME

▲ C **E1825** Dynamic adjustable finger extension and flexion device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

● C **E1826** Dynamic adjustable finger extension only device, includes soft interface material
BETOS: D1E Other DME

● C **E1827** Dynamic adjustable finger flexion only device, includes soft interface material
BETOS: D1E Other DME

● C **E1828** Dynamic adjustable toe extension only device, includes soft interface material
BETOS: D1E Other DME

● C **E1829** Dynamic adjustable toe flexion only device, includes soft interface material
BETOS: D1E Other DME

▲ C **E1830** Dynamic adjustable toe extension and flexion device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **E1831** Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **E1840** Dynamic adjustable shoulder flexion / abduction / rotation device, includes soft interface material DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

C **E1841** Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR

COMMUNICATION BOARDS (E1902)

C **E1902** Communication board, non-electronic augmentative or alternative communication device Y
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

VIRTUAL REALITY COGNITIVE BEHAVIORAL THERAPY DEVICE (CBT) (E1905)

C **E1905** Virtual reality cognitive behavioral therapy device (cbt), including pre-programmed therapy software DME A
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2023, Q2

MISCELLANEOUS PUMPS AND MONITORS (E2000-E2120)

C **E2000** Gastric suction pump, home model, portable or stationary, electric DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2002, Q1

▲ C **E2001** Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system DME Y
BETOS: D1E Other DME
DME Modifier: RR
Coding Clinic: 2024, Q2

D **E2100** Blood glucose monitor with integrated voice synthesizer DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2002, Q1

D **E2101** Blood glucose monitor with integrated lancing/blood sample DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2002, Q1

C **E2102** Adjunctive, non-implanted continuous glucose monitor or receiver DME Y
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

C **E2103** Non-adjunctive, non-implanted continuous glucose monitor or receiver DME Y
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

● D **E2104** Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge DME A
BETOS: D1E Other DME
DME Modifier: NU, RR, UE
Coding Clinic: 2024, Q2

C **E2120** Pulse generator system for tympanic treatment of inner ear endolymphatic fluid DME Y
BETOS: D1E Other DME
DME Modifier: RR

MANUAL WHEELCHAIR ACCESSORIES (E2201-E2295)

C **E2201** Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2202** Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2203** Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2204** Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2205** Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured), any type, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2206** Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

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C **E2207** Wheelchair accessory, crutch and cane holder, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2208** Wheelchair accessory, cylinder tank carrier, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2209** Accessory, arm trough, with or without hand support, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2210** Wheelchair accessory, bearings, any type, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2211** Manual wheelchair accessory, pneumatic propulsion tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2212** Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2213** Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2214** Manual wheelchair accessory, pneumatic caster tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2215** Manual wheelchair accessory, tube for pneumatic caster tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2216** Manual wheelchair accessory, foam filled propulsion tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2217** Manual wheelchair accessory, foam filled caster tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2218** Manual wheelchair accessory, foam propulsion tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2219** Manual wheelchair accessory, foam caster tire, any size, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2220** Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2221** Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2222** Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2224** Manual wheelchair accessory, propulsion wheel excludes tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2225** Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2226** Manual wheelchair accessory, caster fork, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2227** Manual wheelchair accessory, gear reduction drive wheel, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E2228** Manual wheelchair accessory, wheel braking system and lock, complete, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, RR

C **E2230** Manual wheelchair accessory, manual standing system Y
BETOS: D1D Wheelchairs
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **E2231** Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE
Coding Clinic: 2008, Q4

C **E2291** Back, planar, for pediatric size wheelchair including fixed attaching hardware A Y
BETOS: D1D Wheelchairs

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C **E2292** Seat, planar, for pediatric size wheelchair including fixed attaching hardware Ⓐ Y
BETOS: D1D Wheelchairs

C **E2293** Back, contoured, for pediatric size wheelchair including fixed attaching hardware Ⓐ Y
BETOS: D1D Wheelchairs

C **E2294** Seat, contoured, for pediatric size wheelchair including fixed attaching hardware Ⓐ Y
BETOS: D1D Wheelchairs

C **E2295** Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features Ⓐ Y
BETOS: D1D Wheelchairs
Coding Clinic: 2008, Q4

POWER WHEELCHAIR ACCESSORIES (E2298-E2398)

● C **E2298** Complex rehabilitative power wheelchair accessory, power seat elevation system, any type DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR
Coding Clinic: 2024, Q2

C **E2301** Wheelchair accessory, power standing system, any type Y
BETOS: D1D Wheelchairs
Service not separately priced by Part B

C **E2310** Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2311** Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2312** Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KC, RR

C **E2313** Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **E2321** Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KC, KE, KU, RR

C **E2322** Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KC, KE, KU, RR

C **E2323** Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2324** Power wheelchair accessory, chin cup for chin control interface DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2325** Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2326** Power wheelchair accessory, breath tube kit for sip and puff interface DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2327** Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KC, KE, KU, RR

C **E2328** Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2329** Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

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C E2330 Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2331** Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware Y
BETOS: D1D Wheelchairs

C **E2340** Power wheelchair accessory, nonstandard seat frame width, 20-23 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E2341** Power wheelchair accessory, nonstandard seat frame width, 24-27 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E2342** Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E2343** Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **E2351** Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2358** Power wheelchair accessory, group 34 non-sealed lead acid battery, each Y
BETOS: D1D Wheelchairs

C **E2359** Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2360** Power wheelchair accessory, 22 NF non-sealed lead acid battery, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2361** Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2362** Power wheelchair accessory, group 24 non-sealed lead acid battery, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2363** Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2364** Power wheelchair accessory, U-1 non-sealed lead acid battery, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2365** Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2366** Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2367** Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2368** Power wheelchair component, drive wheel motor, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2369** Power wheelchair component, drive wheel gear box, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2370** Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2371** Power wheelchair accessory, group 27 sealed lead acid battery, (e.g., gel cell, absorbed glassmat), each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2372** Power wheelchair accessory, group 27 non-sealed lead acid battery, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

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C **E2373** Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KC, KE, KU, RR

D **E2374** Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

D **E2375** Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

D **E2376** Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

D **E2377** Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **E2378** Power wheelchair component, actuator, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, RR

D **E2381** Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2382** Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2383** Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2384** Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2385** Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2386** Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2387** Power wheelchair accessory, foam filled caster tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2388** Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2389** Power wheelchair accessory, foam caster tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2390** Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2391** Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2392** Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2394** Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2395** Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

D **E2396** Power wheelchair accessory, caster fork, any size, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

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C **E2397** Power wheelchair accessory, lithium-based battery, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2398** Wheelchair accessory, dynamic positioning hardware for back DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

WOUND THERAPY PUMPS (E2402)

C **E2402** Negative pressure wound therapy electrical pump, stationary or portable DME Y
BETOS: D1E Other DME
DME Modifier: RR

SPEECH GENERATING DEVICES, SOFTWARE, AND ACCESSORIES (E2500-E2599)

D **E2500** Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2502** Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2504** Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2506** Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2508** Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2510** Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2511** Speech generating software program, for personal computer or personal digital assistant DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2512** Accessory for speech generating device, mounting system DME Y
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

● D **E2513** Accessory for speech generating device, electromyographic sensor DME
BETOS: D1E Other DME
DME Modifier: NU, RR, UE

D **E2599** Accessory for speech generating device, not otherwise classified Y
BETOS: D1E Other DME

WHEELCHAIR SEAT AND BACK CUSHIONS (E2601-E2625)

C **E2601** General use wheelchair seat cushion, width less than 22 inches, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2602** General use wheelchair seat cushion, width 22 inches or greater, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2603** Skin protection wheelchair seat cushion, width less than 22 inches, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2604** Skin protection wheelchair seat cushion, width 22 inches or greater, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2605** Positioning wheelchair seat cushion, width less than 22 inches, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2606** Positioning wheelchair seat cushion, width 22 inches or greater, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2607** Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2608** Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

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C **E2609** Custom fabricated wheelchair seat cushion, any size Y
BETOS: D1D Wheelchairs

C **E2610** Wheelchair seat cushion, powered B
BETOS: D1D Wheelchairs

C **E2611** General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2612** General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2613** Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2614** Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2615** Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2616** Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2617** Custom fabricated wheelchair back cushion, any size, including any type mounting hardware Y
BETOS: D1D Wheelchairs

C **E2619** Replacement cover for wheelchair seat cushion or back cushion, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2620** Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2621** Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2622** Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2623** Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2624** Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **E2625** Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

WHEELCHAIR MOBILE ARM SUPPORTS (E2626-E2633)

C **E2626** Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2627** Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable rancho type DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2628** Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2629** Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2630** Wheelchair accessory, shoulder elbow, mobile arm support, mono suspension arm and hand support, overhead elbow

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forearm hand sling support, yoke type suspension support DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2631** Wheelchair accessory, addition to mobile arm support, elevating proximal arm DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2632** Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **E2633** Wheelchair accessory, addition to mobile arm support, supinator DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

SPEECH VOLUME MODULATION SYSTEM (E3000)

C **E3000** Speech volume modulation system, any type, including all components and accessories DME Y
BETOS: D1E Other DME
DME Modifier: RR

GAIT MODULATION SYSTEM (E3200)

● C **E3200** Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only
BETOS: D1E Other DME

PEDIATRIC GAIT TRAINERS (E8000-E8002)

I **E8000** Gait trainer, pediatric size, posterior support, includes all accessories and components Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **E8001** Gait trainer, pediatric size, upright support, includes all accessories and components Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **E8002** Gait trainer, pediatric size, anterior support, includes all accessories and components Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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NOTES

PROCEDURES / PROFESSIONAL SERVICES (G0008-G9999)

VACCINE ADMINISTRATION (G0008-G0010)

G0008 Administration of influenza virus vaccine S
CPT® Crosswalk: 90460, 90461, 90471, 90472, 90473, 90474
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2016, Q4; 2009, Q2; 2006, Q2; 2018, Q3; 2003, Q2
Pub: 100-2, Chapter-12, 40.11; 100-4, Chapter-18, 10.2.1; 100-4, Chapter-18, 10.2.5.2; 100-4, Chapter-18, 10.3.1.1; 100-4, Chapter-18, 10.4.1; 100-4, Chapter-18, 10.4.3

G0009 Administration of pneumococcal vaccine S
CPT® Crosswalk: 90460, 90461, 90471, 90472, 90473, 90474
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2016, Q4; 2009, Q2; 2018, Q3; 2003, Q2
Pub: 100-2, Chapter-12, 40.11; 100-4, Chapter-18, 10.2.1; 100-4, Chapter-18, 10.2.5.2; 100-4, Chapter-18, 10.3.1.1; 100-4, Chapter-18, 10.4.1; 100-4, Chapter-18, 10.4.3

G0010 Administration of hepatitis B vaccine S
CPT® Crosswalk: 90460, 90461, 90471, 90472
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2016, Q4; 2018, Q3
Pub: 100-2, Chapter-12, 40.11; 100-4, Chapter-18, 10.2.1; 100-4, Chapter-18, 10.2.5.2; 100-4, Chapter-18, 10.3.1.1

PSYCHOTHERAPY, PRE-EXPOSURE PROPHYLAXIS COUNSELING AND COMMUNITY HEALTH INTEGRATION SERVICES (G0011-G0024)

G0011 Individual counseling for pre-exposure prophylaxis (prep) by physician or qualified health care professional (qhp) to prevent human immunodeficiency virus (hiv), includes hiv risk assessment (initial or continued assessment of risk), hiv risk reduction and medication adherence, 15-30 minutes B
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2024, Q1

G0012 Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle S
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2024, Q1

G0013 Individual counseling for pre-exposure prophylaxis (prep) by clinical staff to prevent human immunodeficiency virus (hiv), includes: hiv risk assessment (initial or continued assessment of risk), hiv risk reduction and medication adherence S
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2024, Q1

G0017 Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes M
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

G0018 Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (list separately in addition to code for primary service) M
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

G0019 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (sdoh) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:

- person-centered assessment, performed to better understand the individualized context of the intersection between the sdoh need(s) and the problem(s) addressed in the initiating visit.

++ conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed).

++ facilitating patient-driven goal-setting and establishing an action plan.

++ providing tailored support to the patient as needed to accomplish the practitioner's treatment plan. practitioner, home-, and community-based care coordination.

++ coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).

++ communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding

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the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the sdoh need(s). health education- helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the sdoh need(s), and educating the patient on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the sdoh need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment. health care access / health system navigation.

++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.

• facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the sdoh need(s), and adjust daily routines to better meet diagnosis and treatment goals. leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals S

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

C **G0022** Community health integration services, each additional 30 minutes per calendar month (list separately in addition to G0019) N

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

C **G0023** Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:

• person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.

++ conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed).

++ facilitating patient-driven goal setting and establishing an action plan.

++ providing tailored support as needed to accomplish the practitioner's treatment plan.

• identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care coordination.

++ coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable).

++ communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address sdoh need(s). health education- helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and sdoh need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based

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services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.

- health care access / health system navigation.

++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.

++ providing the patient with information/ resources to consider participation in clinical trials or clinical research as applicable.

- facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals S

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

C **G0024** Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023) N

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

ANALYSIS OF SEMEN SPECIMEN (G0027)

C **G0027** Semen analysis; presence and/or motility of sperm excluding huhner ♂ Q4

BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Price subject to national limitation amount

MIPS MEASURES (G0029-G0067)

C **G0029** Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0030** Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2005, Q2
Pub: 100-4, Chapter-13, 60.3

C **G0031** Palliative care services given to patient any time during the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0032** Two or more antipsychotic prescriptions ordered for patients who had a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder on or between january 1 of the year prior to the measurement period and the index prescription start date (ipsd) for antipsychotics M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0033** Two or more benzodiazepine prescriptions ordered for patients who had a diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, or severe generalized anxiety disorder on or between january 1 of the year prior to the measurement period and the ipsd for benzodiazepines M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0034** Patients receiving palliative care during the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0035** Patient has any emergency department encounter during the performance period with place of service indicator 23 M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0036** Patient or care partner decline assessment M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0037** On date of encounter, patient is not able to participate in assessment or screening, including non-verbal patients, delirious, severely aphasic, severely developmentally delayed, severe visual or hearing impairment and for those patients, no knowledgeable informant available M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

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C **G0038** Clinician determines patient does not require referral M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0039** Patient not referred, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0040** Patient already receiving physical/occupational/speech/recreational therapy during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0041** Patient and/or care partner decline referral M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0042** Referral to physical, occupational, speech, or recreational therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0043** Patients with mechanical prosthetic heart valve M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0044** Patients with moderate or severe mitral stenosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0045** Clinical follow-up and mrs score assessed at 90 days following endovascular stroke intervention M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0046** Clinical follow-up and mrs score not assessed at 90 days following endovascular stroke intervention M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Pub: 100-4, Chapter-13, 60.3

C **G0047** Pediatric patient with minor blunt head trauma and pecarn prediction criterla are not assessed A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2005, Q2
Pub: 100-4, Chapter-13, 60.3

C **G0048** Patients who receive palliative care services any time during the intake period through the end of the measurement year M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0049** With maintenance hemodialysis (in-center and home hd) for the complete reporting month M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0050** Patients with a catheter that have limited life expectancy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0051** Patients under hospice care in the current reporting month M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0052** Patients on peritoneal dialysis for any portion of the reporting month M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0053** Advancing rheumatology patient care mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0054** Coordinating stroke care to promote prevention and cultivate positive outcomes mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0055** Advancing care for heart disease mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0057** Proposed adopting best practices and promoting patient safety within emergency medicine mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0058** Improving care for lower extremity joint repair mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0059** Patient safety and support of positive experiences with anesthesia mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0060** Allergy/immunology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0061** Anesthesiology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G0062** Audiology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0063** Cardiology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0064** Certified nurse midwife mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0065** Chiropractic medicine mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0066** Clinical social work mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G0067** Dentistry mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PROFESSIONAL SERVICES FOR DRUG INFUSION (G0068-G0070)

D **G0068** Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes A
BETOS: M4A Home visit
Price established using national RVUs

D **G0069** Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes A
BETOS: M4A Home visit
Price established using national RVUs

D **G0070** Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes A
BETOS: M4A Home visit
Price established using national RVUs

TELEMED SERVICES (G0071)

C **G0071** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only A MIPS
BETOS: M5D Specialist - other
Price established by carriers

HOME CARE MANAGEMENT SERVICES (G0076-G0087)

C **G0076** Brief (20 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0077** Limited (30 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0078** Moderate (45 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0079** Comprehensive (60 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0080** Extensive (75 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0081** Brief (20 minutes) care management home visit for an existing patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

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C **G0082** Limited (30 minutes) care management home visit for an existing patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0083** Moderate (45 minutes) care management home visit for an existing patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0084** Comprehensive (60 minutes) care management home visit for an existing patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0085** Extensive (75 minutes) care management home visit for an existing patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0086** Limited (30 minutes) care management home care plan oversight. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

C **G0087** Comprehensive (60 minutes) care management home care plan oversight. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility) B
BETOS: M4A Home visit
Price established by carriers

INITIAL VISIT FOR PROFESSIONAL SERVICES (G0088-G0090)

D **G0088** Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes A
BETOS: M4A Home visit
Price established using national RVUs

D **G0089** Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes A
BETOS: M4A Home visit
Price established using national RVUs

D **G0090** Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes A
BETOS: M4A Home visit
Price established using national RVUs

SCREENING EXAMINATIONS AND DISEASE MANAGEMENT TRAINING (G0101-G0124)

D **G0101** Cervical or vaginal cancer screening; pelvic and clinical breast examination ♀ S MIPS
CPT® Crosswalk: 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99459
BETOS: M1A Office visits - new
Price established using national RVUs
Coding Clinic: 2001, Q3; 2008, Q3; 2024, Q2; 2002, Q4

D **G0102** Prostate cancer screening; digital rectal examination ♂ N MIPS
CPT® Crosswalk: 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

D **G0103** Prostate cancer screening; prostate specific antigen test (PSA) ♂ A
CPT® Crosswalk: 81539, 81541, 81551, 84152, 84153, 84154, 86316, 0005U, 0011M, 0021U, 0047U, 0359U, 0421T, 0443T
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

D **G0104** Colorectal cancer screening; flexible sigmoidoscopy P3 ASC T
CPT® Crosswalk: 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350
BETOS: P8C Endoscopy - sigmoidoscopy
Price established using national RVUs
Coding Clinic: 2011, Q2; 2009, Q2
Pub: 100-4, Chapter-1, 30.3.1; 100-4, Chapter-18, 60.1

D **G0105** Colorectal cancer screening; colonoscopy on individual at high risk A2 ASC T MIPS
CPT® Crosswalk: 44404, 44408, 45378

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BETOS: P8D Endoscopy - colonoscopy
Price established using national RVUs
Coding Clinic: 2023, Q3; 2018, Q2; 2009, Q2
Pub: 100-4, Chapter-1, 30.3.1; 100-4, Chapter-18, 60.1

C **G0108** Diabetes outpatient self-management training services, individual, per 30 minutes A MIPS
CPT® Crosswalk: 98960
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs
Coding Clinic: 2019, Q3
Pub: 100-2, Chapter-15, 300.3; 100-4, Chapter-12, 190.3.6

C **G0109** Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes A
CPT® Crosswalk: 98961, 98962
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs
Coding Clinic: 2019, Q3
Pub: 100-2, Chapter-15, 300.3; 100-4, Chapter-12, 190.3.6

C **G0117** Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist S
CPT® Crosswalk: 92285, 0333T, 0464T
BETOS: T2D Other tests - other
Price established using national RVUs
Coding Clinic: 2001, Q3; 2002, Q1; 2002, Q1

C **G0118** Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist S
CPT® Crosswalk: 92285, 0333T, 0464T
BETOS: T2D Other tests - other
Price established using national RVUs
Coding Clinic: 2002, Q1; 2001, Q3; 2002, Q1

D **G0121** Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk A2 ASC T MIPS
CPT® Crosswalk: 44404, 44408, 45330, 45378, 91299
BETOS: P8D Endoscopy - colonoscopy
Price established using national RVUs
Coding Clinic: 2001, Q3; 2023, Q3; 2018, Q2
Pub: 100-4, Chapter-1, 30.3.1

D **G0123** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision ♀ A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

D **G0124** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician ♀ B
CPT® Crosswalk: 99000
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price established using national RVUs

MISCELLANEOUS DIAGNOSTIC AND THERAPEUTIC SERVICES (G0127-G0372)

D **G0127** Trimming of dystrophic nails, any number Q1 MIPS
BETOS: P5A Ambulatory procedures - skin
Price established using national RVUs

D **G0128** Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes B
BETOS: Y2 Other - Non-Medicare fee schedule
Value not established
Statute: 1833(a)
Pub: 100-2, Chapter-12, 40.8; 100-4, Chapter-5, 20.4

C **G0129** Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more) P
BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2012, Q4; 2024, Q1

D **G0130** Single energy X-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) Z3 ASC S
BETOS: I4B Imaging/procedure - other
Price established using national RVUs

C **G0136** Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes S MIPS
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

C **G0137** Intensive outpatient services; weekly bundle, minimum of 9 services over a 7 contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with

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psychiatric patients; individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services; and such other items and services (excluding meals and transportation) that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services in accordance with a physician certification and plan of treatment (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

● C **G0138** Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga Ⓐ S

BETOS: M1B Office visits - established
Price established by carriers
Coding Clinic: 2024, Q2

C **G0140** Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:

- person-centered interview, performed to better understand the individual context of the serious, high-risk condition.

++ conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet sdoh needs (that are not billed separately).

++ facilitating patient-driven goal setting and establishing an action plan.

++ providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan.

- identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care communication.

++ assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors.

++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address sdoh need(s). health education. helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and sdoh need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.

- building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals. facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals S

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2024, Q1

C **G0141** Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician ♀ B

CPT® Crosswalk: 99000

BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Price established using national RVUs

C **G0143** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision ♀ A

CPT® Crosswalk: 99000

BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Price subject to national limitation amount

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C **G0144** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision ♀ A

CPT® Crosswalk: 99000

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

C **G0145** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision ♀ A

CPT® Crosswalk: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88155, 88160, 88161, 88162, 88164, 88165, 88166, 88167, 88172, 88173, 88174, 88175, 88177, 88199

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

C **G0146** Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to g0140) N

BETOS: M5D Specialist - other

Price established by carriers

Coding Clinic: 2024, Q1

C **G0147** Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision ♀ A

CPT® Crosswalk: 99000

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

C **G0148** Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening ♀ A

CPT® Crosswalk: 99000

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

C **G0151** Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **G0152** Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **G0153** Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **G0155** Services of clinical social worker in home health or hospice settings, each 15 minutes B MIPS

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **G0156** Services of home health/hospice aide in home health or hospice settings, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **G0157** Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **G0158** Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **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 B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **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 B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

C **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 B

BETOS: Y2 Other - Non-Medicare fee schedule

Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **G0162** Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting) B MIPS
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G0166** External counterpulsation, per treatment session Q1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Pub: 100-4, Chapter-32, 130.1

C **G0168** Wound closure utilizing tissue adhesive(s) only B
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2001, Q3; 2001, Q4; 2005, Q1

C **G0175** Scheduled interdisciplinary team conference (minimum of three exclusive of patient care nursing staff) with patient present V
BETOS: M6 Consultations
Service not separately priced by Part B
Coding Clinic: 2001, Q3; 2006, Q4

D **G0176** Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) P MIPS
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2012, Q4

D **G0177** Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) N MIPS
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2012, Q4

C **G0179** Physician or allowed practitioner re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians and allowed practitioners to affirm the initial implementation of the plan of care M
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

C **G0180** Physician or allowed practitioner certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians and allowed practitioners to affirm the initial implementation of the plan of care M
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

C **G0181** Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans M
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

C **G0182** Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more M
BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs

C **G0186** Destruction of localized lesion of choroid (for example, choroidal neovascularization); photocoagulation, feeder vessel technique (one or more sessions) R2 ASC T
BETOS: P4D Eye procedure - treatment of retinal lesions
Service not separately priced by Part B

M **G0219** PET imaging whole body; melanoma for non-covered indications E1
CPT® Crosswalk: 78813, 78816
BETOS: I4B Imaging/procedure - other
Service not separately priced by Part B
Coding Clinic: 2007, Q1; 2001, Q2; 2002, Q1; 2002, Q1
Pub: 100-4, Chapter-13, 60.3

M **G0235** PET imaging, any site, not otherwise specified Z2 ASC S
CPT® Crosswalk: 78811, 78812, 78813, 78814
BETOS: T2D Other tests - other
Service not separately priced by Part B
Coding Clinic: 2007, Q1
Pub: 100-4, Chapter-13, 60.14; 100-4, Chapter-13, 60.3

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C **G0237** Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring) S

BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2002, Q1
Pub: 100-2, Chapter-12, 40.5; 100-4, Chapter-5, 20

C **G0238** Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring) S

BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2002, Q1
Pub: 100-2, Chapter-12, 40.5; 100-4, Chapter-5, 20

C **G0239** Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring) S

BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2002, Q1
Pub: 100-4, Chapter-5, 20; 100-2, Chapter-12, 40.5

D **G0245** Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear and (4) patient education V

BETOS: M1A Office visits - new
Price established using national RVUs
Coding Clinic: 2002, Q4; 2002, Q3
Pub: 100-4, Chapter-32, 80.2; 100-4, Chapter-32, 80.8

D **G0246** Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education V

BETOS: M1B Office visits - established
Price established using national RVUs
Coding Clinic: 2002, Q4
Pub: 100-4, Chapter-32, 80.2; 100-4, Chapter-32, 80.8

D **G0247** Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include, the local care of superficial wounds (i.e. superficial to muscle and fascia) and at least the following if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails Q1

BETOS: M1B Office visits - established
Price established using national RVUs
Coding Clinic: 2002, Q4
Pub: 100-4, Chapter-32, 80.2; 100-4, Chapter-32, 80.8

D **G0248** Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient's ability to perform testing and report results V

BETOS: M1A Office visits - new
Price established using national RVUs
Coding Clinic: 2002, Q4

D **G0249** Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests V

BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs
Coding Clinic: 2002, Q4

D **G0250** Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests M

BETOS: M1B Office visits - established
Price established using national RVUs
Coding Clinic: 2002, Q4; 2002, Q3

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M **G0252** PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes) E1
CPT® Crosswalk: 78811, 78812, 78813, 0422T
BETOS: I2D Advanced imaging - MRI/MRA: other
Service not separately priced by Part B
Coding Clinic: 2007, Q1; 2002, Q4; 2006, Q1
Pub: 100-4, Chapter-13, 60.3

M **G0255** Current perception threshold/sensory nerve conduction test, (SNCT) per limb, any nerve E1
BETOS: T2D Other tests - other
Service not separately priced by Part B
Coding Clinic: 2002, Q4

D **G0257** Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility S
BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2014, Q3; 2003, Q1; 2002, Q4
Pub: 100-4, Chapter-4, 200.2

D **G0259** Injection procedure for sacroiliac joint; arthrography N
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2002, Q4

D **G0260** Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography A2 ASC T
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2021, Q4; 2002, Q4

C **G0268** Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing N
CPT® Crosswalk: 69209, 69210
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2016, Q2; 2003, Q1

D **G0269** Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug) N
CPT® Crosswalk: 34808
BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2012, Q4; 2010, Q4; 2022, Q3

C **G0270** Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes A MIPS
CPT® Crosswalk: 97802, 97803
BETOS: M5D Specialist - other
Price established using national RVUs
Coding Clinic: 2019, Q3

C **G0271** Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes A MIPS
CPT® Crosswalk: 97804
BETOS: M5D Specialist - other
Price established using national RVUs

D **G0276** Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial G2 ASC J1
BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Price established by carriers

D **G0277** Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval S
BETOS: P5E Ambulatory procedures - other
Price established by carriers

C **G0278** Iliac and/or femoral artery angiography, non-selective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and radiologic supervision and interpretation (list separately in addition to primary procedure) N1 ASC N
BETOS: I4A Imaging/procedure - heart including cardiac catheterization
Price established using national RVUs
Coding Clinic: 2006, Q4

C **G0279** Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066) ♀ A
CPT® Crosswalk: 77061, 77062, 0422T
BETOS: I1C Standard imaging - breast
Price established by carriers

C **G0281** Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers,

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diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care A

BETOS: P5E Ambulatory procedures - other
Price established using national RVUs
Coding Clinic: 2003, Q2; 2003, Q1

M **G0282** Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281 E1

BETOS: P5E Ambulatory procedures - other
Service not separately priced by Part B
Coding Clinic: 2003, Q2; 2003, Q1

C **G0283** Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care A

BETOS: P5E Ambulatory procedures - other
Price established using national RVUs
Coding Clinic: 2003, Q2; 2003, Q1; 2009, Q2

C **G0288** Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery N

BETOS: I2B Advanced imaging - CAT/CT/CTA: other
Price established using national RVUs

C **G0289** Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee N

BETOS: P8A Endoscopy - arthroscopy
Price established using national RVUs
Coding Clinic: 2003, Q2; 2011, Q2; 2020, Q4; 2011, Q2

D **G0293** Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day Q1

BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2002, Q4

D **G0294** Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day Q1

BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2002, Q4

M **G0295** Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses E1

BETOS: I2B Advanced imaging - CAT/CT/CTA: other
Service not separately priced by Part B
Coding Clinic: 2003, Q1

C **G0296** Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making) S

CPT® Crosswalk: 99401

BETOS: M6 Consultations
Price established by carriers
Coding Clinic: 2019, Q3; 2005, Q2
Pub: 100-4, Chapter-13, 60.3

C **G0299** Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes B MIPS

BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q2; 2006, Q2; 2003, Q4

C **G0300** Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes B MIPS

BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2003, Q4; 2007, Q1; 2008, Q2

C **G0302** Pre-operative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days of services S

BETOS: T2D Other tests - other
Service not separately priced by Part B

C **G0303** Pre-operative pulmonary surgery services for preparation for LVRS, 10 to 15 days of services S

BETOS: T2D Other tests - other
Service not separately priced by Part B

C **G0304** Pre-operative pulmonary surgery services for preparation for LVRS, 1 to 9 days of services S

BETOS: T2D Other tests - other
Service not separately priced by Part B

C **G0305** Post-discharge pulmonary surgery services after LVRS, minimum of 6 days of services S

BETOS: T2D Other tests - other
Service not separately priced by Part B

C **G0306** Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count Q4

BETOS: T1D Lab tests - blood counts
Price subject to national limitation amount

C **G0307** Complete (CBC), automated (HgB, HCT, RBC, WBC; without platelet count) Q4

BETOS: T1D Lab tests - blood counts
Price subject to national limitation amount

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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I **G0310** Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5 to 15 mins time (this code is used for medicaid billing purposes) E1

BETOS: M5D Specialist - other
Value not established
Coding Clinic: 2008, Q4; 2022, Q4

I **G0311** Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 mins time (this code is used for medicaid billing purposes) E1

BETOS: M5D Specialist - other
Value not established
Coding Clinic: 2008, Q4; 2022, Q4

I **G0312** Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time (this code is used for medicaid billing purposes) ⓐ E1

BETOS: M5D Specialist - other
Value not established
Coding Clinic: 2008, Q4; 2022, Q4

I **G0313** Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time (this code is used for medicaid billing purposes) ⓐ E1

BETOS: M5D Specialist - other
Value not established
Coding Clinic: 2008, Q4; 2022, Q4

I **G0314** Immunization counseling by a physician or other qualified health care professional for covid-19, ages under 21, 16-30 mins time (this code is used for the medicaid early and periodic screening, diagnostic, and treatment benefit (epsdt) ⓐ E1

BETOS: M5D Specialist - other
Value not established
Coding Clinic: 2008, Q4; 2022, Q4

I **G0315** Immunization counseling by a physician or other qualified health care professional for covid-19, ages under 21, 5-15 mins time (this code is used for the medicaid early and periodic screening, diagnostic, and treatment benefit (epsdt) ⓐ E1

BETOS: M5D Specialist - other
Value not established
Coding Clinic: 2022, Q4; 2008, Q4

C **G0316** Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418, 99415, 99416). (do not report G0316 for any time unit less than 15 minutes) N

BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs
Coding Clinic: 2008, Q4; 2023, Q1

C **G0317** Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99306, 99310 for nursing facility evaluation and management services). (do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (do not report G0317 for any time unit less than 15 minutes) B

BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs
Coding Clinic: 2008, Q4

C **G0318** Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99345, 99350 for home or residence evaluation and management services). (do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (do not report G0318 for any time unit less than 15 minutes) B

BETOS: Y1 Other - Medicare fee schedule
Price established using national RVUs
Coding Clinic: 2008, Q4

C **G0320** Home health services furnished using synchronous telemedicine rendered via a real-tlme two-way audio and video telecommunications system A

BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2023, Q1; 2008, Q4

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C **G0321** Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system A
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2023, Q1; 2008, Q4

C **G0322** The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring) A
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2023, Q1; 2008, Q4

C **G0323** Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, clinical social worker, mental health counselor, or marriage and family therapist time, per calendar month. (These services include the following required elements: Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish e/m services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team) S
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q1; 2008, Q4

D **G0327** Colorectal cancer screening; blood-based biomarker A
CPT® Crosswalk: 81327
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2021, Q3; 2021, Q3; 2008, Q4

D **G0328** Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous A
CPT® Crosswalk: 81327, 82270, 82274
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2023, Q3; 2012, Q2
Pub: 100-4, Chapter-18, 60.1

C **G0329** Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care A
BETOS: I2B Advanced imaging - CAT/CT/CTA: other
Service not separately priced by Part B

D **G0330** Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room D2 ASC J1
BETOS: P1G Major procedure - other

D **G0333** Pharmacy dispensing fee for inhalation drug(s); initial 30-day supply as a beneficiary M
BETOS: D1E Other DME

C **G0337** Hospice evaluation and counseling services, pre-election B
BETOS: M5D Specialist - other
Price established using national RVUs

C **G0339** Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment B
CPT® Crosswalk: 61796, 61797, 61798, 61799, 63620, 63621, 77372
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2004, Q1

C **G0340** Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment B
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2004, Q1

D **G0341** Percutaneous islet cell transplant, includes portal vein catheterization and infusion C
BETOS: P1G Major procedure - other
Price established by carriers

D **G0342** Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion C
BETOS: P1G Major procedure - other
Price established by carriers

D **G0343** Laparotomy for islet cell transplant, includes portal vein catheterization and infusion C
BETOS: P1G Major procedure - other
Price established by carriers

D **G0372** Physician service required to establish and document the need for a power mobility device M
BETOS: M5D Specialist - other
Price established by carriers

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HOSPITAL OBSERVATION AND EMERGENCY SERVICES (G0378-G0384)

D G0378 Hospital observation service, per hour N
BETOS: M2A Hospital visit - initial
Service not separately priced by Part B
Coding Clinic: 2005, Q4; 2005, Q4; 2007, Q1; 2005, Q4; 2006, Q3
Pub: 100-4, Chapter-4, 290.5.2; 100-4, Chapter-4, 290.5.1; 100-4, Chapter-4, 290.4.3; 100-4, Chapter-4, 290.4.2; 100-4, Chapter-4, 290.4.1; 100-4, Chapter-4, 290.2.2; 100-2, Chapter-6, 20.6

D G0379 Direct admission of patient for hospital observation care J2
BETOS: M2A Hospital visit - initial
Service not separately priced by Part B
Coding Clinic: 2005, Q4; 2005, Q4; 2007, Q1; 2005, Q4
Pub: 100-4, Chapter-4, 290.5.2; 100-4, Chapter-4, 290.5.1; 100-4, Chapter-4, 290.4.3; 100-4, Chapter-4, 290.4.1

C G0380 Level 1 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) J2
BETOS: M3 Emergency room visit
Service not separately priced by Part B
Coding Clinic: 2006, Q4; 2009, Q1; 2013, Q4; 2007, Q4; 2007, Q2

C G0381 Level 2 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) J2
BETOS: M3 Emergency room visit
Service not separately priced by Part B
Coding Clinic: 2006, Q4; 2013, Q4; 2007, Q4

C G0382 Level 3 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) J2
BETOS: M3 Emergency room visit
Service not separately priced by Part B
Coding Clinic: 2007, Q4; 2006, Q4; 2013, Q4

C G0383 Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) J2
BETOS: M3 Emergency room visit
Service not separately priced by Part B
Coding Clinic: 2013, Q4; 2007, Q4

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C **G0384** Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) J2

BETOS: M3 Emergency room visit
Service not separately priced by Part B
Coding Clinic: 2013, Q4; 2006, Q4; 2009, Q1; 2007, Q2

OTHER EMERGENCY SERVICES (G0390)

D **G0390** Trauma response team associated with hospital critical care service S

BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2006, Q4; 2007, Q2

ALCOHOL AND SUBSTANCE ABUSE ASSESSMENTS (G0396-G0397)

C **G0396** Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes S

BETOS: M5D Specialist - other
Price established using national RVUs
Coding Clinic: 2019, Q3; 2007, Q4

C **G0397** Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes S

BETOS: M5D Specialist - other
Price established using national RVUs
Coding Clinic: 2019, Q3

SLEEP STUDIES, IN HOME (G0398-G0400)

C **G0398** Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: eeg, eog, emg, ecg/heart rate, airflow, respiratory effort and oxygen saturation S

BETOS: T2D Other tests - other
Price established by carriers
Coding Clinic: 2008, Q3

C **G0399** Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation S

BETOS: T2D Other tests - other
Price established by carriers
Coding Clinic: 2008, Q3

C **G0400** Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels S

BETOS: T2D Other tests - other
Price established by carriers
Coding Clinic: 2008, Q3

INITIAL SERVICES FOR MEDICARE ENROLLMENT (G0402-G0405)

C **G0402** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment V MIPS

CPT® Crosswalk: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429

BETOS: M1A Office visits - new
Price established using national RVUs
Coding Clinic: 2008, Q4; 2009, Q4
Pub: 100-4, Chapter-18, 140.6; 100-4, Chapter-18, 80.4; 100-4, Chapter-18, 80.3.3; 100-4, Chapter-18, 80.2; 100-4, Chapter-18, 80.1; 100-4, Chapter-12, 100.1.1

C **G0403** Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report M

CPT® Crosswalk: 93000, 93040

BETOS: T2C Other tests - EKG monitoring
Price established using national RVUs
Coding Clinic: 2008, Q4
Pub: 100-4, Chapter-18, 80.1; 100-4, Chapter-18, 80.2

C **G0404** Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination S

CPT® Crosswalk: 93005

BETOS: T2C Other tests - EKG monitoring
Price established using national RVUs
Coding Clinic: 2008, Q4
Pub: 100-4, Chapter-18, 80.3.3; 100-4, Chapter-18, 80.2; 100-4, Chapter-18, 80.1

C **G0405** Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination B

CPT® Crosswalk: 93010, 93042

BETOS: T2C Other tests - EKG monitoring
Price established using national RVUs
Coding Clinic: 2008, Q4
Pub: 100-4, Chapter-18, 80.2

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FOLLOW-UP TELEHEALTH CONSULTATIONS (G0406-G0408), SEE ALSO INITIAL TELEHEALTH CONSULTATIONS (G0425-G0427)

C **G0406** Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth B

BETOS: M6 Consultations
Price established by carriers
Coding Clinic: 2008, Q4; 2019, Q3
Pub: 100-4, Chapter-12, 190.3.3

C **G0407** Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth B

BETOS: M6 Consultations
Price established using national RVUs
Coding Clinic: 2008, Q4; 2019, Q3
Pub: 100-4, Chapter-12, 190.3.3

C **G0408** Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth B

BETOS: M6 Consultations
Price established using national RVUs
Coding Clinic: 2019, Q3; 2008, Q4
Pub: 100-4, Chapter-12, 190.3.3

PSYCHOLOGICAL SERVICES (G0409-G0411)

C **G0409** Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF-qualified social worker or psychologist in a CORF) B MIPS

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2008, Q4
Pub: 100-4, Chapter-5, 100.4

C **G0410** Group psychotherapy other than of a multiple-family group, in a partial hospitalization or intensive outpatient setting, approximately 45 to 50 minutes P MIPS

BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Price established by carriers
Coding Clinic: 2008, Q4; 2009, Q4; 2024, Q1; 2012, Q4

C **G0411** Interactive group psychotherapy, in a partial hospitalization or intensive outpatient setting, approximately 45 to 50 minutes P MIPS

BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Price established by carriers
Coding Clinic: 2008, Q4; 2009, Q4; 2024, Q1; 2012, Q4

FRACTURE TREATMENT (G0412-G0415)

C **G0412** Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed C

CPT® Crosswalk: 27215

BETOS: P3D Major procedure, orthopedic - other
Price established by carriers
Coding Clinic: 2008, Q4

C **G0413** Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, (includes ilium, sacroiliac joint and/or sacrum) J1

CPT® Crosswalk: 27216

BETOS: P3D Major procedure, orthopedic - other
Price established by carriers
Coding Clinic: 2008, Q4

C **G0414** Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami) C

CPT® Crosswalk: 27217

BETOS: P3D Major procedure, orthopedic - other
Price established by carriers
Coding Clinic: 2008, Q4

C **G0415** Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum) C

BETOS: P3D Major procedure, orthopedic - other
Price established by carriers
Coding Clinic: 2008, Q4

GROSS AND MICROSCOPIC EXAMINATIONS, PROSTATE BIOPSY (G0416)

C **G0416** Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method ♂ Q2

BETOS: T1G Lab tests - other (Medicare fee schedule)
Price established by carriers
Coding Clinic: 2022, Q2; 2008, Q4

FACE-TO-FACE EDUCATIONAL SERVICES (G0420, G0421)

C **G0420** Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour A

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BETOS: M1B Office visits - established
Price established using national RVUs
Coding Clinic: 2019, Q3
Pub: 100-2, Chapter-15, 310.3

C **G0421** Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour A
BETOS: M1B Office visits - established
Price established using national RVUs
Coding Clinic: 2019, Q3
Pub: 100-2, Chapter-15, 310.3

CARDIAC AND PULMONARY REHABILITATION SERVICES (G0422-G0423)

C **G0422** Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session S
CPT® Crosswalk: 93797, 93798, 93799
BETOS: M5D Specialist - other
Price established using national RVUs
Pub: 100-4, Chapter-32, 140.3.1

C **G0423** Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session S
BETOS: M5D Specialist - other
Price established using national RVUs
Pub: 100-4, Chapter-32, 140.3.1

INITIAL TELEHEALTH CONSULTATIONS (G0425-G0427), SEE ALSO FOLLOW-UP TELEHEALTH CONSULTATIONS (G0406-G0408)

C **G0425** Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth B
BETOS: M6 Consultations
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-12, 190.3.2

C **G0426** Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth B
BETOS: M6 Consultations
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-12, 190.3.2

C **G0427** Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth B
BETOS: M6 Consultations
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-12, 190.3.2

FILLER PROCEDURES (G0428, G0429)

M **G0428** Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) E1
BETOS: P1G Major procedure - other
Service not separately priced by Part B

C **G0429** Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy) P3 ASC T
CPT® Crosswalk: 11950, 11951, 11952, 11954
BETOS: P6A Minor procedures - skin
Price established by carriers
Coding Clinic: 2010, Q3
Pub: 100-4, Chapter-32, 260.2.1; 100-4, Chapter-32, 260.2.2

LABORATORY SCREENING TESTS (G0432-G0435)

C **G0432** Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening A
CPT® Crosswalk: 86701, 86702, 86703, 87389, 87390, 87391, 87806
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2010, Q1
Pub: 100-4, Chapter-18, 130.1; 100-4, Chapter-18, 130.2; 100-4, Chapter-18, 130.3

C **G0433** Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening A
CPT® Crosswalk: 86701, 86702, 86703, 87389, 87390, 87391, 87806
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2010, Q1
Pub: 100-4, Chapter-18, 130.1; 100-4, Chapter-18, 130.2; 100-4, Chapter-18, 130.3

C **G0435** Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening A
CPT® Crosswalk: 86689, 86701, 86702, 86703, 87389, 87390, 87391, 87806
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2010, Q1
Pub: 100-4, Chapter-18, 130.1; 100-4, Chapter-18, 130.2; 100-4, Chapter-18, 130.3

♂ Male only ♀ Female only Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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COUNSELING, SCREENING, AND PREVENTION SERVICES (G0438-G0451)

C G0438 Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit A MIPS
CPT® Crosswalk: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99429
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-18, 140.6; 100-4, Chapter-18, 140.1; 100-4, Chapter-12, 100.1.1

C G0439 Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit A MIPS
CPT® Crosswalk: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99429
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-18, 140.6

C G0442 Annual alcohol misuse screening, 5 to 15 minutes S
CPT® Crosswalk: 99408
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers
Coding Clinic: 2019, Q3; 2012, Q1
Pub: 100-4, Chapter-18, 180.1

C G0443 Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes S
CPT® Crosswalk: 99409
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers
Coding Clinic: 2019, Q3; 2012, Q1
Pub: 100-4, Chapter-18, 180.1; 100-4, Chapter-18, 180.4

C G0444 Annual depression screening, 5 to 15 minutes S MIPS
CPT® Crosswalk: 96127, 96160, 96161, 99401
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-18, 190.3; 100-4, Chapter-18, 190.2; 100-4, Chapter-18, 190.1

C 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-annually, 30 minutes S
CPT® Crosswalk: 96158
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers
Coding Clinic: 2019, Q3
Pub: 100-4, Chapter-18, 170.1; 100-4, Chapter-18, 170.3; 100-4, Chapter-18, 170.4.1

C G0446 Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes S
CPT® Crosswalk: 99401
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers
Coding Clinic: 2012, Q2; 2019, Q3
Pub: 100-4, Chapter-18, 160.4; 100-4, Chapter-18, 160.3; 100-4, Chapter-18, 160.2.2; 100-4, Chapter-18, 160.2.1; 100-4, Chapter-18, 160.1

C G0447 Face-to-face behavioral counseling for obesity, 15 minutes S MIPS
CPT® Crosswalk: 96158, 96159, 99401
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers
Coding Clinic: 2019, Q3; 2012, Q1
Pub: 100-4, Chapter-18, 200.1; 100-4, Chapter-18, 200.3; 100-4, Chapter-18, 200.4

C 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 B
CPT® Crosswalk: 33230, 33231, 33240, 33241, 33249, 33262, 33263, 33264, 33270, 33999
BETOS: Y1 Other - Medicare fee schedule
Price established by carriers

C G0451 Development testing, with interpretation and report, per standardized instrument form Q3
BETOS: M5D Specialist - other
Price established by carriers

MISCELLANEOUS SERVICES (G0452-G0465)

C G0452 Molecular pathology procedure; physician interpretation and report B
BETOS: T2D Other tests - other
Price established by carriers

C G0453 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure) N
BETOS: T2D Other tests - other
Price established by carriers

C G0454 Physician documentation of face-to-face visit for durable medical equipment determination performed by nurse practitioner, physician assistant or clinical nurse specialist B
BETOS: M5D Specialist - other
Price established by carriers

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G0455 Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen T
BETOS: T2D Other tests - other
Price established by carriers
Coding Clinic: 2013, Q3

G0458 Low dose rate (LDR) prostate brachytherapy services, composite rate ♂ B
BETOS: P7A Oncology - radiation therapy
Service not separately priced by Part B

G0459 Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy B
CPT® Crosswalk: 90863
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3

G0460 Autologous platelet rich plasma or other blood-derived product for non-diabetic chronic wounds/ulcers, including as applicable phlebotomy, centrifugation or mixing, and all other preparatory procedures, administration and dressings, per treatment T
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2022, Q3; 2023, Q3
Pub: 100-4, Chapter-32, 11.3.6; 100-4, Chapter-32, 11.3.2

G0463 Hospital outpatient clinic visit for assessment and management of a patient J2 MIPS
BETOS: M1B Office visits - established
Service not separately priced by Part B
Coding Clinic: 2020, Q4; 2014, Q4; 2020, Q2; 2013, Q4
Pub: 100-4, Chapter-4, 290.5.1

G0465 Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes as applicable administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)
BETOS: P5E Ambulatory procedures - other
Price established by carriers
Coding Clinic: 2022, Q3; 2023, Q3

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISITS (G0466-G0470)

G0466 Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit A
BETOS: M1A Office visits - new
Price established by carriers

G0467 Federally qualified health center (FQHC) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit A
BETOS: M1B Office visits - established
Price established by carriers

G0468 Federally qualified health center (FQHC) visit, ippe or awv; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV A MIPS
BETOS: M1B Office visits - established
Price established by carriers

G0469 Federally qualified health center (FQHC) visit, mental health, new patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit A MIPS
BETOS: M1A Office visits - new
Price established by carriers

G0470 Federally qualified health center (FQHC) visit, mental health, established patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit A MIPS
BETOS: M1B Office visits - established
Price established by carriers

OTHER SERVICES (G0471-G0659)

G0471 Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA) A
CPT® Crosswalk: 36400, 36405, 36406, 36410, 36415, 51701
BETOS: Z2 Undefined codes
Price subject to national limitation amount
Pub: 100-4, Chapter-16, 60.1.4

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D **G0472** Hepatitis C antibody screening, for individual at high risk and other covered indication(s) A

CPT® Crosswalk: 86803, 86804

BETOS: P5E Ambulatory procedures - other

Price established by carriers

Statute: 1861SSA

C **G0473** Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes S MIPS

CPT® Crosswalk: 96164, 99078, 99411

BETOS: M1B Office visits - established

Price established by carriers

Pub: 100-4, Chapter-18, 200.3; 100-4, Chapter-18, 200.1

C **G0475** Hiv antigen/antibody, combination assay, screening A

CPT® Crosswalk: 86701, 86702, 86703, 87389, 87390, 87391, 87806

BETOS: T2D Other tests - other

Price established by carriers

Pub: 100-4, Chapter-18, 130.2; 100-4, Chapter-18, 130.3

C **G0476** Infectious agent detection by nucleic acid (dna or rna); human papillomavirus (hpv), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test ♀ A

CPT® Crosswalk: 87624, 87625

BETOS: T2D Other tests - other

Price established by carriers

C **G0480** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed Q4

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

Coding Clinic: 2022, Q2; 2018, Q1

C **G0481** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed Q4

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

Coding Clinic: 2022, Q2; 2018, Q1

C **G0482** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed Q4

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)

Price subject to national limitation amount

Coding Clinic: 2022, Q2; 2018, Q1

C **G0483** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-

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matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed Q4

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2022, Q2; 2018, Q1

C **G0490** Face-to-face home health nursing visit by a rural health clinic (RHC) or federally qualified health center (FQHC) in an area with a shortage of home health agencies; (services limited to RN or LPN only) A

BETOS: M4A Home visit
Price established by carriers

C **G0491** Dialysis procedure at a Medicare certified ESRD facility for acute kidney injury without ESRD B

BETOS: P9A Dialysis services (Medicare fee schedule)
Price established by carriers

C **G0492** Dialysis procedure with single evaluation by a physician or other qualified health care professional for acute kidney injury without ESRD B

BETOS: P9A Dialysis services (Medicare fee schedule)
Price established by carriers

C **G0493** Skilled services of a registered nurse (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) B MIPS

BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

C **G0494** Skilled services of a licensed practical nurse (LPN) 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) B MIPS

BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

C **G0495** Skilled services of a registered nurse (rn), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

C **G0496** Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes B

BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

C **G0498** Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion S

BETOS: P7B Oncology - other
Price established by carriers
Coding Clinic: 2017, Q2

C **G0499** Hepatitis b screening in non-pregnant, high risk individual includes hepatitis b surface antigen (hbsag), antibodies to hbsag (anti-hbs) and antibodies to hepatitis b core antigen (anti-hbc), and is followed by a neutralizing confirmatory test, when performed, only for an initially reactive hbsag result A

CPT® Crosswalk: 86704, 86706, 87340, 87341

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price established by carriers

C **G0500** Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate) Ⓐ N

CPT® Crosswalk: 99151, 99152, 99153

BETOS: P0 Anesthesia
Price established by carriers

C **G0501** Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service) N

BETOS: M5D Specialist - other
Price established by carriers

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C **G0506** Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service) N
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3

C **G0508** Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth B
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3

C **G0509** Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth B
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3

D **G0511** Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month A
BETOS: M5D Specialist - other
Price established by carriers

D **G0512** Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric cocm services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month A
BETOS: M5D Specialist - other
Price established by carriers

C **G0513** Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service) N
CPT® Crosswalk: 99415
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3

C **G0514** Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service) N
CPT® Crosswalk: 99416
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2019, Q3

C **G0516** Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant) N1 ASC Q1
CPT® Crosswalk: 11981, 0278T
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established by carriers

C **G0517** Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants) N1 ASC Q1
CPT® Crosswalk: 11982
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established by carriers

C **G0518** Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants) N1 ASC Q1
CPT® Crosswalk: 11983, 0278T
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established by carriers

● C **G0519** Management of new patient-caregiver dyad with dementia, low complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0520** Management of new patient-caregiver dyad with dementia, moderate complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0521** Management of new patient-caregiver dyad with dementia, high complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0522** Management of a new patient with dementia, low complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0523** Management of a new patient with dementia, moderate to high complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

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● C **G0524** Management of established patient-caregiver dyad with dementia, low complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0525** Management of established patient-caregiver dyad with dementia, moderate complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0526** Management of established patient-caregiver dyad with dementia, high complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0527** Management of established patient with dementia, low complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0528** Management of established patient with dementia, moderate to high complexity, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0529** In-home respite care, 4-hour unit, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0530** Adult day center, 8-hour unit, for use in cmmi model Ⓐ M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0531** Facility-based respite, 24-hour unit, for use in cmmi model M
BETOS: Z2 Undefined codes
Price established by carriers
Coding Clinic: 2024, Q3

● C **G0532** Take-home supply of nasal nalmefene hydrochloride; one carton of two, 2.7 mg per 0.1 ml nasal sprays (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
BETOS: Z2 Undefined codes
Price established using national RVUs

● C **G0533** Medication assisted treatment, buprenorphine (injectable) administered on a weekly basis; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program)
BETOS: M5D Specialist - other
Price established by carriers

● C **G0534** Coordinated care and/or referral services, such as to adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an opioid use disorder; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
BETOS: M5D Specialist - other
Price established by carriers

● C **G0535** Patient navigational services, provided directly or by referral; including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self-advocacy and communication skills with care providers, and to promote patient-driven action plans and goals; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
BETOS: M5D Specialist - other
Price established by carriers

● C **G0536** Peer recovery support services, provided directly or by referral; including leveraging knowledge of the condition or lived experience to provide support, mentorship, or inspiration to meet oud treatment and recovery goals; conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes; developing and proposing strategies to help meet person-centered treatment goals; assisting the patient in locating or navigating recovery support services; each additional 30 minutes of services (provision of the services by a Medicare-enrolled opioid treatment program); (list separately in addition to each primary code)
BETOS: M5D Specialist - other
Price established by carriers

● C **G0537** Administration of a standardized, evidence-based atherosclerotic cardiovascular disease (ascvd) risk assessment, 5-15 minutes, not more often than every 12 months
BETOS: M5D Specialist - other
Price established by carriers

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment Indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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● C **G0538** Atherosclerotic cardiovascular disease (ascvd) risk management services; clinical staff time; per calendar month
BETOS: M5D Specialist - other
Price established by carriers

● C **G0539** Caregiver training in behavior management/ modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
BETOS: M5D Specialist - other
Price established by carriers

● C **G0540** Caregiver training in behavior management/ modification for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
BETOS: M5D Specialist - other
Price established by carriers

● C **G0541** Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
BETOS: M5D Specialist - other
Price established by carriers

● C **G0542** Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service) (use g0542 in conjunction with g0541)
BETOS: M5D Specialist - other
Price established by carriers

● C **G0543** Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
BETOS: M5D Specialist - other
Price established by carriers

● C **G0544** Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month
BETOS: M5D Specialist - other
Price established by carriers

● C **G0545** Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious diseases specialist, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment (add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, subsequent or discharge)
BETOS: M5D Specialist - other
Price established by carriers

● C **G0546** Interprofessional telephone/internet/ electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review
BETOS: M5D Specialist - other
Price established by carriers

● C **G0547** Interprofessional telephone/internet/ electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review
BETOS: M5D Specialist - other
Price established by carriers

● C **G0548** Interprofessional telephone/internet/ electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review
BETOS: M5D Specialist - other
Price established by carriers

● C **G0549** Interprofessional telephone/internet/ electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services

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for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review

BETOS: M5D Specialist - other
Price established by carriers

● C **G0550** Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time

BETOS: M5D Specialist - other
Price established by carriers

● C **G0551** Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes

BETOS: M5D Specialist - other
Price established by carriers

● C **G0552** Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan

BETOS: M5D Specialist - other
Price established by carriers

● C **G0553** First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month

BETOS: M5D Specialist - other
Price established by carriers

● C **G0554** Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month

BETOS: M5D Specialist - other
Price established by carriers

● C **G0555** Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring

BETOS: Z2 Undefined codes
Price established by carriers

● C **G0556** Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:

- consent;

++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply.

++ document in patient's medical record that consent was obtained.

- initiation during a qualifying visit for new patients or patients not seen within 3 years;
- provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week; continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours;
- overall comprehensive care management;

++ systematic needs assessment (medical and psychosocial).

++ system-based approaches to ensure receipt of preventive services.

++ medication reconciliation, management and oversight of self-management.

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- development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan with typical care plan elements when clinically relevant;

++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver;

- coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable;

++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.

++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

- ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record;

- enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate;

++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits).

- analyze patient population data to identify gaps in care and offer additional interventions, as appropriate;

- risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients;

- be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

BETOS: M5D Specialist - other
Price established by carriers

- C **G0557** Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:

  - consent;

  ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply.

  ++ document in patient's medical record that consent was obtained.

  - initiation during a qualifying visit for new patients or patients not seen within 3 years;

  - provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week;

  - continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;

  - deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours;

  - overall comprehensive care management;

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++ systematic needs assessment (medical and psychosocial).

++ system-based approaches to ensure receipt of preventive services.

++ medication reconciliation, management and oversight of self-management.

- development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan;

++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver;

- coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable;

++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.

++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

- ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record;

- enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate;

++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits).

- analyze patient population data to identify gaps in care and offer additional interventions, as appropriate;

- risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients;

- be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

BETOS: M5D Specialist - other
Price established by carriers

- C **G0558** Advanced primary care management services for a patient that is a qualified Medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:

  - consent;

  ++ inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply.

  ++ document in patient's medical record that consent was obtained.

  - initiation during a qualifying visit for new patients or patients not seen within 3 years;

  - provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week;

  - continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;

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- deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours;
- overall comprehensive care management;

++ systematic needs assessment (medical and psychosocial).

++ system-based approaches to ensure receipt of preventive services.

++ medication reconciliation, management and oversight of self-management.

- development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan;

++ care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver;

- coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable;

++ ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.

++ ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

- ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record;
- enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/ehr referral service(s), to maintain ongoing communication with patients, as appropriate;

++ ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and e/m visits (or e-visits).

- analyze patient population data to identify gaps in care and offer additional interventions, as appropriate;
- risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients;
- be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of certified ehr technology

BETOS: M5D Specialist - other
Price established by carriers

- C **G0559** Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:
  - reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.
  - research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).
  - evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.
  - communicate with the practitioner who performed the procedure if any questions or concerns arise. (list separately in addition to office/outpatient evaluation and management visit, new or established)

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BETOS: M5D Specialist - other
Price established by carriers

● C **G0560** Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky substance use; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe
BETOS: M5D Specialist - other
Price established by carriers

● C **G0561** Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583t)
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established by carriers

● C **G0562** Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)
BETOS: P7A Oncology - radiation therapy
Price established by carriers

● C **G0563** Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions
BETOS: P7A Oncology - radiation therapy
Price established by carriers

● C **G0564** Creation of subcutaneous pocket with insertion of 365 day implantable interstitial glucose sensor, including system activation and patient training
BETOS: P5E Ambulatory procedures - other
Price established by carriers

● C **G0565** Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365 day implantable sensor, including system activation
BETOS: P5E Ambulatory procedures - other
Price established by carriers

C **G0659** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes Q4
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount
Coding Clinic: 2022, Q2

QUALITY MEASURES FOR CATARACT SURGERY (G0913-G0918)

C **G0913** Improvement in visual function achieved within 90 days following cataract surgery M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G0914** Patient care survey was not completed by patient M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G0915** Improvement in visual function not achieved within 90 days following cataract surgery M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G0916** Satisfaction with care achieved within 90 days following cataract surgery M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G0917** Patient care survey was not completed by patient M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G0918** Satisfaction with care not achieved within 90 days following cataract surgery M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

CLINICAL DECISION SUPPORT MECHANISM (CDSM) (G1001-G1028)

C **G1001** Clinical decision support mechanism evicore, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C G1002 Clinical decision support mechanism medcurrent, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1003 Clinical decision support mechanism medicalis, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1004 Clinical decision support mechanism national decision support company, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1007 Clinical decision support mechanism aim specialty health, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1008 Clinical decision support mechanism cranberry peak, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1010 Clinical decision support mechanism stanson, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1011 Clinical decision support mechanism, qualified tool not otherwise specified, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1012 Clinical decision support mechanism agilemd, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1013 Clinical decision support mechanism evidence care imaging care, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1014 Clinical decision support mechanism inveniqa semantic answers in medicine, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1015 Clinical decision support mechanism reliant medical group, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1016 Clinical decision support mechanism speed of care, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1017 Clinical decision support mechanism healthhelp, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1018 Clinical decision support mechanism infinx, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1019 Clinical decision support mechanism logicnets, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1020 Clinical decision support mechanism curbside clinical augmented workflow, as defined by the Medicare appropriate use criteria program E1
CPT® Crosswalk: 96130, 96131, 96132, 96133, 96156, 97161, 97162, 97163, 97165, 97166, 97167, 97169, 97170, 97171
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1021 Clinical decision support mechanism ehealthline clinical decision support mechanism, as defined by the Medicare appropriate use criteria program E1
CPT® Crosswalk: 96130, 96131, 96132, 96133, 96156, 97161, 97162, 97163, 97165, 97166, 97167, 97169, 97170, 97171
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1022 Clinical decision support mechanism intermountain clinical decision support mechanism, as defined by the Medicare appropriate use criteria program E1
CPT® Crosswalk: 96130, 96131, 96132, 96133, 96156, 97161, 97162, 97163, 97165, 97166, 97167, 97169, 97170, 97171
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G1023 Clinical decision support mechanism persivia clinical decision support, as defined by the Medicare appropriate use criteria program E1
CPT® Crosswalk: 96130, 96131, 96132, 96133, 96156, 97161, 97162, 97163, 97165, 97166, 97167, 97169, 97170, 97171
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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G1024 Clinical decision support mechanism radrite, as defined by the Medicare appropriate use criteria program E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

G1025 Patient-months where there are more than one Medicare capitated payment (mcp) provider listed for the month M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

G1026 The number of adult patient-months in the denominator who were on maintenance hemodialysis using a catheter continuously for three months or longer under the care of the same practitioner or group partner as of the last hemodialysis session of the reporting month Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

G1027 The number of adult patient-months in the denominator who were on maintenance hemodialysis under the care of the same practitioner or group partner as of the last hemodialysis session of the reporting month using a catheter continuously for less than three months Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

G1028 Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 ml nasal spray (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A
BETOS: Z2 Undefined codes
Price established using national RVUs

CONVULSIVE THERAPY PROCEDURE (G2000)

G2000 Blinded administration of convulsive therapy procedure, either electroconvulsive therapy (ect, current covered gold standard) or magnetic seizure therapy (mst, non-covered experimental therapy), performed in an approved ide-based clinical trial, per treatment session S
BETOS: P6D Minor procedures - other (Non-Medicare fee schedule)
Service not separately priced by Part B

OTHER EVALUATION AND MANAGEMENT SERVICES (G2001-G2020)

G2001 Brief (20 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B
BETOS: M4A Home visit
Price established by carriers

G2002 Limited (30 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B
BETOS: M4A Home visit
Price established by carriers

G2003 Moderate (45 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B
BETOS: M4A Home visit
Price established by carriers

G2004 Comprehensive (60 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B
BETOS: M4A Home visit
Price established by carriers

G2005 Extensive (75 minutes) in-home visit for a new patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B
BETOS: M4A Home visit
Price established by carriers

G2006 Brief (20 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B
BETOS: M4A Home visit
Price established by carriers

G2007 Limited (30 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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90 days following discharge from an inpatient facility and no more than 9 times.) B

BETOS: M4A Home visit

Price established by carriers

C **G2008** Moderate (45 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B

BETOS: M4A Home visit

Price established by carriers

C **G2009** Comprehensive (60 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B

BETOS: M4A Home visit

Price established by carriers

C **G2010** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment B MIPS

BETOS: M5D Specialist - other

Price established by carriers

C **G2011** Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes S

BETOS: M1B Office visits - established

Price established by carriers

C **G2013** Extensive (75 minutes) in-home visit for an existing patient post-discharge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B

BETOS: M4A Home visit

Price established by carriers

C **G2014** Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than 9 times.) B

BETOS: M4A Home visit

Price established by carriers

C **G2015** Comprehensive (60 mins) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility.) B

BETOS: M4A Home visit

Price established by carriers

C **G2020** Services for high intensity clinical services associated with the initial engagement and outreach of beneficiaries assigned to the sip component of the pcf model (do not bill with chronic care management codes) A

BETOS: Z2 Undefined codes

Service not separately priced by Part B

Coding Clinic: 2021, Q2

CARE MANAGEMENT SERVICES (G2021-G2025)

C **G2021** Health care practitioners rendering treatment in place (tip) E1

BETOS: M5D Specialist - other

Service not separately priced by Part B

C **G2022** A model participant (ambulance supplier/ provider), the beneficiary refuses services covered under the model (transport to an alternate destination/treatment in place) E1

BETOS: M5D Specialist - other

Service not separately priced by Part B

C **G2025** Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only A

BETOS: M6 Consultations

Price established by carriers

Coding Clinic: 2020, Q2

MEDICATION ASSISTED TREATMENT PROGRAM (G2067-G2075)

C **G2067** Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) A

BETOS: M5D Specialist - other

Price established by carriers

C **G2068** Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) A

BETOS: M5D Specialist - other

Price established by carriers

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▲ C **G2069** Medication assisted treatment, buprenorphine (injectable) administered on a monthly basis; bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) A
BETOS: M5D Specialist - other
Price established by carriers

C **G2073** Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) A
BETOS: M5D Specialist - other
Price established by carriers

C **G2074** Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program) A
BETOS: M5D Specialist - other
Price established by carriers

C **G2075** Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program) A
BETOS: M5D Specialist - other
Price established by carriers

OPIOID USE DISORDER - EVALUATION AND TREATMENT (G2076-G2081)

▲ C **G2076** Intake activities, including initial medical examination that is conducted by an appropriately licensed practitioner and preparation of a care plan, which may be informed by administration of a standardized, evidence-based social determinants of health risk assessment to identify unmet health-related social needs, and that includes the patient's goals and mutually agreed-upon actions for the patient to meet those goals, including harm reduction interventions; the patient's needs and goals in the areas of education, vocational training, and employment; and the medical and psychiatric, psychosocial, economic, legal, housing, and other recovery support services that a patient needs and wishes to pursue, conducted by an appropriately licensed/credentialed personnel (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to each primary code A
BETOS: M5D Specialist - other
Price established by carriers

▲ C **G2077** Periodic assessment; assessing periodically by an otp practitioner and includes a review of moud dosing, treatment response, other substance use disorder treatment needs, responses and patient-identified goals, and other relevant physical and psychiatric treatment needs and goals; assessment may be informed by administration of a standardized, evidence-based social determinants of health risk assessment to identify unmet health related social needs, or the need and interest for harm reduction interventions and recovery support services (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to each primary code A
BETOS: M5D Specialist - other
Price established by carriers

C **G2078** Take-home supply of methadone; up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A
BETOS: M5D Specialist - other
Price established by carriers

C **G2079** Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A
BETOS: M5D Specialist - other
Price established by carriers

C **G2080** Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A
BETOS: M5D Specialist - other
Price established by carriers

C **G2081** Patients age 66 and older in institutional special needs plans (snp) or residing in long-term care with a pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

EVALUATION AND MANAGEMENT SERVICES (G2082-G2083)

C **G2082** Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified

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health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation S

BETOS: M1B Office visits - established
Price established by carriers

C **G2083** Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation S

BETOS: M1B Office visits - established
Price established by carriers

OPIOID USE DISORDER - TREATMENT (OFFICE BASED) (G2086-G2088)

C **G2086** Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month S

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2020, Q1

C **G2087** Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month S

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2020, Q1

C **G2088** Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure) N

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2020, Q1

FUNCTIONAL STATUS (G2090-G2152)

C **G2090** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period A M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G2091** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period A M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2092** Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy prescribed or currently being taken M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2093** Documentation of medical reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2094** Documentation of patient reason(s) for not prescribing ace inhibitor or arb or arni therapy (e.g., patient declined, other patient reasons) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2096** Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) or angiotensin receptor-neprilysin inhibitor (arni) therapy was not prescribed, reason not given M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2097** Episodes where the patient had a competing diagnosis on or within three days after the episode date (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, chronic sinusitis, infection of the adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis or uti) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2098** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period A M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

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▲ C **G2099** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2100** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G2101** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2105** Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2106** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G2107** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2112** Patient receiving <=5 mg daily prednisone (or equivalent), or ra activity is worsening, or glucocorticoid use is for less than 6 months M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2113** Patient receiving >5 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2115** Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G2116** Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2118** Patients 81 years of age and older with at least one claim/encounter for frailty during the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2121** Depression, anxiety, apathy, and psychosis assessed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2122** Depression, anxiety, apathy, and psychosis not assessed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2125** Patients 81 years of age and older with at least one claim/encounter for frailty during the six months prior to the measurement period through december 31 of the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G2126** Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2127** Patients 66 - 80 years of age with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **G2128** Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g. history of gastrointestinal bleed, intra-cranial bleed, blood disorders, idiopathic thrombocytopenic purpura (itp), gastric bypass or documentation of active anticoagulant use during the measurement period) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2129** Procedure-related bp's not taken during an outpatient visit. examples include same day surgery, ambulatory service center, g.i. lab, dialysis, infusion center, chemotherapy M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2136** Back pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2137** Back pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated improvement of less than 5.0 points M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G2138** Back pain as measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2139** Back pain measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was greater than 3.0 and back pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated improvement of less than 5.0 points M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G2140** Leg pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 5.0 points or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2021, Q2

C **G2141** Leg pain measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated improvement of less than 5.0 points M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G2142** Functional status measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively was less than or equal to 22 or functional status measured by the odi version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 30 points or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2143** Functional status measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively was greater than 22 and functional status measured by the odi version 2.1a within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of less than 30 points M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2144** Functional status measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively was less than or equal to 22 or functional status measured by the odi version 2.1a within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of 30 points or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G2145** Functional status measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively was greater than 22 and functional status measured by the odi version 2.1a within three months preoperatively and at three months (6 - 20 weeks) postoperatively demonstrated an improvement of less than 30 points M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2146** Leg pain as measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was less than or equal to 3.0 or leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated an improvement of 5.0 points or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2147** Leg pain measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively was greater than 3.0 and leg pain measured by the visual analog scale (vas) or numeric pain scale within three months preoperatively and at one year (9 to 15 months) postoperatively demonstrated improvement of less than 5.0 points M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G2148** Multimodal pain management was used M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2149** Documentation of medical reason(s) for not using multimodal pain management (e.g., allergy to multiple classes of analgesics, intubated patient, hepatic failure, patient reports no pain during pacu stay, other medical reason(s)) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2150** Multimodal pain management was not used M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2151** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2152** Residual score for the neck impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

PERFORMANCE MEASURES (G2167)

C **G2167** Residual score for the neck impairment successfully calculated and the score was less than zero (< 0) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

THERAPY MAINTENANCE PROGRAM IN HOME HEALTH SETTING (G2168-G2169)

C **G2168** Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes B

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G2169** Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes B

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

OPIOID USE DISORDER (OUD) TREATMENT SERVICES (G2172)

C **G2172** All inclusive payment for services related to highly coordinated and integrated opioid use disorder (oud) treatment services furnished for the demonstration project A

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2021, Q2

CLINICIAN DOCUMENTATION AND MANAGEMENT SERVICES (G2173-G2210)

C **G2173** Uri episodes where the patient had a comorbid condition during the 12 months prior to or on the episode date (e.g., tuberculosis, neutropenia, cystic fibrosis, chronic bronchitis, pulmonary edema, respiratory failure, rheumatoid lung disease) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2174** Uri episodes where the patient is taking antibiotics (table 1) in the 30 days prior to the episode date M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

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C **G2175** Episodes where the patient had a comorbid condition during the 12 months prior to or on the episode date (e.g., tuberculosis, neutropenia, cystic fibrosis, chronic bronchitis, pulmonary edema, respiratory failure, rheumatoid lung disease) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2176** Outpatient, ed, or observation visits that result in an inpatient admission M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2177** Acute bronchitis/bronchiolitis episodes when the patient had a new or refill prescription of antibiotics (table 1) in the 30 days prior to the episode date M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2178** Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee; patient has condition that would not allow them to accurately respond to a neurological exam (dementia, alzheimer's, etc.); patient has previously documented diabetic peripheral neuropathy with loss of protective sensation M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2179** Clinician documented that patient had medical reason for not performing lower extremity neurological exam M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2180** Clinician documented that patient was not an eligible candidate for evaluation of footwear as patient is bilateral lower extremity amputee M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2181** Bmi not documented due to medical reason or patient refusal of height or weight measurement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2182** Patient receiving first-time biologic and/or immune response modifier therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2183** Documentation patient unable to communicate and informant not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2184** Patient does not have a caregiver M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2185** Documentation caregiver is trained and certified in dementia care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2186** Patient /caregiver dyad has been referred to appropriate resources and connection to those resources is confirmed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2187** Patients with clinical indications for imaging of the head: head trauma M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2188** Patients with clinical indications for imaging of the head: new or change in headache above 50 years of age A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2189** Patients with clinical indications for imaging of the head: abnormal neurologic exam M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2190** Patients with clinical indications for imaging of the head: headache radiating to the neck M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2191** Patients with clinical indications for imaging of the head: positional headaches M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2192** Patients with clinical indications for imaging of the head: temporal headaches in patients over 55 years of age A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2193** Patients with clinical indications for imaging of the head: new onset headache in pre-school children or younger (<6 years of age) A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2194** Patients with clinical indications for imaging of the head: new onset headache in pediatric patients with disabilities for which headache is a concern as inferred from behavior A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2195** Patients with clinical indications for imaging of the head: occipital headache in children A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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C **G2196** Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2197** Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2199** Patient not screened for unhealthy alcohol use using a systematic screening method M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2200** Patient identified as an unhealthy alcohol user received brief counseling M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2202** Patient did not receive brief counseling if identified as an unhealthy alcohol user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2204** Patients between 45 and 85 years of age who received a screening colonoscopy during the performance period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2205** Patients with pregnancy during adjuvant treatment course ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2206** Patient received adjuvant treatment course including both chemotherapy and her2-targeted therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2207** Reason for not administering adjuvant treatment course including both chemotherapy and her2-targeted therapy (e.g. poor performance status (ecog 3-4; karnofsky <=50), cardiac contraindications, insufficient renal function, insufficient hepatic function, other active or secondary cancer diagnoses, other medical contraindications, patients who died during initial treatment course or transferred during or after initial treatment course) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2208** Patient did not receive adjuvant treatment course including both chemotherapy and her2-targeted therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2209** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2210** Residual score for the neck impairment not measured because the patient did not complete the neck fs prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

EVALUATION AND CARE MANAGEMENT SERVICES (G2211-G2214)

C **G2211** Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established) B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G2212** Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes) N
BETOS: M5D Specialist - other
Price established using national RVUs

C **G2213** Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (list separately in addition to code for primary procedure) N
BETOS: Z2 Undefined codes
Price established using national RVUs

C **G2214** Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional S
BETOS: M5D Specialist - other
Price established using national RVUs

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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TAKE HOME SUPPLIES (G2215-G2216)

C **G2215** Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 ml nasal spray (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A

BETOS: Z2 Undefined codes
Price established using national RVUs

C **G2216** Take-home supply of injectable naloxone (provision of the services by a Medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure A

BETOS: Z2 Undefined codes
Price established using national RVUs

DOCUMENTATION ASSESSMENT (REMOTE) (G2250)

C **G2250** Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment A MIPS

BETOS: M5D Specialist - other
Price established by carriers

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICES (G2251-G2252)

C **G2251** Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion A MIPS

BETOS: M5D Specialist - other
Price established by carriers

C **G2252** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion A MIPS

BETOS: M5D Specialist - other
Price established by carriers

CHRONIC PAIN MANAGEMENT AND TREATMENT SERVICES (G3002-G3003)

C **G3002** Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using G3002, 30 minutes must be met or exceeded.) M

BETOS: P5E Ambulatory procedures - other
Price established using national RVUs

C **G3003** Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for G3002. when using G3003, 15 minutes must be met or exceeded.) M

BETOS: P5E Ambulatory procedures - other
Price established using national RVUs

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MIPS SPECIALTY SET (G4000-G4038)

C **G4000** Dermatology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4001** Diagnostic radiology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4002** Electrophysiology cardiac specialist mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4003** Emergency medicine mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4004** Endocrinology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4005** Family medicine mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4006** Gastro-enterology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4007** General surgery mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4008** Geriatrics mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4009** Hospitalists mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4010** Infectious disease mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4011** Internal medicine mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4012** Interventional radiology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4013** Mental/behavioral and psychiatry mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4014** Nephrology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4015** Neurology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4016** Neurosurgical mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4017** Nutrition/dietician mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4018** Obstetrics/gynecology mips specialty set ♀ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4019** Oncology/hematology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4020** Ophthalmology/optometry mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4021** Orthopedic surgery mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4022** Otolaryngology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4023** Pathology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4024** Pediatrics mips specialty set Ⓐ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4025** Physical medicine mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4026** Physical therapy/occupational therapy mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4027** Plastic surgery mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4028** Podiatry mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4029** Preventive medicine mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4030** Pulmonology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4031** Radiation oncology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4032** Rheumatology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **G4033** Skilled nursing facility mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4034** Speech language pathology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4035** Thoracic surgery mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4036** Urgent care mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4037** Urology mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G4038** Vascular surgery mips specialty set M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

RADIATION THERAPY SERVICES (G6001-G6017)

D **G6001** Ultrasonic guidance for placement of radiation therapy fields B
CPT® Crosswalk: 76978, 76979, 77373, 77387, 77402, 77407, 77412
BETOS: I3F Echography/ultrasonography - other
Price established by carriers

C **G6002** Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy B
CPT® Crosswalk: 19294, 77373, 77387, 77402, 77407, 77412
BETOS: I4B Imaging/procedure - other
Price established by carriers

C **G6003** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6004** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6005** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6006** Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 MeV or greater B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6007** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6008** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6009** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6010** Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 MeV or greater B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6011** Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6012** Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6013** Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6014** Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6015** Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

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C **G6016** Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session B
BETOS: P7A Oncology - radiation therapy
Price established by carriers

C **G6017** Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment B
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established by carriers

ADDITIONAL QUALITY MEASURES (G8395-G8635)

C **G8395** Left ventricular ejection fraction (LVEF) >= 40% or documentation as normal or mildly depressed left ventricular systolic function M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8396** Left ventricular ejection fraction (LVEF) not performed or documented M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8397** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema and level of severity of retinopathy M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8399** Patient with documented results of a central dual-energy X-ray absorptiometry (DXA) ever being performed M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8400** Patient with central dual-energy X-ray absorptiometry (DXA) results not documented, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8404** Lower extremity neurological exam performed and documented M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8405** Lower extremity neurological exam not performed M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8410** Footwear evaluation performed and documented M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8415** Footwear evaluation was not performed M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8416** Clinician documented that patient was not an eligible candidate for footwear evaluation measure M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8417** BMI is documented above normal parameters and a follow-up plan is documented Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8418** BMI is documented below normal parameters and a follow-up plan is documented Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8419** BMI documented outside normal parameters, no follow-up plan documented, no reason given Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8420** BMI is documented within normal parameters and no follow-up plan is required Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8421** BMI not documented and no reason is given Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8427** Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8428** Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8430** Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medications list (e.g., patient is in an urgent or emergent medical situation) M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8431** Screening for depression is documented as being positive and a follow-up plan is documented M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

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C **G8432** Depression screening not documented, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8433** Screening for depression not completed, documented patient or medical reason M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8450** Beta-blocker therapy prescribed M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8451** Beta-blocker therapy for lvef <=40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons) M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8452** Beta-blocker therapy not prescribed M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8465** High or very high risk of recurrence of prostate cancer ♂ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8473** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8474** Angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy not prescribed for reasons documented by the clinician (e.g., allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (e.g., patient declined, other patient reasons) M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8475** Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8476** Most recent blood pressure has a systolic measurement of < 140 mmHg and a diastolic measurement of < 90 mmHg M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8477** Most recent blood pressure has a systolic measurement of >=140 mmHg and/or a diastolic measurement of >=90 mmHg M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8478** Blood pressure measurement not performed or documented, reason not given M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8510** Screening for depression is documented as negative, a follow-up plan is not required M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8511** Screening for depression documented as positive, follow-up plan not documented, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8535** Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter related to one of the following reasons: (1) patient refuses to participate in the screening and has reasonable decisional capacity for self-protection, or (2) patient is in an urgent or emergent situation where time is of the essence and to delay treatment to perform the screening would jeopardize the patient's health status Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4; 2024, Q1

C **G8536** No documentation of an elder maltreatment screen, reason not given Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8539** Functional outcome assessment documented as positive using a standardized tool and a care plan based on identified deficiencies is documented within two days of the functional outcome assessment Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8540** Functional outcome assessment not documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter Ⓐ M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

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C **G8541** Functional outcome assessment using a standardized tool not documented, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8542** Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required A M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8543** Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment, reason not given A M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C **G8559** Patient referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8560** Patient has a history of active drainage from the ear within the previous 90 days M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8561** Patient is not eligible for the referral for otologic evaluation for patients with a history of active drainage measure M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8562** Patient does not have a history of active drainage from the ear within the previous 90 days M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8563** Patient not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8564** Patient was referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not specified) M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8565** Verification and documentation of sudden or rapidly progressive hearing loss M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8566** Patient is not eligible for the "referral for otologic evaluation for sudden or rapidly progressive hearing loss" measure M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8567** Patient does not have verification and documentation of sudden or rapidly progressive hearing loss M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8568** Patient was not referred to a physician (preferably a physician with training in disorders of the ear) for an otologic evaluation, reason not given M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8569** Prolonged postoperative intubation (> 24 hrs) required M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8570** Prolonged postoperative intubation (> 24 hrs) not required M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8575** Developed postoperative renal failure or required dialysis M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8576** No postoperative renal failure/dialysis not required M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

▲ C **G8577** Re-exploration required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

▲ C **G8578** Re-exploration not required due to mediastinal bleeding with or without tamponade, unplanned coronary artery intervention (native, vessel, graft, or both), valve dysfunction, aortic reintervention, or other cardiac reason M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8598** Aspirin or another antiplatelet therapy used M
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8599** Aspirin or another antiplatelet therapy not used, reason not given M
BETOS: M5D Specialist - other
Service not separately priced by Part B

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C **G8600** Iv thrombolytic therapy initiated within 4.5 hours (<= 270 minutes) of time last known well M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8601** Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well for reasons documented by clinician (e.g. patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8602** Iv thrombolytic therapy not initiated within 4.5 hours (<= 270 minutes) of time last known well, reason not given M MIPS
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G8633** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8635** Pharmacologic therapy for osteoporosis was not prescribed, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

QUALITY MEASURES RELATED FOR RISK-ADJUSTED FUNCTIONAL STATUS SCORING (G8647-G8670)

C **G8647** Residual score for the knee impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8648** Residual score for the knee impairment successfully calculated and the score was less than zero (< 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8650** Residual score for the knee impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8651** Residual score for the hip impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8652** Residual score for the hip impairment successfully calculated and the score was less than zero (< 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8654** Residual score for the hip impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8655** Residual score for the lower leg, foot or ankle impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8656** Residual score for the lower leg, foot or ankle impairment successfully calculated and the score was less than zero (< 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8658** Residual score for the lower leg, foot or ankle impairment not measured because the patient did not complete the lepf prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8659** Residual score for the low back impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8660** Residual score for the low back impairment successfully calculated and the score was less than zero (< 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8661** Risk-adjusted functional status change residual score for the low back impairment not measured because the patient did not complete the fs status survey near discharge, patient not appropriate M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8662** Residual score for the low back impairment not measured because the patient did not complete the low back fs prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8663** Residual score for the shoulder impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

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C **G8664** Residual score for the shoulder impairment successfully calculated and the score was less than zero (< 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8666** Residual score for the shoulder impairment not measured because the patient did not complete the shoulder fs prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8667** Residual score for the elbow, wrist or hand impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8668** Residual score for the elbow, wrist or hand impairment successfully calculated and the score was less than zero (< 0) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8670** Residual score for the elbow, wrist or hand impairment not measured because the patient did not complete the elbow/wrist/hand fs prom at initial evaluation and/or near discharge, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

ADDITIONAL QUALITY MEASURES (G8694-G8970)

▲ C **G8694** Current or prior left ventricular ejection fraction (lvef) < = 40% or documentation of moderate or severe lvsd M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8708** Patient not prescribed antibiotic Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8709** Uri episodes when the patient had competing diagnoses on or three days after the episode date (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis or uti, and acne) Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8710** Patient prescribed antibiotic Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8711** Prescribed antibiotic on or within 3 days after the episode date M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8712** Antibiotic not prescribed or dispensed M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8721** pT category (primary tumor), pN category (regional lymph nodes), and histologic grade were documented in pathology report M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8722** Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade in the pathology report (e.g., re-excision without residual tumor; non-carcinomasanal canal) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8723** Specimen site is other than anatomic location of primary tumor M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8724** pT category, pN category and histologic grade were not documented in the pathology report, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8733** Elder maltreatment screen documented as positive and a follow-up plan is documented M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8734** Elder maltreatment screen documented as negative, follow-up is not required M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8735** Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8749** Absence of signs of melanoma (tenderness, jaundice, localized neurologic signs such as weakness, or any other sign suggesting systemic spread) or absence of symptoms of melanoma (cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

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C **G8752** Most recent systolic blood pressure < 140 mmHg M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8753** Most recent systolic blood pressure >= 140 mmHg M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8754** Most recent diastolic blood pressure < 90 mmHg M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8755** Most recent diastolic blood pressure >= 90 mmHg M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8756** No documentation of blood pressure measurement, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8783** Normal blood pressure reading documented, follow-up not required M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8785** Blood pressure reading not documented, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8797** Specimen site other than anatomic location of esophagus M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8798** Specimen site other than anatomic location of prostate ♂ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8806** Performance of trans-abdominal or trans-vaginal ultrasound and pregnancy location documented ♀ A M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8807** Trans-abdominal or trans-vaginal ultrasound not performed for reasons documented by clinician (e.g., patient has a documented intrauterine pregnancy [iup]) ♀ A M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8808** Trans-abdominal or trans-vaginal ultrasound not performed, reason not given ♀ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8815** Documented reason in the medical records for why the statin therapy was not prescribed (i.e., lower extremity bypass was for a patient with non-artherosclerotic disease) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8816** Statin medication prescribed at discharge M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8817** Statin therapy not prescribed at discharge, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8826** Patient discharged to home no later than post-operative day #2 following evar M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8833** Patient not discharged to home by post-operative day #2 following evar M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8834** Patient discharged to home no later than post-operative day #2 following CEA M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8838** Patient not discharged to home by post-operative day #2 following CEA M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8839** Sleep apnea symptoms assessed, including presence or absence of snoring and daytime sleepiness M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8840** Documentation of reason(s) for not documenting an assessment of sleep symptoms (e.g., patient didn't have initial daytime sleepiness, patient visited between initial testing and initiation of therapy) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8841** Sleep apnea symptoms not assessed, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G8842** Apnea hypopnea index (ahi), respiratory disturbance index (rdi) or respiratory event index (rei) documented or measured within 2 months after initial evaluation for suspected obstructive sleep apnea M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G8843** Documentation of reason(s) for not measuring an apnea hypopnea index (ahi), a respiratory disturbance index (rdi), or a respiratory event index (rei) within 2 months

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after initial evaluation for suspected obstructive sleep apnea (e.g., medical, neurological, or psychiatric disease that prohibits successful completion of a sleep study, patients for whom a sleep study would present a bigger risk than benefit or would pose an undue burden, dementia, patients previously diagnosed with osa and severity assessed by another provider, patients who decline ahi/rdi/rei measurement, patients who had a financial reason for not completing testing, test was ordered but not completed, patients decline because their insurance (payer) does not cover the expense) M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G8844** Apnea hypopnea index (ahi), respiratory disturbance index (rdi), or respiratory event index (rei) not documented or measured within 2 months after initial evaluation for suspected obstructive sleep apnea, reason not given M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8845** Positive airway pressure therapy prescribed M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8846** Moderate or severe obstructive sleep apnea (apnea hypopnea index (AHI) or respiratory disturbance index (RDI) of 15 or greater) M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8849** Documentation of reason(s) for not prescribing positive airway pressure therapy (e.g., patient unable to tolerate, alternative therapies use, patient declined, financial, insurance coverage) M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8850** Positive airway pressure therapy not prescribed, reason not given M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8851** Adherence to therapy was assessed at least annually through an objective informatics system or through self-reporting (if objective reporting is not available, documented) M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8854** Documentation of reason(s) for not objectively reporting adherence to evidence-based therapy (e.g., patients who have been diagnosed with a terminal or advanced disease with an expected life span of less than 6 months, patients who decline therapy, patients who do not return for follow-up at least annually, patients unable to access/ afford therapy, patient's insurance will not cover therapy) M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8855** Adherence to therapy was not assessed at least annually through an objective informatics system or through self-reporting (if objective reporting is not available), reason not given M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8856** Referral to a physician for an otologic evaluation performed M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **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) M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8858** Referral to a physician for an otologic evaluation not performed, reason not given M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8863** Patients not assessed for risk of bone loss, reason not given M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8864** Pneumococcal vaccine administered or previously received M

BETOS: M5B Speciallst - psychlatry
Service not separately priced by Part B

C **G8865** Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccine (e.g., patient allergic reaction, potential adverse drug reaction) M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8866** Documentation of patient reason(s) for not administering or previously receiving pneumococcal vaccine (e.g., patient refusal) M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8867** Pneumococcal vaccine not administered or previously received, reason not given M

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

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C **G8869** Patient has documented immunity to hepatitis B and initiating anti-TNF therapy M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8875** Clinician diagnosed breast cancer preoperatively by a minimally invasive biopsy method M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8876** Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer preoperatively (e.g., lesion too close to skin, implant, chest wall, etc., lesion could not be adequately visualized for needle biopsy, patient condition prevents needle biopsy [weight, breast thickness, etc.], duct excision without imaging abnormality, prophylactic mastectomy, reduction mammoplasty, excisional biopsy performed by another physician) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8877** Clinician did not attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8878** Sentinel lymph node biopsy procedure performed M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8880** Documentation of reason(s) sentinel lymph node biopsy not performed (e.g., reasons could include but not limited to; non-invasive cancer, incidental discovery of breast cancer on prophylactic mastectomy, incidental discovery of breast cancer on reduction mammoplasty, pre-operative biopsy proven lymph node (ln) metastases, inflammatory carcinoma, stage 3 locally advanced cancer, recurrent invasive breast cancer, clinically node positive after neoadjuvant systemic therapy, patient refusal after informed consent, patient with significant age, comorbidities, or limited life expectancy and favorable tumor; adjuvant systemic therapy unlikely to change) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8881** Stage of breast cancer is greater than T1N0M0 or T3N0M0 M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8882** Sentinel lymph node biopsy procedure not performed, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8907** Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site/side/patient/procedure/implant event; or a hospital transfer or hospital admission upon discharge from the facility M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8908** Patient documented to have received a burn prior to discharge M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8909** Patient documented not to have received a burn prior to discharge M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8910** Patient documented to have experienced a fall within ASC M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8911** Patient documented not to have experienced a fall within ambulatory surgical center M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8912** Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8913** Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8914** Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8915** Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8916** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic initiated on time M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8917** Patient with preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis, antibiotic not initiated on time M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

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C **G8918** Patient without preoperative order for IV antibiotic surgical site infection (SSI) prophylaxis M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G8923** Current or prior left ventricular ejection fraction (lvef) <= 40% or documentation of moderately or severely depressed left ventricular systolic function M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8924** Spirometry results documented (fev1/fvc < 70%) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

▲ C **G8934** Current or prior left ventricular ejection fraction (lvef) <=40% or documentation of moderately or severely depressed left ventricular systolic function M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8935** Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8936** Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy (eg, allergy, intolerance, pregnancy, renal failure due to ace inhibitor, diseases of the aortic or mitral valve, other medical reasons) or (eg, patient declined, other patient reasons) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8937** Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not given Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8942** Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan, based on identified deficiencies is documented within two days of the functional outcome assessment Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8944** AJCC melanoma cancer Stage 0 through IIC melanoma M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8946** Minimally invasive biopsy method attempted but not diagnostic of breast cancer (e.g., high risk lesion of breast such as atypical ductal hyperplasia, lobular neoplasia, atypical lobular hyperplasia, lobular carcinoma in situ, atypical columnar hyperplasia, flat epithelial atypia, radial scar, complex sclerosing lesion, papillary lesion, or any lesion with spindle cells) Ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8950** Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8952** Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8955** Most recent assessment of adequacy of volume management documented Ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8956** Patient receiving maintenance hemodialysis in an outpatient dialysis facility Ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8958** Assessment of adequacy of volume management not documented, reason not given Ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8961** Cardiac stress imaging test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8962** Cardiac stress imaging test performed on patient for any reason including those who did not have low risk surgery or test that was performed more than 30 days preceding low risk surgery Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8967** Fda approved oral anticoagulant is prescribed Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

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C **G8968** Documentation of medical reason(s) for not prescribing an fda-approved anticoagulant (e.g., present or planned atrial appendage occlusion or ligation or patient being currently enrolled in a clinical trial related to af/atrial flutter treatment) ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G8969** Documentation of patient reason(s) for not prescribing an oral anticoagulant that is fda approved for the prevention of thromboembolism (e.g., patient preference for not receiving anticoagulation) ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G8970** No risk factors or one moderate risk factor for thromboembolism ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

MEDICARE COORDINATED CARE DEMONSTRATION (MCCD) SERVICES (G9001-G9012)

D **G9001** Coordinated care fee, initial rate B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9002** Coordinated care fee, maintenance rate B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9003** Coordinated care fee, risk adjusted high, initial B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9004** Coordinated care fee, risk adjusted low, initial B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9005** Coordinated care fee, risk adjusted maintenance B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9006** Coordinated care fee, home monitoring B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9007** Coordinated care fee, scheduled team conference B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9008** Coordinated care fee, physician coordinated care oversight services B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9009** Coordinated care fee, risk adjusted maintenance, level 3 B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9010** Coordinated care fee, risk adjusted maintenance, level 4 B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9011** Coordinated care fee, risk adjusted maintenance, level 5 B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **G9012** Other specified case management service not elsewhere classified B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

MEDICARE DEMONSTRATION PROJECTS (G9013-G9140)

M **G9013** ESRD demo basic bundle level I E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

M **G9014** ESRD demo expanded bundle including venous access and related services E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

M **G9016** Smoking cessation counseling, individual, in the absence of or in addition to any other evaluation and management service, per session (6-10 minutes) [demo project code only] E1
CPT® Crosswalk: 99406
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

● C **G9037** Interprofessional telephone/internet/electronic health record clinical question/request for specialty recommendations by a treating/requesting physician or other qualified health care professional for the care of the patient (i.e. not for professional education or scheduling) and may include subsequent follow up on the specialist's recommendations; 30 minutes A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q3

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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● C **G9038** Co-management services with the following elements: new diagnosis or acute exacerbation and stabilization of existing condition; condition which may benefit from joint care planning; condition for which specialist is taking a co-management role; condition expected to last at least 3 months; comprehensive care plan established, implemented, revised or monitored in partnership with co-managing clinicians; ongoing communication and care coordination between co-managing clinicians furnishing care A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q3

I **G9050** Oncology; primary focus of visit; work-up, evaluation, or staging at the time of cancer diagnosis or recurrence (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9051** Oncology; primary focus of visit; treatment decision-making after disease is staged or restaged, discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9052** Oncology; primary focus of visit; surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9053** Oncology; primary focus of visit; expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9054** Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a Medicare-approved demonstration project) E1 MIPS
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9055** Oncology; primary focus of visit; other, unspecified service not otherwise listed (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9056** Oncology; practice guidelines; management adheres to guidelines (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9057** Oncology; practice guidelines; management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9058** Oncology; practice guidelines; management differs from guidelines because the treating physician disagrees with guideline recommendations (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9059** Oncology; practice guidelines; management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9060** Oncology; practice guidelines; management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9061** Oncology; practice guidelines; patient's condition not addressed by available guidelines (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

I **G9062** Oncology; practice guidelines; management differs from guidelines for other reason(s) not listed (for use in a Medicare-approved demonstration project) E1
BETOS: P7B Oncology - other
Service not separately priced by Part B

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C **G9063** Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as Stage I (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9064** Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as Stage II (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9065** Oncology; disease status; limited to non-small cell lung cancer; extent of disease initially established as Stage III A (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9066** Oncology; disease status; limited to non-small cell lung cancer; Stage III B- IV at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9067** Oncology; disease status; limited to non-small cell lung cancer; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9068** Oncology; disease status; limited to small cell and combined small cell/ non-small cell; extent of disease initially established as limited with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9069** Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small cell; extensive Stage at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9070** Oncology; disease status; small cell lung cancer, limited to small cell and combined small cell/non-small; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9071** Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage I or Stage IIA-IIB; or T3, N1, M0; and ER and/or pr positive; with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9072** Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage I, or Stage IIA-IIB; or T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9073** Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage IIIA-IIIB; and not T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9074** Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage IIIA-IIIB; and not T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9075** Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

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C **G9077** Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T1-T3C and gleason 2-7 and PSA < or equal to 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9078** Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T2 or T3A Gleason 8-10 or PSA > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9079** Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; T3B-T4, any N; any T, N1 at diagnosis with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9080** Oncology; disease status; prostate cancer, limited to adenocarcinoma; after initial treatment with rising PSA or failure of PSA decline (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9083** Oncology; disease status; prostate cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9084** Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-3, N0, M0 with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9085** Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T4, N0, M0 with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9086** Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-4, N1-2, M0 with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9087** Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive with current clinical, radiologic, or biochemical evidence of disease (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9088** Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive without current clinical, radiologic, or biochemical evidence of disease (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9089** Oncology; disease status; colon cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9090** Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-2, N0, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9091** Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T3, N0, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

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C **G9092** Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T1-3, N1-2, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9093** Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9094** Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9095** Oncology; disease status; rectal cancer, limited to invasive cancer, adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9096** Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T1-T3, N0-N1 or NX (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9097** Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9098** Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9099** Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9100** Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post R0 resection (with or without neoadjuvant therapy) with no evidence of disease recurrence, progression, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9101** Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; post R1 or R2 resection (with or without neoadjuvant therapy) with no evidence of disease progression, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9102** Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic M0, unresectable with no evidence of disease progression, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9103** Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; clinical or pathologic M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9104** Oncology; disease status; gastric cancer, limited to adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

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C **G9105** Oncology; disease status; pancreatic cancer, limited to adenocarcinoma as predominant cell type; post R0 resection without evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9106** Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; post R1 or R2 resection with no evidence of disease progression, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9107** Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; unresectable at diagnosis, M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9108** Oncology; disease status; pancreatic cancer, limited to adenocarcinoma; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9109** Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as T1-T2 and N0, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9110** Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease initially established as T3-4 and/or N1-3, M0 (prior to neo-adjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9111** Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9112** Oncology; disease status; head and neck cancer, limited to cancers of oral cavity, pharynx and larynx with squamous cell as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9113** Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic Stage IA-B (Grade 1) without evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) ♀ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9114** Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic Stage IA-B (Grade 2-3); or Stage IC (all grades); or Stage II; without evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) ♀ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9115** Oncology; disease status; ovarian cancer, limited to epithelial cancer; pathologic Stage III-IV; without evidence of progression, recurrence, or metastases (for use in a Medicare-approved demonstration project) ♀ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9116** Oncology; disease status; ovarian cancer, limited to epithelial cancer; evidence of disease progression, or recurrence, and/or platinum resistance (for use in a Medicare-approved demonstration project) ♀ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9117** Oncology; disease status; ovarian cancer, limited to epithelial cancer; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) ♀ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9123** Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; chronic phase not in hematologic, cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

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C **G9124** Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; accelerated phase not in hematologic cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9125** Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; blast phase not in hematologic, cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9126** Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; in hematologic, cytogenetic, or molecular remission (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9128** Oncology; disease status; limited to multiple myeloma, systemic disease; smoldering, Stage I (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9129** Oncology; disease status; limited to multiple myeloma, systemic disease; Stage II or higher (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9130** Oncology; disease status; limited to multiple myeloma, systemic disease; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9131** Oncology; disease status; invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; extent of disease unknown, staging in progress, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9132** Oncology; disease status; prostate cancer, limited to adenocarcinoma; hormone-refractory/androgen-independent (e.g., rising PSA on anti-androgen therapy or post-orchiectomy); clinical metastases (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9133** Oncology; disease status; prostate cancer, limited to adenocarcinoma; hormone-responsive; clinical metastases or M1 at diagnosis (for use in a Medicare-approved demonstration project) ♂ M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9134** Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; Stage i, II at diagnosis, not relapsed, not refractory (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9135** Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; Stage III, IV, not relapsed, not refractory (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9136** Oncology; disease status; non-Hodgkin's lymphoma, transformed from original cellular diagnosis to a second cellular classification (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9137** Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; relapsed/refractory (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9138** Oncology; disease status; non-Hodgkin's lymphoma, any cellular classification; diagnostic evaluation, stage not determined, evaluation of possible relapse or non-response to therapy, or not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

C **G9139** Oncology; disease status; chronic myelogenous leukemia, limited to Philadelphia chromosome positive and/or BCR-ABL positive; extent of disease unknown, staging in progress, not listed (for use in a Medicare-approved demonstration project) M
BETOS: P7B Oncology - other
Service not separately priced by Part B

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C **G9140** Frontier extended stay clinic demonstration; for a patient stay in a clinic approved for the CMS demonstration project; the following measures should be present: the stay must be equal to or greater than 4 hours; weather or other conditions must prevent transfer or the case falls into a category of monitoring and observation cases that are permitted by the rules of the demonstration; there is a maximum frontier extended stay clinic (FESC) visit of 48 hours, except in the case when weather or other conditions prevent transfer; payment is made on each period up to 4 hours, after the first 4 hours A

BETOS: Z2 Undefined codes
Service not separately priced by Part B

WARFARIN RESPONSIVENESS TESTING (G9143)

C **G9143** Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s) N

BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2010, Q1
Pub: 100-4, Chapter-32, 250.1; 100-4, Chapter-32, 250.2

OUTPATIENT INTRAVENOUS INSULIN TREATMENT (G9147)

M **G9147** Outpatient intravenous insulin treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration E1

BETOS: P5E Ambulatory procedures - other
Service not separately priced by Part B
Coding Clinic: 2010, Q1
Pub: 100-4, Chapter-4, 320.2; 100-4, Chapter-4, 320.1

PRIMARY CARE QUALITY MEASURES (G9148-G9153)

C **G9148** National Committee for Quality Assurance - Level 1 medical home M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9149** National Committee for Quality Assurance - Level 2 medical home M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9150** National Committee for Quality Assurance - Level 3 medical home M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9151** MAPCP Demonstration - state provided services M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9152** MAPCP Demonstration - Community Health Teams M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9153** MAPCP Demonstration - Physician Incentive Pool M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

PROVIDER ASSESSMENT FOR WHEELCHAIR (G9156)

C **G9156** Evaluation for wheelchair requiring face to face visit with physician M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

DIAGNOSTIC CARDIAC DOPPLER ULTRASOUND (G9157)

C **G9157** Transesophageal Doppler Measurement Of Cardiac Output (Including Probe Placement, Image Acquisition, And Interpretation Per Course Of Treatment) For Monitoring Purposes B

BETOS: T2C Other tests - EKG monitoring
Service not separately priced by Part B
Pub: 100-4, Chapter-32, 310; 100-4, Chapter-32, 310.2; 100-4, Chapter-32, 310.3

BUNDLED PAYMENT CARE (G9187)

C **G9187** Bundled payments for care improvement initiative home visit for patient assessment performed by a qualified health care professional for individuals not considered homebound including, but not limited to, assessment of safety, falls, clinical status, fluid status, medication reconciliation/ management, patient compliance with orders/plan of care, performance of activities of daily living, appropriateness of care setting; (for use only in the Medicare-approved bundled payments for care improvement initiative); may not be billed for a 30-day period covered by a transitional care management code E1

BETOS: M5D Specialist - other
Price established by carriers

ADDITIONAL ASSORTED QUALITY MEASURES (G9188-G9891)

C **G9188** Beta-blocker therapy not prescribed, reason not given M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9189** Beta-blocker therapy prescribed or currently being taken M MIPS

BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **G9190** Documentation of medical reason(s) for not prescribing beta-blocker therapy (e.g., allergy, intolerance, other medical reasons) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9191** Documentation of patient reason(s) for not prescribing beta-blocker therapy (e.g., patient declined, other patient reasons) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9212** DSM-IVTM criteria for major depressive disorder documented at the initial evaluation M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9213** DSM-IV-TR criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9223** Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count below 500 cells/mm3 or a CD4 percentage below 15% M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9225** Foot exam was not performed, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9226** Foot examination performed (includes examination through visual inspection, sensory exam with 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold, and pulse exam; report when all of the 3 components are completed) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9227** Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9228** Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9230** Chlamydia, gonorrhea, and syphilis not screened, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9231** Documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period ♀ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9242** Documentation of viral load equal to or greater than 200 copies/ml or viral load not performed M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9243** Documentation of viral load less than 200 copies/ml M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G9246** Patient did not have two eligible encounters at least 90 days apart or one eligible encounter and one hiv viral load test at least 90 days apart M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G9247** Patient had two eligible encounters at least 90 days apart or one eligible encounter and one hiv viral load test at least 90 days apart M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G9254** Documentation of patient discharged to home later than post-operative day 2 following cea or cas M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G9255** Documentation of patient discharged to home no later than post operative day 2 following cea or cas M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9273** Blood pressure has a systolic value of < 140 and a diastolic value of < 90 M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9274** Blood pressure has a systolic value of =140 and a diastolic value of = 90 or systolic value < 140 and diastolic value = 90 or systolic value = 140 and diastolic value < 90 M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9275** Documentation that patient is a current non-tobacco user Ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9276** Documentation that patient is a current tobacco user Ⓐ M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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C **G9277** Documentation that the patient is on daily aspirin or anti-platelet or has documentation of a valid contraindication or exception to aspirin/anti-platelet; contraindications/ exceptions include anti-coagulant use, allergy to aspirin or anti-platelets, history of gastrointestinal bleed and bleeding disorder; additionally, the following exceptions documented by the physician as a reason for not taking daily aspirin or anti-platelet are acceptable (use of non-steroidal anti-inflammatory agents, documented risk for drug interaction, uncontrolled hypertension defined as >180 systolic or >110 diastolic or gastroesophageal reflux) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9278** Documentation that the patient is not on daily aspirin or anti-platelet regimen M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9279** Pneumococcal screening performed and documentation of vaccination received prior to discharge M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9280** Pneumococcal vaccination not administered prior to discharge, reason not specified M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9281** Screening performed and documentation that vaccination not indicated/patient refusal M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9282** Documentation of medical reason(s) for not reporting the histological type or NSCLC-NOS classification with an explanation (e.g., biopsy taken for other purposes in a patient with a history of non-small cell lung cancer or other documented medical reasons) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9283** Non small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as NSCLC-NOS with an explanation M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9284** Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as NSCLC-NOS with an explanation M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9285** Specimen site other than anatomic location of lung or is not classified as non small cell lung cancer M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9286** Antibiotic regimen prescribed within10 days after onset of symptoms M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9287** Antibiotic regimen not prescribed within 10 days after onset of symptoms M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9288** Documentation of medical reason(s) for not reporting the histological type or NSCLC-NOS classification with an explanation (e.g., a solitary fibrous tumor in a person with a history of non-small cell carcinoma or other documented medical reasons) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9289** Non small cell lung cancer biopsy and cytology specimen report documents classification into specific histologic type or classified as NSCLC-NOS with an explanation M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9290** Non small cell lung cancer biopsy and cytology specimen report does not document classification into specific histologic type or classified as NSCLC-NOS with an explanation M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9291** Specimen site other than anatomic location of lung, is not classified as non small cell lung cancer or classified as NSCLC-NOS M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9292** Documentation of medical reason(s) for not reporting pt category and a statement on thickness and ulceration and for PT1, mitotic rate (e.g., negative skin biopsies in a patient with a history of melanoma or other documented medical reasons) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9293** Pathology report does not include the pt category and a statement on thickness and ulceration and for PT1, mitotic rate M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9294** Pathology report includes the pt category and a statement on thickness and ulceration and for PT1, mitotic rate M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **G9295** Specimen site other than anatomic cutaneous location M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9296** Patients with documented shared decision-making including discussion of conservative (non-surgical) therapy (e.g., nsaids, analgesics, weight loss, exercise, injections) prior to the procedure M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9297** Shared decision-making including discussion of conservative (non-surgical) therapy (e.g., nsaids, analgesics, weight loss, exercise, injections) prior to the procedure, not documented, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9298** Patients who are evaluated for venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g. history of DVT, PE, MI, arrhythmia and stroke) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9299** Patients who are not evaluated for venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure (e.g., history of dvt, pe, mi, arrhythmia and stroke, reason not given) M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9305** Intervention for presence of leak of endoluminal contents through an anastomosis not required M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9306** Intervention for presence of leak of endoluminal contents through an anastomosis required M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9307** No return to the operating room for a surgical procedure, for complications of the principal operative procedure, within 30 days of the principal operative procedure M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9308** Unplanned return to the operating room for a surgical procedure, for complications of the principal operative procedure, within 30 days of the principal operative procedure M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9309** No unplanned hospital readmission within 30 days of principal procedure M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9310** Unplanned hospital readmission within 30 days of principal procedure M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9311** No surgical site infection M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9312** Surgical site infection M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9313** Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis for documented reason M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9314** Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9315** Amoxicillin, with or without clavulanate, prescribed as a first line antibiotic at the time of diagnosis M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9316** Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9317** Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family not completed M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9318** Imaging study named according to standardized nomenclature M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9319** Imaging study not named according to standardized nomenclature, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

▲ C **G9321** Count of previous ct (any type of ct) and cardiac nuclear medicine (myocardial perfusion or infarct avid imaging) studies documented in the 12-month period prior to the current study M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

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▲ C **G9322** Count of previous ct and cardiac nuclear medicine (myocardial perfusion or infarct avid imaging) studies not documented in the 12-month period prior to the current study, reason not given M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9341** Search conducted for prior patient CT studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure, authorized, media-free, shared archive prior to an imaging study being performed M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9342** Search not conducted prior to an imaging study being performed for prior patient CT studies completed at non-affiliated external healthcare facilities or entities within the past 12-months and are available through a secure, authorized, media-free, shared archive, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9344** Due to system reasons search not conducted for dicom format images for prior patient CT imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., non-affiliated external healthcare facilities or entities does not have archival abilities through a shared archival system) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9345** Follow-up recommendations documented according to recommended guidelines for incidentally detected pulmonary nodules (e.g., follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size and patient risk factors Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9347** Follow-up recommendations not documented according to recommended guidelines for incidentally detected pulmonary nodules, reason not given Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9351** More than one CT scan of the paranasal sinuses ordered or received within 90 days after diagnosis M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9352** More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis, reason not given M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9353** More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis for documented reasons (e.g., patients with complications, second CT obtained prior to surgery, other medical reasons) M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9354** One CT scan or no CT scan of the paranasal sinuses ordered within 90 days after the date of diagnosis M
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9355** Elective delivery (without medical indication) by cesarean birth or induction of labor not performed (<39 weeks of gestation) ♀ Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9356** Elective delivery (without medical indication) by cesarean birth or induction of labor performed (<39 weeks of gestation) ♀ Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9357** Post-partum screenings, evaluations and education performed ♀ Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9358** Post-partum screenings, evaluations and education not performed ♀ Ⓐ M MIPS
BETOS: M5B Specialist - psychiatry
Service not separately priced by Part B

C **G9361** Medical indication for delivery by cesarean birth or induction of labor (<39 weeks of gestation) [documentation of reason(s) for elective delivery (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes (premature or prolonged), maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, late pregnancy, prior uterine surgery, or participation in clinical trial)] ♀ Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9364** Sinusitis caused by, or presumed to be caused by, bacterial infection M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C G9367 At least two orders for high-risk medications from the same drug class M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9368 At least two orders for high-risk medications from the same drug class not ordered M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9380 Patient offered assistance with end of life issues or existing end of life plan was reviewed or updated during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C G9382 Patient not offered assistance with end of life issues or existing end of life plan was not reviewed or updated during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C G9383 Patient received screening for HCV infection within the 12 month reporting period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9384 Documentation of medical reason(s) for not receiving annual screening for HCV infection (e.g., decompensated cirrhosis indicating advanced disease [i.e., ascites, esophageal variceal bleeding, hepatic encephalopathy], hepatocellular carcinoma, waitlist for organ transplant, limited life expectancy, other medical reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9385 Documentation of patient reason(s) for not receiving annual screening for HCV infection (e.g., patient declined, other patient reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9386 Screening for HCV infection not received within the 12 month reporting period, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9393 Patient with an initial PHQ-9 score greater than nine who achieves remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9394 Patient who had a diagnosis of bipolar disorder or personality disorder, death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement or assessment period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9395 Patient with an initial PHQ-9 score greater than nine who did not achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score greater than or equal to five M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9396 Patient with an initial PHQ-9 score greater than nine who was not assessed for remission at twelve months (+/- 30 days) M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9408 Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9409 Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9410 Patient admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9411 Patient not admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9412 Patient admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9413 Patient not admitted within 180 days, status post cied implantation, replacement, or revision with an infection requiring device removal or surgical revision M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9414 Patient had one dose of meningococcal vaccine (serogroups a, c, w, y) on or between the patient's 11th and 13th birthdays A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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C **G9415** Patient did not have one dose of meningococcal vaccine (serogroups a, c, w, y) on or between the patient's 11th and 13th birthdays Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9416** Patient had one tetanus, diphtheria toxoids and acellular pertussis vaccine (TDAP) on or between the patient's 10th and 13th birthdays Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9417** Patient did not have one tetanus, diphtheria toxoids and acellular pertussis vaccine (TDAP) on or between the patient's 10th and 13th birthdays Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9418** Primary non-small cell lung cancer lung biopsy and cytology specimen report documents classification into specific histologic type following iaslc guidance or classified as nsclc-nos with an explanation M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9419** Documentation of medical reason(s) for not including the histological type or nsclc-nos classification with an explanation (e.g. specimen insufficient or non-diagnostic, specimen does not contain cancer, or other documented medical reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9420** Specimen site other than anatomic location of lung or is not classified as primary non-small cell lung cancer M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9421** Primary non-small cell lung cancer lung biopsy and cytology specimen report does not document classification into specific histologic type or histologic type does not follow iaslc guidance or is classified as nsclc-nos but without an explanation M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9422** Primary lung carcinoma resection report documents pt category, pn category and for non-small cell lung cancer, histologic type (e.g., squamous cell carcinoma, adenocarcinoma and not nsclc-nos) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9423** Documentation of medical reason for not including pt category, pn category and histologic type [for patient with appropriate exclusion criteria (e.g., metastatic disease, benign tumors, malignant tumors other than carcinomas, inadequate surgical specimens)] M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9424** Specimen site other than anatomic location of lung, or classified as NSCLC-NOS M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9425** Primary lung carcinoma resection report does not document pt category, pn category and for non-small cell lung cancer, histologic type (e.g., squamous cell carcinoma, adenocarcinoma) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9426** Improvement in median time from ED arrival to initial ED oral or parenteral pain medication administration performed for ED admitted patients M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9427** Improvement in median time from ED arrival to initial ED oral or parenteral pain medication administration not performed for ED admitted patients M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9428** Pathology report includes the pt category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9429** Documentation of medical reason(s) for not including pt category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors (e.g., negative skin biopsies, insufficient tissue, or other documented medical reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9430** Specimen site other than anatomic cutaneous location M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9431** Pathology report does not include the pt category, thickness, ulceration and mitotic rate, peripheral and deep margin status and presence or absence of microsatellitosis for invasive tumors M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9432** Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score and results documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9434** Asthma not well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score, or specified asthma control tool not used, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9452** Documentation of medical reason(s) for not receiving hcv antibody test due to limited life expectancy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9455** Patient underwent abdominal imaging with ultrasound, contrast enhanced CT or contrast MRI for HCC M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9456** Documentation of medical or patient reason(s) for not ordering or performing screening for HCC. medical reason: comorbid medical conditions with expected survival < 5 years, hepatic decompensation and not a candidate for liver transplantation, or other medical reasons; patient reasons: patient declined or other patient reasons (e.g., cost of tests, time related to accessing testing equipment) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9457** Patient did not undergo abdominal imaging and did not have a documented reason for not undergoing abdominal imaging in the submission period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9468** Patient not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9470** Patients not receiving corticosteroids greater than or equal to 10 mg/day of prednisone equivalents for 60 or greater consecutive days or a single prescription equating to 600 mg prednisone or greater for all fills M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9471** Within the past 2 years, central dual-energy X-ray absorptiometry (DXA) not ordered or documented M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9473** Services performed by chaplain in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9474** Services performed by dietary counselor in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9475** Services performed by other counselor in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9476** Services performed by volunteer in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9477** Services performed by care coordinator in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9478** Services performed by other qualified therapist in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9479** Services performed by qualified pharmacist in the hospice setting, each 15 minutes B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9480** Admission to Medicare care choice model program (MCCM) B
BETOS: M5D Specialist - other
Service not separately priced by Part B

C **G9481** Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are self limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

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G9482 Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of low to moderate severity. typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

G9483 Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate severity. typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

G9484 Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

G9485 Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

G9486 Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires at least 2 of the following 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are self limited or minor. typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

G9487 Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires at least 2 of the following 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. counseling and coordination of

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care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of low to moderate severity. typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

C **G9488** Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires at least 2 of the following 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

C **G9489** Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS innovation center demonstration project, which requires at least 2 of the following 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. usually, the presenting problem(s) are of moderate to high severity. typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

C **G9490** CMS innovation center models, home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/ management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. (for use only in Medicare-approved CMS innovation center models); may not be billed for a 30 day period covered by a transitional care management code B

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q1

C **G9497** Received instruction from the anesthesiologist or proxy prior to the day of surgery to abstain from smoking on the day of surgery M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9498** Antibiotic regimen prescribed M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9500** Radiation exposure indices documented in final report for procedure using fluoroscopy M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9501** Radiation exposure indices not documented in final report for procedure using fluoroscopy, reason not given M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9502** Documentation of medical reason for not performing foot exam (i.e., patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period) M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9504** Documented reason for not assessing hepatitis B virus (HBV) status (e.g., patient not initiating anti-TNF therapy, patient declined) prior to initiating anti-TNF therapy M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9505** Antibiotic regimen prescribed within 10 days after onset of symptoms for documented medical reason M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9507** Documentation that the patient is on a statin medication or has documentation of a valid contraindication or exception to statin medications; contraindications/exceptions that can be defined by diagnosis codes include

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pregnancy during the measurement period, active liver disease, rhabdomyolysis, end stage renal disease on dialysis and heart failure; provider documented contraindications/ exceptions include breastfeeding during the measurement period, woman of child-bearing age not actively taking birth control, allergy to statin, drug interaction (HIV protease inhibitors, nefazodone, cyclosporine, gemfibrozil, and danazol) and intolerance (with supporting documentation of trying a statin at least once within the last 5 years or diagnosis codes for myostitis or toxic myopathy related to drugs) M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9508** Documentation that the patient is not on a statin medication M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9509** Adult patients 18 years of age or older with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5 Ⓐ M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9510** Adult patients 18 years of age or older with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. either phq- 9 or phq-9m score was not assessed or is greater than or equal to 5 Ⓐ M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9511** Index event date phq-9 or phq-9m score greater than 9 documented during the twelve month denominator identification period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9512** Individual had a PDC of 0.8 or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9513** Individual did not have a PDC of 0.8 or greater M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9514** Patient required a return to the operating room within 90 days of surgery M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9515** Patient did not require a return to the operating room within 90 days of surgery M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9516** Patient achieved an improvement in visual acuity, from their preoperative level, within 90 days of surgery M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9517** Patient did not achieve an improvement in visual acuity, from their preoperative level, within 90 days of surgery, reason not given M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9518** Documentation of active injection drug use M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9519** Patient achieves final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9520** Patient does not achieve final refraction (spherical equivalent) +/- 1.0 diopters of their planned refraction within 90 days of surgery M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9521** Total number of emergency department visits and inpatient hospitalizations less than two in the past 12 months M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9522** Total number of emergency department visits and inpatient hospitalizations equal to or greater than two in the past 12 months or patient not screened, reason not given M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9529** Patient with minor blunt head trauma had an appropriate indication(s) for a head CT M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9530** Patient presented with a minor blunt head trauma and had a head ct ordered for trauma by an emergency care provider M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9531** Patient has documentation of ventricular shunt, brain tumor, multisystem trauma, or is currently taking an antiplatelet medication including: abciximab, anagrelide, cangrelor, cilostazol, clopidogrel, dipyridamole, eptifibatide, prasugrel, ticlopidine, ticagrelor, tirofiban, or vorapaxar M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9533** Patient with minor blunt head trauma did not have an appropriate indication(s) for a head CT M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9537** Imaging needed as part of a clinical trial; or other clinician ordered the study M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9539** Intent for potential removal at time of placement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9540** Patient alive 3 months post procedure M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9541** Filter removed within 3 months of placement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9542** Documented re-assessment for the appropriateness of filter removal within 3 months of placement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9543** Documentation of at least two attempts to reach the patient to arrange a clinical re-assessment for the appropriateness of filter removal within 3 months of placement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9544** Patients that do not have the filter removed, documented re-assessment for the appropriateness of filter removal, or documentation of at least two attempts to reach the patient to arrange a clinical re-assessment for the appropriateness of filter removal within 3 months of placement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9547** Cystic renal lesion that is simple appearing (bosniak i or ii), or adrenal lesion less than or equal to 1.0 cm or adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign by unenhanced ct or washout protocol ct, or mri with in- and opposed-phase sequences or other equivalent institutional imaging protocols M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9548** Final reports for imaging studies stating no follow-up imaging is recommended M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9549** Documentation of medical reason(s) that follow-up imaging is indicated (e.g., patient has lymphadenopathy, signs of metastasis or an active diagnosis or history of cancer, and other medical reason(s)) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9550** Final reports for imaging studies with follow-up imaging recommended, or final reports that do not include a specific recommendation of no follow-up M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9551** Final reports for imaging studies without an incidentally found lesion noted M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9552** Incidental thyroid nodule < 1.0 cm noted in report M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9553** Prior thyroid disease diagnosis M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9554** Final reports for ct, cta, mri or mra of the chest or neck with follow-up imaging recommended M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9555** Documentation of medical reason(s) for recommending follow up imaging (e.g., patient has multiple endocrine neoplasia, patient has cervical lymphadenopathy, other medical reason(s)) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9556** Final reports for ct, cta, mri or mra of the chest or neck with follow-up imaging not recommended M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9557** Final reports for ct, cta, mri or mra studies of the chest or neck without an incidentally found thyroid nodule < 1.0 cm noted or no nodule found M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9580** Door to puncture time of 90 minutes or less M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9582** Door to puncture time of greater than 90 minutes, no reason given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9593** Pediatric patient with minor blunt head trauma classified as low risk according to the pecarn prediction rules Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9594** Patient presented with a minor blunt head trauma and had a head ct ordered for trauma by an emergency care provider M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9595** Patient has documentation of ventricular shunt, brain tumor, or coagulopathy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9597** Pediatric patient with minor blunt head trauma not classified as low risk according to the pecarn prediction rules Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9598** Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9599** Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9603** Patient survey score improved from baseline following treatment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9604** Patient survey results not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9605** Patient survey score did not improve from baseline following treatment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9606** Intraoperative cystoscopy performed to evaluate for lower tract injury M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9607** Documented medical reasons for not performing intraoperative cystoscopy (e.g., urethral pathology precluding cystoscopy, any patient who has a congenital or acquired absence of the urethra) or in the case of patient death M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9608** Intraoperative cystoscopy not performed to evaluate for lower tract injury M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9609** Documentation of an order for anti-platelet agents M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9610** Documentation of medical reason(s) in the patient's record for not ordering anti-platelet agents M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9611** Order for anti-platelet agents was not documented in the patient's record, reason not given M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9621** Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9622** Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9624** Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9625** Patient sustained bladder injury at the time of surgery or discovered subsequently up to 30 days post-surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9626** Documented medical reason for not reporting bladder injury (e.g., gynecologic or other pelvic malignancy documented, concurrent surgery involving bladder pathology, injury that occurs during a urinary incontinence procedure, patient death from non-medical causes not related to surgery, patient died during procedure without evidence of bladder injury) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9627** Patient did not sustain bladder injury at the time of surgery nor discovered subsequently up to 30 days post-surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9628** Patient sustained bowel injury at the time of surgery or discovered subsequently up to 30 days post-surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9629** Documented medical reasons for not reporting bowel injury (e.g., gynecologic or other pelvic malignancy documented, planned (e.g., not due to an unexpected bowel injury) resection and/or re-anastomosis of bowel, or patient death from non-medical causes not related to surgery, patient died during procedure without evidence of bowel injury) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9630** Patient did not sustain a bowel injury at the time of surgery nor discovered subsequently up to 30 days post-surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9637** Final reports with documentation of one or more dose reduction techniques (e.g., automated exposure control, adjustment of the ma and/or kv according to patient size, use of iterative reconstruction technique) A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9638** Final reports without documentation of one or more dose reduction techniques (e.g., automated exposure control, adjustment of the ma and/or kv according to patient size, use of iterative reconstruction technique) A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9642** Current smoker (e.g., cigarette, cigar, pipe, e-cigarette or marijuana) A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9643** Elective surgery A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9644** Patients who abstained from smoking prior to anesthesia on the day of surgery or procedure M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9645** Patients who did not abstain from smoking prior to anesthesia on the day of surgery or procedure M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9646** Patients with 90 day MRS score of 0 to 2 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9648** Patients with 90 day MRS score greater than 2 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9649** Psoriasis assessment tool documented meeting any one of the specified benchmarks (e.g., (pga; 5-point or 6-point scale), body surface area (bsa), psoriasis area and severity index (pasi) and/or dermatology life quality index) (dlqi)) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9651** Psoriasis assessment tool documented not meeting any one of the specified benchmarks (e.g., (pga; 5-point or 6-point scale), body surface area (bsa), psoriasis area and severity index (pasi) and/or dermatology life quality index) (dlqi)) or psoriasis assessment tool not documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9654** Monitored anesthesia care (MAC) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9655** A transfer of care protocol or handoff tool/ checklist that includes the required key handoff elements is used M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9656** Patient transferred directly from anesthetizing location to PACU or other non-ICU location M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9658** A transfer of care protocol or handoff tool/ checklist that includes the required key handoff elements is not used M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G9659** Patients greater than or equal to 86 years of age who underwent a screening colonoscopy and did not have a history of colorectal cancer or other valid medical reason for the colonoscopy, including: iron deficiency anemia, lower gastrointestinal bleeding, familial adenomatous polyposis, lynch syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease (i.e., crohn's disease or ulcerative colitis), abnormal finding of gastrointestinal tract, weight loss, or changes in bowel habits A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **G9660** Documentation of medical reason(s) for a colonoscopy performed on a patient greater than or equal to 86 years of age (e.g., iron deficiency anemia, lower gastrointestinal bleeding, familial history of adenomatous polyposis, lynch syndrome (i.e., hereditary non-polyposis colorectal cancer),

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inflammatory bowel disease (i.e., crohn's disease or ulcerative colitis), abnormal finding of gastrointestinal tract, weight loss, or changes in bowel habits) Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9661** Patients greater than or equal to 86 years of age who received a colonoscopy for an assessment of signs/symptoms of gi tract illness, and/or because the patient meets high risk criteria, and/or to follow-up on previously diagnosed advanced lesions Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9662** Previously diagnosed or have a diagnosis of clinical ascvd, including ascvd procedure Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9663** Any ldl-c laboratory result >= 190 mg/dl Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9664** Patients who are currently statin therapy users or received an order (prescription) for statin therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9665** Patients who are not currently statin therapy users or did not receive an order (prescription) for statin therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9674** Patients with clinical ASCVD diagnosis M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9675** Patients who have ever had a fasting or direct laboratory result of LDL-C = 190 mg/dl M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9676** Patients aged 40 to 75 years at the beginning of the measurement period with type 1 or type 2 diabetes and with an LDL-C result of 70-189 mg/dl recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period Ⓐ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9679** This code is for onsite acute care treatment of a nursing facility resident with pneumonia; may only be billed once per day per beneficiary B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9680** This code is for onsite acute care treatment of a nursing facility resident with CHF; may only be billed once per day per beneficiary B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9681** This code is for onsite acute care treatment of a resident with COPD or asthma; may only be billed once per day per beneficiary B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9682** This code is for the onsite acute care treatment a nursing facility resident with a skin infection; may only be billed once per day per beneficiary B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9683** Facility service(s) for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder. (may only be billed once per day per beneficiary), this service is for a demonstration project B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9684** This code is for the onsite acute care treatment of a nursing facility resident for a UTI; may only be billed once per day per beneficiary B
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9685** Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility, this service is for a demonstration project M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9687** Hospice services provided to patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9688** Patients using hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9689** Patient admitted for performance of elective carotid intervention M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9690** Patient receiving hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9691** Patient had hospice services any time during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9692** Hospice services received by patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9693** Patient use of hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9694** Hospice services utilised by patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9695** Long-acting inhaled bronchodilator prescribed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9696** Documentation of medical reason(s) for not prescribing a long-acting inhaled bronchodilator (e.g., patient intolerance or history of side effects) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9698** Documentation of system reason(s) for not prescribing a long-acting inhaled bronchodilator (e.g., cost of treatment or lack of insurance) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9699** Long-acting inhaled bronchodilator not prescribed, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9700** Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9702** Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9703** Episodes where the patient is taking antibiotics (table 1) in the 30 days prior to the episode date ♂ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9704** AJCC breast cancer stage i: t1 mic or t1a documented M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9705** AJCC breast cancer stage i: t1b (tumor > 0.5 cm but <= 1 cm In greatest dimension) documented M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9706** Low (or very low) risk of recurrence, prostate cancer ♂ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9708** Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9709** Hospice services used by patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9710** Patient was provided hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9711** Patients with a diagnosis or past history of total colectomy or colorectal cancer M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9712** Documentation of medical reason(s) for prescribing or dispensing antibiotic (e.g., intestinal infection, pertussis, bacterial infection, lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/ mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/ asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9713** Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9714** Patient is using hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9716** Bmi is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9717** Documentation stating the patient has had a diagnosis of bipolar disorder M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9719** Patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9720** Hospice services for patient occurred any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9721** Patient not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9722** Documented history of renal failure or baseline serum creatinine >= 4.0 mg/dl; renal transplant recipients are not considered to have preoperative renal failure, unless, since transplantation the cr has been or is 4.0 or higher M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9723** Hospice services for patient received any time during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9724** Patients who had documentation of use of anticoagulant medications overlapping the measurement year M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9726** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9727** Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9728** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9729** Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9730** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9731** Patient unable to complete the lepf prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9732** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9733** Patient unable to complete the low back fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9734** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9735** Patient unable to complete the shoulder fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9736** Patient refused to participate M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9737** Patient unable to complete the elbow/wrist/hand fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9740** Hospice services given to patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C G9741 Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9744 Patient not eligible due to active diagnosis of hypertension M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9745 Documented reason for not screening or recommending a follow-up for high blood pressure M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9746 Patient has mitral stenosis or prosthetic heart valves or patient has transient or reversible cause of AF (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery) M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9752 Emergency surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9753 Documentation of medical reason for not conducting a search for dicom format images for prior patient CT imaging studies completed at non-affiliated external healthcare facilities or entities within the past 12 months that are available through a secure, authorized, media-free, shared archive (e.g., trauma, acute myocardial infarction, stroke, aortic aneurysm where time is of the essence) M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9754 A finding of an incidental pulmonary nodule M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9755 Documentation of medical reason(s) for not including a recommended interval and modality for follow-up or for no follow-up, and source of recommendations (e.g., patients with unexplained fever, immunocompromised patients who are at risk for infection) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9756 Surgical procedures that included the use of silicone oil M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9757 Surgical procedures that included the use of silicone oil M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9758 Patient in hospice at any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9761 Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9762 Patient had at least two HPV vaccines (with at least 146 days between the two) or three HPV vaccines on or between the patient's 9th and 13th birthdays ♀ ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9763 Patient did not have at least two HPV vaccines (with at least 146 days between the two) or three HPV vaccines on or between the patient's 9th and 13th birthdays ♀ ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9764 Patient has been treated with a systemic medication for psoriasis vulgaris M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9765 Documentation that the patient declined change in medication or alternative therapies were unavailable, has documented contraindications, or has not been treated with a systemic medication for at least six consecutive months (e.g., experienced adverse effects or lack of efficacy with all other therapy options) in order to achieve better disease control as measured by pga, bsa, pasi, or dlqi M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9766 Patients who are transferred from one institution to another with a known diagnosis of CVA for endovascular stroke treatment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9767 Hospitalized patients with newly diagnosed CVA considered for endovascular stroke treatment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9768 Patients who utilise hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C G9769 Patient had a bone mineral density test in the past two years or received osteoporosis medication or therapy in the past 12 months M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9770** Peripheral nerve block (PNB) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9771** At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) achieved within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9772** Documentation of medical reason(s) for not achieving at least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time (e.g., emergency cases, intentional hypothermia, etc.) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9773** At least 1 body temperature measurement equal to or greater than 35.5 degrees celsius (or 95.9 degrees fahrenheit) not achieved within the 30 minutes immediately before or 15 minutes immediately after anesthesia end time, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9775** Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9776** Documentation of medical reason for not receiving at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9777** Patient did not receive at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9779** Patients who are breastfeeding at any time during the performance period ♀ Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9780** Patients who have a diagnosis of rhabdomyolysis at any time during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9781** Documentation of medical reason(s) for not currently being a statin therapy user or receiving an order (prescription) for statin therapy (e.g., patients with statin-associated muscle symptoms or an allergy to statin medication therapy, patients who are receiving palliative or hospice care, patients with active liver disease or hepatic disease or insufficiency, patients with end stage renal disease [esrd], or other medical reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9782** History of or active diagnosis of familial hypercholesterolemia M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9784** Pathologists/dermatopathologists providing a second opinion on a biopsy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9785** Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9786** Pathology report diagnosing cutaneous basal cell carcinoma, squamous cell carcinoma, or melanoma (to include in situ disease) was not sent from the pathologist/ dermatopathologist to the biopsying clinician for review within 7 days from the time when the tissue specimen was received by the pathologist M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9787** Patient alive as of the last day of the measurement year M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9788** Most recent bp is less than or equal to 140/90 mm hg M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9789** Blood pressure recorded during inpatient stays, emergency room visits, or urgent care visits M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9790** Most recent bp is greater than 140/90 mm hg, or blood pressure not documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9791** Most recent tobacco status is tobacco free M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9792** Most recent tobacco status is not tobacco free M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9793** Patient is currently on a daily aspirin or other antiplatelet M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9794** Documentation of medical reason(s) for not on a daily aspirin or other antiplatelet (e.g., history of gastrointestinal bleed, intracranial bleed, idiopathic thrombocytopenic purpura (ITP), gastric bypass or documentation of active anticoagulant use during the measurement period) M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9795** Patient is not currently on a daily aspirin or other antiplatelet M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9796** Patient is currently on a statin therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9797** Patient is not on a statin therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9805** Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9806** Patients who received cervical cytology or an HPV test ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9807** Patients who did not receive cervical cytology or an HPV test ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9812** Patient died including all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and those deaths occurring after discharge from the hospital, but within 30 days of the procedure M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9813** Patient did not die within 30 days of the procedure or during the index hospitalization M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9818** Documentation of sexual activity M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9819** Patients who use hospice services any time during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9820** Documentation of a chlamydia screening test with proper follow-up M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9821** No documentation of a chlamydia screening test with proper follow-up M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9822** Patients who had an endometrial ablation procedure during the 12 months prior to the index date (exclusive of the index date) ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9823** Endometrial sampling or hysteroscopy with biopsy and results documented during the 12 months prior to the index date (exclusive of the index date) of the endometrial ablation ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9824** Endometrial sampling or hysteroscopy with biopsy and results not documented during the 12 months prior to the index date (exclusive of the index date) of the endometrial ablation ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9830** HER-2/neu positive ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9831** AJCC Stage at breast cancer diagnosis = II Or III M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9832** AJCC Stage at breast cancer diagnosis = I (Ia Or Ib) And t-Stage At breast cancer diagnosis does not equal = T1, T1A, T1B M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9838** Patient has metastatic disease at diagnosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9839** Anti-EGFR monoclonal antibody therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9840** RAS (KRAS and NRAS) gene mutation testing performed before initiation of anti-EGFR moab M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9841** RAS (KRAS and NRAS) gene mutation testing not performed before initiation of anti-EGFR moab M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9842** Patient has metastatic disease at diagnosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9843** RAS (KRAS and NRAS) gene mutation M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9844** Patient did not receive Anti-EGFR monoclonal antibody therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9845** Patient received Anti-EGFR monoclonal antibody therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9846** Patients who died from cancer M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9847** Patient received systemic cancer-directed therapy in the last 14 days of life M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9848** Patient did not receive systemic cancer-directed therapy in the last 14 days of life M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9858** Patient enrolled in hospice M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9859** Patients who died from cancer M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9860** Patient spent less than three days in hospice care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9861** Patient spent greater than or equal to three days in hospice care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9862** Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is = 66 years old, or life expectancy < 10 years old, other medical reasons) M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9868** Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved cmmi model, less than 10 minutes B
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2021, Q2

C **G9869** Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved cmmi model, 10-20 minutes B
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2021, Q2

C **G9870** Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use only in a Medicare-approved cmmi model, more than 20 minutes B
BETOS: M5D Specialist - other
Price established by carriers
Coding Clinic: 2021, Q2

C **G9873** First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions M
BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G9874** Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions. M
BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

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G9875 Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9876 Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9877 Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9878 Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9879 Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12 M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9880 The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9881 The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

G9882 Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 13-15 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one

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in-person weight measurement at an ongoing maintenance session in months 13-15. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G9883** Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 16-18 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 16-18. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G9884** Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 19-21 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G9885** Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 22-24 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions.

The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 22-24. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G9886** Behavioral counseling for diabetes prevention, in-person, group, 60 minutes M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9887** Behavioral counseling for diabetes prevention, distance learning, 60 minutes M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9888** Maintenance 5% wl from baseline weight in months 7-12 Ⓐ M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9890** Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary. M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

C **G9891** MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model (EM) HCPCS code for a session furnished by the billing supplier under the MDPP Expanded Model and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code.(This code is for reporting purposes only). M

BETOS: Y1 Other - Medicare fee schedule
Service not separately priced by Part B

RADIOLOGY SERVICES PROSTATE (G9894-G9897)

C **G9894** Androgen deprivation therapy prescribed/ administered in combination with external beam radiotherapy to the prostate ♂ M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9895** Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (e.g., salvage therapy) ♂ M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9896** Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate ♂ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9897** Patients who were not prescribed/ administered androgen deprivation therapy in combination with external beam radiotherapy to the prostate, reason not given ♂ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

GERIATRIC CARE MANAGEMENT (G9898)

C **G9898** Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

BREAST SCREENING/DIAGNOSTICS/THERAPEUTICS (G9899-G9900)

C **G9899** Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results documented and reviewed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9900** Screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography results were not documented and reviewed, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ADDITIONAL GERIATRIC CARE MANAGEMENT (G9901)

C **G9901** Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

TOBACCO SCREENING (G9902-G9908)

C **G9902** Patient screened for tobacco use and identified as a tobacco user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9903** Patient screened for tobacco use and identified as a tobacco non-user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9905** Patient not screened for tobacco use M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9906** Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9908** Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

OTHER GERIATRIC CARE MANAGEMENT (G9910)

C **G9910** Patients age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

BREAST CANCER CLASSIFICATION (G9911)

C **G9911** Clinically node negative (t1n0m0 or t2n0m0) invasive breast cancer before or after neoadjuvant systemic therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ANTI-TNF DIAGNOSTICS FOR HBV STATUS (G9912-G9915)

C **G9912** Hepatitis B virus (HBV) status assessed and results interpreted prior to initiating anti-TNF (tumor necrosis factor) therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9913** Hepatitis b virus (hbv) status not assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9914** Patient initiated an anti-tnf agent M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
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C **G9915** No record of HBV results documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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FUNCTIONAL STATUS CODES (G9916-G9918)

C **G9916** Functional status performed once in the last 12 months M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9917** Documentation of advanced stage dementia and caregiver knowledge is limited M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9918** Functional status not performed, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

SCREENING (G9922-G9931)

C **G9922** Safety concerns screen provided and if positive then documented mitigation recommendations M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9923** Safety concerns screen provided and negative M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9925** Safety concerns screening not provided, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9926** Safety concerns screening positive screen is without provision of mitigation recommendations, including but not limited to referral to other resources M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9928** Fda-approved anticoagulant not prescribed, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9929** Patient with transient or reversible cause of AF (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9930** Patients who are receiving comfort care only M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9931** Documentation of CHA2DS2-VASC risk score of 0 or 1 for men; or 0, 1, or 2 for women M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

GERIATRIC CARE MANAGEMENT AND OTHER SERVICES (G9938-G9940)

C **G9938** Patients aged 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the six months prior to the measurement period through december 31 of the measurement period Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

C **G9939** Pathologists/dermatopathologists is the same clinician who performed the biopsy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9940** Documentation of medical reason(s) for not on a statin (e.g., pregnancy, in vitro fertilization, clomiphene Rx, ESRD, cirrhosis, muscular pain and disease during the measurement period or prior year) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PAIN ASSESSMENT (G9943-G9949)

C **G9943** Back pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9945** Patient had cancer, acute fracture or infection related to the lumbar spine or patient had neuromuscular, idiopathic or congenital lumbar scoliosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9946** Back pain was not measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9949** Leg pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MEDICATIONS (ANTIEMETICS AND ANTIMICROBIALS) (G9954-G9961)

C **G9954** Patient exhibits 2 or more risk factors for post-operative vomiting M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **G9955** Cases in which an inhalational anesthetic is used only for induction M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9956** Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9957** Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9958** Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9959** Systemic antimicrobials not prescribed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9960** Documentation of medical reason(s) for prescribing systemic antimicrobials M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9961** Systemic antimicrobials prescribed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

EMBOLIZATION (G9962-G9963)

C **G9962** Embolization endpoints are documented separately for each embolized vessel and ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9963** Embolization endpoints are not documented separately for each embolized vessel or ovarian artery angiography or embolization not performed in the presence of variant uterine artery anatomy ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

SCREENING, WELLNESS AND PHYSICIAN VISITS (G9964-G9970)

C **G9964** Patient received at least one well-child visit with a PCP during the performance period Ⓐ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9965** Patient did not receive at least one well-child visit with a PCP during the performance period Ⓐ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9968** Patient was referred to another clinician or specialist during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9969** Clinician who referred the patient to another clinician received a report from the clinician to whom the patient was referred M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9970** Clinician who referred the patient to another clinician did not receive a report from the clinician to whom the patient was referred M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

REMOTE IN-HOUSE EVALUATION AND MANAGEMENT ASSESSMENT (G9978-G9987)

C **G9978** Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:

- A problem focused history;
- A problem focused examination; and
- Straightforward medical decision making, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B
BETOS: M1A Office visits - new
Price established by carriers

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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C **G9979** Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Straightforward medical decision making, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1A Office visits - new
Price established by carriers

C **G9980** Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of low complexity, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1A Office visits - new
Price established by carriers

C **G9981** Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1A Office visits - new
Price established by carriers

C **G9982** Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1A Office visits - new
Price established by carriers

C **G9983** Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1B Office visits - established
Price established by carriers

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C **G9984** Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1B Office visits - established
Price established by carriers

C **G9985** Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1B Office visits - established
Price established by carriers

C **G9986** Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least 2 of the following 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity, furnished in real time using interactive audio and video technology.

Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology. B

BETOS: M1B Office visits - established
Price established by carriers

C **G9987** Bundled Payments for Care Improvement Advanced (BPCI Advanced) model home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/ management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services; for use only for a BPCI Advanced model episode of care; may not be billed for a 30-day period covered by a transitional care management code. B

BETOS: M5D Specialist - other
Price established by carriers

PALLIATIVE CARE SERVICES (G9988-G9999)

C **G9988** Palliative care services provided to patient any time during the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9992** Palliative care services used by patient any time during the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9993** Patient was provided palliative care services any time during the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9994** Patient is using palliative care services any time during the measurement period M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9996** Documentation stating the patient has received or is currently receiving palliative or hospice care M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **G9997** Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter ♀ Ⓐ M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **G9998** Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or sessile serrated polyps >= 20 mm in size, last colonoscopy found greater than 10 adenomas, lower gastrointestinal bleeding, or patient at high risk for colon cancer due to underlying medical history ([i.e. crohn's disease, ulcerative colitis, personal or family history of colon cancer, hereditary colorectal cancer syndromes]) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q1

▲ C **G9999** Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., unable to locate previous colonoscopy report, patient cannot provide precise date or details from previous colonoscopy, previous colonoscopy report was incomplete) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2009, Q2

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NOTES

ALCOHOL AND DRUG ABUSE TREATMENT (H0001-H2041)

DRUG, ALCOHOL, AND BEHAVIORAL HEALTH SERVICES (H0001-H0030)

H0001 Alcohol and/or drug assessment
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2009, Q2

H0002 Behavioral health screening to determine eligibility for admission to treatment program MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0003 Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0004 Behavioral health counseling and therapy, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0005 Alcohol and/or drug services; group counseling by a clinician
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0006 Alcohol and/or drug services; case management
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0007 Alcohol and/or drug services; crisis intervention (outpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0008 Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0009 Alcohol and/or drug services; acute detoxification (hospital inpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0010 Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0011 Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0012 Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0013 Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0014 Alcohol and/or drug services; ambulatory detoxification
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0015 Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0016 Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0017 Behavioral health; residential (hospital residential treatment program), without room and board, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0018 Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0019 Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0021 Alcohol and/or drug training service (for staff and personnel not employed by providers)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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H0022 Alcohol and/or drug intervention service (planned facilitation)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0023 Behavioral health outreach service (planned approach to reach a targeted population)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0024 Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0025 Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0026 Alcohol and/or drug prevention process service, community-based (delivery of services to develop skills of impactors)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0027 Alcohol and/or drug prevention environmental service (broad range of external activities geared toward modifying systems in order to mainstream prevention through policy and law)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0028 Alcohol and/or drug prevention problem identification and referral service (e.g., student assistance and employee assistance programs), does not include assessment
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0029 Alcohol and/or drug prevention alternatives service (services for populations that exclude alcohol and other drug use e.g., alcohol free social events)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0030 Behavioral health hotline service
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MENTAL HEALTH PROGRAMS AND MEDICATION ADMINISTRATION TRAINING (H0031-H0040)

H0031 Mental health assessment, by non-physician MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0032 Mental health service plan development by non-physician
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0033 Oral medication administration, direct observation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0034 Medication training and support, per 15 minutes MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0035 Mental health partial hospitalization, treatment, less than 24 hours MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0036 Community psychiatric supportive treatment, face-to-face, per 15 minutes MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0037 Community psychiatric supportive treatment program, per diem MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0038 Self-help/peer services, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0039 Assertive community treatment, face-to-face, per 15 minutes MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0040 Assertive community treatment program, per diem MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

FOSTER CARE (H0041, H0042)

H0041 Foster care, child, non-therapeutic, per diem A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0042 Foster care, child, non-therapeutic, per month A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

SUPPORTED HOUSING (H0043, H0044)

H0043 Supported housing, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0044 Supported housing, per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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MISCELLANEOUS DRUG AND ALCOHOL SERVICES (H0045-H0051)

H0045 Respite care services, not in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0046 Mental health services, not otherwise specified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0047 Alcohol and/or other drug abuse services, not otherwise specified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0048 Alcohol and/or other drug testing: collection and handling only, specimens other than blood
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0049 Alcohol and/or drug screening
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H0050 Alcohol and/or drug services, brief intervention, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● **H0051** Traditional healing service
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q2

MENTAL HEALTH PROGRAMS FOR INDIGENOUS PEOPLE (H0052-H0053)

● **H0052** Missing and murdered indigenous persons (mmip) mental health and clinical care
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● **H0053** Historical trauma (ht) mental health and clinical care for indigenous persons
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PRENATAL CARE AND FAMILY PLANNING ASSESSMENT (H1000-H1011)

H1000 Prenatal care, at-risk assessment ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

H1001 Prenatal care, at-risk enhanced service; antepartum management ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

H1002 Prenatal care, at risk enhanced service; care coordination ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

H1003 Prenatal care, at-risk enhanced service; education ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

H1004 Prenatal care, at-risk enhanced service; follow-up home visit ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

H1005 Prenatal care, at-risk enhanced service package (includes H1001-H1004) ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

H1010 Non-medical family planning education, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H1011 Family assessment by licensed behavioral health professional for state defined purposes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

OTHER MENTAL HEALTH AND COMMUNITY SUPPORT SERVICES (H2000-H2041)

H2000 Comprehensive multidisciplinary evaluation MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2001 Rehabilitation program, per 1/2 day MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2010 Comprehensive medication services, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2011 Crisis intervention service, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2012 Behavioral health day treatment, per hour MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2013 Psychiatric health facility service, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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H2014 Skills training and development, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2015 Comprehensive community support services, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2016 Comprehensive community support services, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2017 Psychosocial rehabilitation services, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2018 Psychosocial rehabilitation services, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2019 Therapeutic behavioral services, per 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2020 Therapeutic behavioral services, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2021 Community-based wrap-around services, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2022 Community-based wrap-around services, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2023 Supported employment, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2024 Supported employment, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2025 Ongoing support to maintain employment, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2026 Ongoing support to maintain employment, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2027 Psychoeducational service, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2028 Sexual offender treatment service, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2029 Sexual offender treatment service, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2030 Mental health clubhouse services, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2031 Mental health clubhouse services, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2032 Activity therapy, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2033 Multisystemic therapy for juveniles, per 15 minutes A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2034 Alcohol and/or drug abuse halfway house services, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2035 Alcohol and/or other drug treatment program, per hour
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2036 Alcohol and/or other drug treatment program, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2037 Developmental delay prevention activities, dependent child of client, per 15 minutes A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2009, Q2

H2038 Skills training and development, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

H2040 Coordinated specialty care, team-based, for first episode psychosis, per month A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q4

H2041 Coordinated specialty care, team-based, for first episode psychosis, per encounter A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q4

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DRUGS ADMINISTERED OTHER THAN ORAL METHOD (J0120-J8999)

DRUGS, ADMINISTERED BY INJECTION (J0120-J7175)

D **J0120** Injection, tetracycline, up to 250 mg N1 ASC N
BETOS: O1E Other drugs

C **J0121** Injection, omadacycline, 1 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: NUZYRA
Coding Clinic: 2019, Q4

C **J0122** Injection, eravacycline, 1 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: XERAVA
Coding Clinic: 2019, Q4

C **J0129** Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) K2 ASC K
BETOS: O1E Other drugs
Drugs: ORENCIA
Coding Clinic: 2006, Q4

D **J0130** Injection abciximab, 10 mg N1 ASC N
BETOS: O1E Other drugs

C **J0131** Injection, acetaminophen, not otherwise specified,10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ACETAMINOPHEN
Coding Clinic: 2023, Q1; 2023, Q3

C **J0132** Injection, acetylcysteine, 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ACETADOTE, ACETYLCYSTEINE

C **J0133** Injection, acyclovir, 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ACYCLOVIR SODIUM

▲ C **J0134** Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to J0131, 10 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: ACETAMINOPHEN
Coding Clinic: 2023, Q1

▲ C **J0136** Injection, acetaminophen (b braun), not therapeutically equivalent to J0131, 10 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: ACETAMINOPHEN
Coding Clinic: 2023, Q1

▲ C **J0137** Injection, acetaminophen (hikma), not therapeutically equivalent to J0131, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ACETAMINOPHEN
Coding Clinic: 2023, Q3

● C **J0138** Injection, acetaminophen 10 mg and ibuprofen 3 mg ♂ N
BETOS: O1E Other drugs

● C **J0139** Injection, adalimumab, 1 mg ♂
BETOS: O1E Other drugs

D **J0153** Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds) N1 ASC N
BETOS: O1E Other drugs
Drugs: ADENOSINE

D **J0171** Injection, Adrenalin, epinephrine, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ADRENALIN, EPINEPHRINE HCL
Coding Clinic: 2011, Q1; 2023, Q1

D **J0172** Injection, aducanumab-avwa, 2 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Service not separately priced by Part B
Drugs: ADUHELM
Coding Clinic: 2022, Q1

▲ D **J0173** Injection, epinephrine (belcher), not therapeutically equivalent to J0171, 0.1 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: EPINEPHRINE HCL (BELCHER)
Coding Clinic: 2023, Q1

C **J0174** Injection, lecanemab-irmb, 1 mg K2 ASC G
BETOS: O1E Other drugs
Service not separately priced by Part B
Drugs: LEQEMBI
Coding Clinic: 2023, Q3

● C **J0175** Injection, donanemab-azbt, 2 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KISUNLA

● C **J0177** Injection, aflibercept hd, 1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: EYLEA HD
Coding Clinic: 2024, Q2

C **J0178** Injection, aflibercept, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: EYLEA

C **J0179** Injection, brolucizumab-dbll, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BEOVU
Coding Clinic: 2020, Q1

C **J0180** Injection, agalsidase beta, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FABRAZYME
Coding Clinic: 2005, Q2

C **J0184** Injection, amisulpride, 1 mg K2 ♂ ASC G
BETOS: O1E Other drugs
Drugs: BARHEMSYS
Coding Clinic: 2024, Q1

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C **J0185** Injection, aprepitant, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CINVANTI
Coding Clinic: 2019, Q1

D **J0190** Injection, biperiden lactate, per 5 mg K5 ASC E2
BETOS: O1E Other drugs

D **J0200** Injection, alatrofloxacin mesylate, 100 mg K5 ASC E2
BETOS: O1E Other drugs

C **J0202** Injection, alemtuzumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LEMTRADA
Coding Clinic: 2016, Q1

D **J0205** Injection, alglucerase, per 10 units K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2005, Q2

C **J0206** Injection, allopurinol sodium, 1 mg K2 ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: ALLOPURINOL, ALOPRIM
Coding Clinic: 2023, Q3

D **J0207** Injection, amifostine, 500 mg K5 ASC E2
BETOS: O1D Chemotherapy

▲ C **J0208** Injection, sodium thiosulfate (pedmark), 100 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: SODIUM THIOSULFATE
Coding Clinic: 2023, Q2; 2024, Q2

● C **J0209** Injection, sodium thiosulfate (hope), 100 mg N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

D **J0210** Injection, methyldopate HCl, up to 250 mg K5 ASC E2
BETOS: O1E Other drugs

● C **J0211** Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg (nithiodote) K2 ASC K
BETOS: O1E Other drugs
Drugs: NITHIODOTE
Coding Clinic: 2024, Q3

C **J0215** Injection, alefacept, 0.5 mg K5 ASC E2
BETOS: O1E Other drugs

C **J0216** Injection, alfentanil hydrochloride, 500 micrograms N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **J0217** Injection, velmanase alfa-tycv, 1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: LAMZEDE
Coding Clinic: 2024, Q1

C **J0218** Injection, olipudase alfa-rpcp, 1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: XENPOZYME
Coding Clinic: 2023, Q2

C **J0219** Injection, avalglucosidase alfa-ngpt, 4 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: NEXVIAZYME
Coding Clinic: 2022, Q2

C **J0220** Injection, alglucosidase alfa, 10 mg, not otherwise specified K2 ASC K
BETOS: O1E Other drugs
Coding Clinic: 2008, Q1; 2012, Q1

C **J0221** Injection, alglucosidase alfa, (Lumizyme), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LUMIZYME

C **J0222** Injection, Patisiran, 0.1 mg K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ONPATTRO
Coding Clinic: 2019, Q4

C **J0223** Injection, givosiran, 0.5 mg K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: GIVLAARI
Coding Clinic: 2020, Q2

C **J0224** Injection, lumasiran, 0.5 mg K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: OXLUMO
Coding Clinic: 2021, Q3

C **J0225** Injection, vutrisiran, 1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: AMVUTTRA
Coding Clinic: 2023, Q1

C **J0248** Injection, remdesivir, 1 mg ⓐ G
BETOS: O1E Other drugs
Drugs: VEKLURY
Coding Clinic: 2022, Q1

D **J0256** Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ARALAST NP, PROLASTIN-C, ZEMAIRA
Coding Clinic: 2005, Q2; 2012, Q1

D **J0257** Injection, alpha 1 proteinase inhibitor (human), (GLASSIA), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GLASSIA
Coding Clinic: 2012, Q1

D **J0270** Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) B
BETOS: O1E Other drugs

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D **J0275** Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) B
BETOS: O1E Other drugs

C **J0278** Injection, amikacin sulfate, 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: AMIKACIN SULFATE

D **J0280** Injection, aminophyllin, up to 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: AMINOPHYLLINE
Coding Clinic: 2005, Q4

D **J0282** Injection, amiodarone hydrochloride, 30 mg N1 ASC N
BETOS: O1E Other drugs

D **J0283** Injection, amiodarone hydrochloride (nexterone), 30 mg K5 ASC E2
BETOS: O1E Other drugs
Drugs: NEXTERONE
Coding Clinic: 2023, Q1

D **J0285** Injection, amphotericin B, 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: AMPHOTERICIN B

D **J0287** Injection, amphotericin B lipid complex, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ABELCET

D **J0288** Injection, amphotericin B cholesteryl sulfate complex, 10 mg K5 ASC E2
BETOS: O1E Other drugs

D **J0289** Injection, amphotericin B liposome, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AMBISOME, AMPHOTERICIN B LIPOSOME

D **J0290** Injection, ampicillin sodium, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: AMPICILLIN SODIUM

C **J0291** Injection, plazomicin, 5 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ZEMDRI
Coding Clinic: 2019, Q4

D **J0295** Injection, ampicillin sodium/sulbactam sodium, per 1.5 gm N1 ASC N
BETOS: O1E Other drugs
Drugs: AMPICILLIN-SULBACTAM, UNASYN

D **J0300** Injection, amobarbital, up to 125 mg K2 ASC K
BETOS: O1E Other drugs

D **J0330** Injection, succinylcholine chloride, up to 20 mg N1 ASC N
BETOS: O1E Other drugs

C **J0348** Injection, anidulafungin, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ERAXIS

C **J0349** Injection, rezafungin, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: REZZAYO
Coding Clinic: 2023, Q4

D **J0350** Injection, anistreplase, per 30 units K5 ASC E2
BETOS: O1E Other drugs

D **J0360** Injection, hydralazine HCl, up to 20 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: HYDRALAZINE HCL

C **J0364** Injection, apomorphine hydrochloride, 1 mg K5 ASC E2
BETOS: O1E Other drugs

D **J0365** Injection, aprotinin, 10,000 kiu K5 ASC E2
BETOS: O1E Other drugs

D **J0380** Injection, metaraminol bitartrate, per 10 mg K5 ASC E2
BETOS: O1E Other drugs

D **J0390** Injection, chloroquine hydrochloride, up to 250 mg N1 ASC N
BETOS: O1E Other drugs

C **J0391** Injection, artesunate, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARTESUNATE
Coding Clinic: 2024, Q1

D **J0395** Injection, arbutamine HCl, 1 mg K5 ASC E2
BETOS: O1E Other drugs

C **J0400** Injection, aripiprazole, intramuscular, 0.25 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q1

▲ C **J0401** Injection, aripiprazole (abilify maintena), 1 mg K2 ASC K MIPS
BETOS: O1E Other drugs
Drugs: ABILIFY MAINTENA
Coding Clinic: 2014, Q1; 2024, Q3

C **J0402** Injection, aripiprazole (abilify asimtufii), 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ABILIFY ASIMTUFII
Coding Clinic: 2024, Q1

D **J0456** Injection, azithromycin, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: AZITHROMYCIN, ZITHROMAX

C **J0457** Injection, aztreonam, 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AZACTAM, AZTREONAM
Coding Clinic: 2023, Q3

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D J0461 Injection, atropine sulfate, 0.01 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ATROPINE SULFATE

D J0470 Injection, dimercaprol, per 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BAL IN OIL

D J0475 Injection, baclofen, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BACLOFEN, GABLOFEN, LIORESAL

D J0476 Injection, baclofen, 50 mcg for intrathecal trial N1 ASC N
BETOS: O1E Other drugs
Drugs: BACLOFEN, GABLOFEN, LIORESAL

D J0480 Injection, basiliximab, 20 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SIMULECT

C J0485 Injection, belatacept, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: NULOJIX

C J0490 Injection, belimumab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BENLYSTA

C J0491 Injection, anifrolumab-fnia, 1 mg K2 ◎ ASC G
BETOS: O1E Other drugs
Drugs: SAPHNELO
Coding Clinic: 2022, Q2

D J0500 Injection, dicyclomine HCl, up to 20 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BENTYL, DICYCLOMINE HCL

D J0515 Injection, benztropine mesylate, per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BENZTROPINE, COGENTIN

C J0517 Injection, benralizumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FASENRA
Coding Clinic: 2019, Q1

D J0520 Injection, bethanechol chloride, myotonachol or urecholine, up to 5 mg K5 ASC E2
BETOS: O1E Other drugs

C J0558 Injection, penicillin G benzathine and penicillin G procaine, 100,000 units K2 ASC K
BETOS: O1E Other drugs
Drugs: BICILLIN CR
Coding Clinic: 2011, Q1

D J0561 Injection, penicillin G benzathine, 100,000 units K2 ASC K
BETOS: O1E Other drugs
Drugs: BICILLIN L-A
Coding Clinic: 2011, Q1

C J0565 Injection, bezlotoxumab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ZINPLAVA

C J0567 Injection, cerliponase alfa, 1 mg K5 ◎ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

D J0571 Buprenorphine, oral, 1 mg E1
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2014, Q4; 2016, Q1

D J0572 Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine E1
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2014, Q4; 2016, Q1

D J0573 Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine E1
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2014, Q4; 2016, Q1

D J0574 Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine E1
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2014, Q4; 2016, Q1

D J0575 Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine E1
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2014, Q4; 2016, Q1

● **C J0577** Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy K2 ASC G
BETOS: O1E Other drugs
Drugs: BRIXADI (WEEKLY DOSING)
Coding Clinic: 2024, Q2

● **C J0578** Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy K2 ASC G
BETOS: O1E Other drugs
Drugs: BRIXADI (MONTHLY DOSING)
Coding Clinic: 2024, Q2

C J0583 Injection, bivalirudin, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ANGIOMAX, BIVALIRUDIN

C J0584 Injection, burosumab-twza 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CRYSVITA
Coding Clinic: 2019, Q1

D J0585 Injection, onabotulinumtoxinA, 1 unit K2 ASC K
BETOS: O1E Other drugs
Drugs: BOTOX, BOTOX COSMETIC
Coding Clinic: 2021, Q2

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C **J0586** Injection, abobotulinumtoxinA, 5 Units K2 ASC K
BETOS: O1E Other drugs
Drugs: DYSPORT

D **J0587** Injection, rimabotulinumtoxinB, 100 units K2 ASC K
BETOS: O1E Other drugs
Drugs: MYOBLOC
Coding Clinic: 2002, Q1; 2002, Q2

C **J0588** Injection, incobotulinumtoxinA, 1 unit K2 ASC K
BETOS: O1E Other drugs
Drugs: XEOMIN

● C **J0589** Injection, daxibotulinumtoxina-lanm, 1 unit K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: DAXXIFY
Coding Clinic: 2024, Q2

C **J0591** Injection, deoxycholic acid, 1 mg Ⓐ E1
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

D **J0592** Injection, buprenorphine hydrochloride, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BUPRENEX, BUPRENORPHINE HCL

C **J0593** Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) K5 Ⓐ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **J0594** Injection, Busulfan, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BUSULFAN

C **J0595** Injection, butorphanol tartrate, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BUTORPHANOL TARTRATE
Coding Clinic: 2005, Q2

C **J0596** Injection, C1 esterase inhibitor (recombinant), ruconest, 10 units K2 ASC K
BETOS: O1E Other drugs
Drugs: RUCONEST
Coding Clinic: 2016, Q1

C **J0597** Injection, C-1 esterase inhibitor (human), Berinert, 10 units K2 ASC K
BETOS: O1E Other drugs
Drugs: BERINERT
Coding Clinic: 2011, Q1

C **J0598** Injection, C-1 esterase inhibitor (human), Cinryze, 10 units K2 ASC K
BETOS: O1E Other drugs
Drugs: CINRYZE

C **J0599** Injection, c-1 esterase inhibitor (human), (HAEGARDA®), 10 units K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

D **J0600** Injection, edetate calcium disodium, up to 1000 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CALCIUM DISODIUM EDETATE, CALCIUM DISODIUM VERSENATE

● C **J0601** Sevelamer carbonate (renvela or therapeutically equivalent), oral, 20 mg (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

● C **J0602** Sevelamer carbonate (renvela or therapeutically equivalent), oral, powder, 20 mg (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

● C **J0603** Sevelamer hydrochloride (renagel or therapeutically equivalent), oral, 20 mg (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

D **J0604** Cinacalcet, oral, 1 mg, (for ESRD on dialysis) B
BETOS: O1E Other drugs
Coding Clinic: 2018, Q1

● C **J0605** Sucroferric oxyhydroxide, oral, 5 mg (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

D **J0606** Injection, etelcalcetide, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PARSABIV
Coding Clinic: 2018, Q1; 2018, Q2

● C **J0607** Lanthanum carbonate, oral, 5 mg (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

● C **J0608** Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to J0607 (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

● C **J0609** Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

▲ D **J0612** Injection, calcium gluconate, not otherwise specified, 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CALCIUM GLUCONATE
Coding Clinic: 2023, Q2; 2024, Q2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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▲ D **J0613** Injection, calcium gluconate (wg critical care), not therapeutically equivalent to J0612, 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CALCIUM GLUCONATE
Coding Clinic: 2023, Q2; 2024, Q2

● C **J0615** Calcium acetate, oral, 23 mg (for esrd on dialysis)
BETOS: O1E Other drugs
Other carrier priced

D **J0620** Injection, calcium glycerophosphate and calcium lactate, per 10 ml N1 ASC N
BETOS: O1E Other drugs

D **J0630** Injection, calcitonin salmon, up to 400 units K2 ASC K
BETOS: O1E Other drugs
Drugs: CALCITONIN SALMON, MIACALCIN

D **J0636** Injection, calcitriol, 0.1 mcg N1 ASC N
BETOS: O1E Other drugs

C **J0637** Injection, caspofungin acetate, 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CANCIDAS, CASPOFUNGIN, CASPOFUNGIN ACETATE

C **J0638** Injection, canakinumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ILARIS
Coding Clinic: 2011, Q1; 2011, Q4

D **J0640** Injection, leucovorin calcium, per 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: LEUCOVORIN CALCIUM
Coding Clinic: 2009, Q1

D **J0641** Injection, levoleucovorin, not otherwise specified, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LEVOLEUCOVORIN CALCIUM
Coding Clinic: 2008, Q4; 2009, Q1; 2019, Q4

C **J0642** Injection, levoleucovorin (khapzory), 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KHAPZORY
Coding Clinic: 2019, Q4; 2020, Q1

● C **J0650** Injection, levothyroxine sodium, not otherwise specified, 10 mcg N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

▲ C **J0651** Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to J0650, 10 mcg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: LEVOTHYROXINE SODIUM
Coding Clinic: 2024, Q2

▲ C **J0652** Injection, levothyroxine sodium (hikma), not therapeutically equivalent to J0650, 10 mcg K2 ASC K
BETOS: O1E Other drugs
Drugs: LEVOTHYROXINE SODIUM
Coding Clinic: 2024, Q2

C **J0665** Injection, bupivicaine, not otherwise specified, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BUPIVACAINE HCL, BUPIVICAINE, BUPIVICAINE W EPI, MARCAINE, MARCAINE SPINAL, SENSORCAINE, SENSORCAINE-MPF
Coding Clinic: 2023, Q3

● C **J0666** Injection, bupivacaine liposome, 1 mg Ⓐ
BETOS: O1E Other drugs

D **J0670** Injection, mepivacaine hydrochloride, per 10 ml N1 ASC N
BETOS: O1E Other drugs
Drugs: POLOCAINE, POLOCAINE - MPF, POLOCAINE-MPF

● D **J0687** Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to J0690, 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CEFAZOLIN SODIUM
Coding Clinic: 2024, Q3

D **J0688** Injection, cefazolin sodium (hikma), not therapeutically equivalent to J0690, 500 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: CEFAZOLIN SODIUM
Coding Clinic: 2024, Q1

D **J0689** Injection, cefazolin sodium (baxter), not therapeutically equivalent to J0690, 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CEFAZOLIN SODIUM
Coding Clinic: 2023, Q1

D **J0690** Injection, cefazolin sodium, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CEFAZOLIN SODIUM, CEFAZOLIN SODIUM IN DEXTROSE
Coding Clinic: 2023, Q1; 2024, Q3

C **J0691** Injection, lefamulin, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: XENLETA
Coding Clinic: 2020, Q2

C **J0692** Injection, cefepime hydrochloride, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CEFEPIME, MAXIPIME
Coding Clinic: 2002, Q1

D **J0694** Injection, cefoxitin sodium, 1 gm N1 ASC N
BETOS: O1E Other drugs
Drugs: CEFOXITIN SODIUM

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C **J0695** Injection, ceftolozane 50 mg and tazobactam 25 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ZERBAXA
Coding Clinic: 2016, Q1

D **J0696** Injection, ceftriaxone sodium, per 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CEFTRIAXONE, CEFTRIAXONE IN D5W

D **J0697** Injection, sterile cefuroxime sodium, per 750 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CEFTRIAXONE, CEFUROXIME SODIUM, ZINACEF

D **J0698** Injection, cefotaxime sodium, per gm N1 ASC N
BETOS: O1E Other drugs

C **J0699** Injection, cefiderocol, 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: FETROJA
Coding Clinic: 2021, Q4

C **J0701** Injection, cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CEFEPIME HCL
Coding Clinic: 2023, Q1

D **J0702** Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BETAMETHASONE SODIUM PHOSPHATE AND BETAMETHASONE ACETATE, CELESTONE SOLUSPAN
Coding Clinic: 2018, Q4; 2024, Q3

C **J0703** Injection, cefepime hydrochloride (b braun), not therapeutically equivalent to maxipime, 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CEFEPIME HCL IN DEXTROSE
Coding Clinic: 2023, Q1

C **J0706** Injection, Caffeine Citrate, 5 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2002, Q1; 2002, Q2

D **J0710** Injection, cephapirin sodium, up to 1 gm K5 ASC E2
BETOS: O1E Other drugs

C **J0712** Injection, ceftaroline fosamil, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TEFLARO

D **J0713** Injection, ceftazidime, per 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CEFTAZIDIME, TAZICEF

C **J0714** Injection, ceftazidime and avibactam, 0.5 g/0.125 g K2 ASC K
BETOS: O1E Other drugs
Drugs: AVYCAZ
Coding Clinic: 2016, Q1

D **J0715** Injection, ceftizoxime sodium, per 500 mg N1 ASC N
BETOS: O1E Other drugs

C **J0716** Injection, centruroides immune f(ab)2, up to 120 milligrams K2 ASC K
BETOS: O1E Other drugs
Drugs: ANASCORP

C **J0717** Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) K2 ASC K
BETOS: O1E Other drugs
Drugs: CIMZIA
Coding Clinic: 2014, Q1

D **J0720** Injection, chloramphenicol sodium succinate, up to 1 gm N1 ASC N
BETOS: O1E Other drugs

D **J0725** Injection, chorionic gonadotropin, per 1,000 USP units N1 ♀ Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL

D **J0735** Injection, clonidine hydrochloride, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CLONIDINE HYDROCHLORIDE INJECTION, DURACLON

C **J0736** Injection, clindamycin phosphate, 300 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CLEOCIN, CLINDAMYCIN PHOSPHATE
Coding Clinic: 2023, Q3

C **J0737** Injection, clindamycin phosphate (baxter), not therapeutically equivalent to J0736, 300 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CLINDAMYCIN PHOSPHATE
Coding Clinic: 2023, Q3

D **J0739** Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv) Ⓐ K
BETOS: O1E Other drugs
Other carrier priced
Statute: 1861(ddd)
Coding Clinic: 2022, Q3

D **J0740** Injection, cidofovir, 375 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CIDOFOVIR

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ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **J0741** Injection, cabotegravir and rilpivirine, 2mg/3mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CABENUVA
Coding Clinic: 2021, Q4

C **J0742** Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: RECARBRIO
Coding Clinic: 2020, Q2

D **J0743** Injection, cilastatin sodium; imipenem, per 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: IMIPENEM/CILASTATIN, PRIMAXIN IV

C **J0744** Injection, ciprofloxacin for intravenous infusion, 200 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CIPRO, CIPROFLOXACIN
Coding Clinic: 2002, Q1

D **J0745** Injection, codeine phosphate, per 30 mg N1 ASC N
BETOS: O1E Other drugs

D **J0750** Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv) Ⓐ K
BETOS: O1E Other drugs
Other carrier priced
Statute: 1861(ddd)
Drugs: EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE, TRUVADA
Coding Clinic: 2024, Q1

D **J0751** Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv) Ⓐ K
BETOS: O1E Other drugs
Other carrier priced
Statute: 1861(ddd)
Coding Clinic: 2024, Q1

D **J0770** Injection, colistimethate sodium, up to 150 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: COLISTIMETHATE SODIUM, COLY-MYCIN M PARENTERAL

C **J0775** Injection, collagenase, clostridium histolyticum, 0.01 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: XIAFLEX
Coding Clinic: 2011, Q1

D **J0780** Injection, prochlorperazine, up to 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PROCHLORPERAZINE EDISYLATE

C **J0791** Injection, crizanlizumab-tmca, 5 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ADAKVEO
Coding Clinic: 2020, Q2

D **J0795** Injection, corticorelin ovine triflutate, 1 microgram K5 ASC E2
BETOS: O1E Other drugs

D **J0799** Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified A
BETOS: O1E Other drugs
Statute: 1861(ddd)
Coding Clinic: 2024, Q1

C **J0801** Injection, corticotropin (acthar gel), up to 40 units K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: H.P. ACTHAR
Coding Clinic: 2023, Q4

C **J0802** Injection, corticotropin (ani), up to 40 units K2 ASC K
BETOS: O1E Other drugs
Drugs: CORTROPHIN GEL, PURIFIED CORTROPHIN GEL
Coding Clinic: 2023, Q4

C **J0834** Injection, cosyntropin, 0.25 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CORTROSYN, COSYNTROPIN

C **J0840** Injection, crotalidae polyvalent immune FAB(Ovine), up to 1 gram K2 ASC K
BETOS: O1E Other drugs
Drugs: CROFAB

C **J0841** Injection, crotalidae immune f(ab')2 (equine), 120 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ANAVIP
Coding Clinic: 2019, Q1

D **J0850** Injection, cytomegalovirus immune globulin intravenous (human), per vial K2 ASC K
BETOS: O1E Other drugs
Drugs: CYTOGAM

● C **J0870** Injection, imetelstat, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **J0872** Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: DAPTOMYCIN
Coding Clinic: 2024, Q3

▲ C **J0873** Injection, daptomycin (xellia), not therapeutically equivalent to J0878 or J0872, 1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: DAPTOMYCIN
Coding Clinic: 2024, Q1; 2024, Q3

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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C **J0874** Injection, daptomycin (baxter), not therapeutically equivalent to J0878, 1 mg K5 Ⓐ ASC E2
BETOS: O1E Other drugs
Drugs: DAPTOMYCIN IN NACL (BAXTER)
Coding Clinic: 2023, Q4

C **J0875** Injection, dalbavancin, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: DALVANCE
Coding Clinic: 2016, Q1

C **J0877** Injection, daptomycin (hospira), not therapeutically equivalent to J0878, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: DAPTOMYCIN
Coding Clinic: 2023, Q1

C **J0878** Injection, daptomycin, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CUBICIN, DAPTOMYCIN
Coding Clinic: 2005, Q2; 2023, Q1; 2024, Q3

C **J0879** Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis) N1 Ⓐ ASC N
BETOS: O1E Other drugs
Other carrier priced
Coding Clinic: 2022, Q2

D **J0881** Injection, darbepoetin alfa, 1 microgram (non-ESRD use) K2 ASC K
BETOS: O1E Other drugs
Drugs: ARANESP

D **J0882** Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis) K2 ASC K
BETOS: O1E Other drugs
Other carrier priced
Drugs: ARANESP

D **J0883** Injection, argatroban, 1 mg (for non-ESRD use) K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARGATROBAN
Coding Clinic: 2023, Q1

D **J0884** Injection, argatroban, 1 mg (for ESRD on dialysis) K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARGATROBAN
Coding Clinic: 2023, Q1

D **J0885** Injection, epoetin alfa, (for non-ESRD use), 1000 units K2 ASC K
BETOS: O1E Other drugs
Drugs: EPOGEN, PROCRIT
Coding Clinic: 2006, Q2; 2006, Q2

D **J0887** Injection, epoetin beta, 1 microgram, (for ESRD on dialysis) K2 ASC K
BETOS: O1E Other drugs
Other carrier priced
Drugs: MIRCERA

D **J0888** Injection, epoetin beta, 1 microgram, (for Non ESRD use) K2 ASC K
BETOS: O1E Other drugs
Other carrier priced
Drugs: MIRCERA

C **J0889** Daprodustat, oral, 1 mg, (for esrd on dialysis) K5 Ⓐ ASC E2
BETOS: O1E Other drugs
Other carrier priced
Coding Clinic: 2023, Q4

C **J0890** Injection, peginesatide, 0.1 mg (for ESRD on dialysis) E1
BETOS: O1E Other drugs

D **J0891** Injection, argatroban (accord), not therapeutically equivalent to J0883, 1 mg (for non-esrd use) K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARGATROBAN
Coding Clinic: 2023, Q1

D **J0892** Injection, argatroban (accord), not therapeutically equivalent to J0884, 1 mg (for esrd on dialysis) K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARGATROBAN
Coding Clinic: 2023, Q1

▲ C **J0893** Injection, decitabine (sun pharma), not therapeutically equivalent to J0894, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: DECITABINE
Coding Clinic: 2023, Q1

C **J0894** Injection, decitabine, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DACOGEN, DECITABINE
Coding Clinic: 2023, Q1

D **J0895** Injection, deferoxamine mesylate, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DEFEROXAMINE MESYLATE, DESFERAL

C **J0896** Injection, luspatercept-aamt, 0.25 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: REBLOZYL
Coding Clinic: 2020, Q2

C **J0897** Injection, denosumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PROLIA, XGEVA
Coding Clinic: 2013, Q1; 2016, Q1

D **J0898** Injection, argatroban (auromedics), not therapeutically equivalent to J0883, 1 mg (for non-esrd use) K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARGATROBAN
Coding Clinic: 2023, Q1

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D **J0899** Injection, argatroban (auromedics), not therapeutically equivalent to J0884, 1 mg (for esrd on dialysis) K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARGATROBAN
Coding Clinic: 2023, Q1

● C **J0901** Vadadustat, oral, 1 mg (for esrd on dialysis) Ⓐ
BETOS: O1E Other drugs

● C **J0911** Instillation, taurolidine 1.35 mg and heparin sodium 100 units (central venous catheter lock for adult patients receiving chronic hemodialysis) K2 Ⓐ ASC G
BETOS: P9A Dialysis services (Medicare fee schedule)
Drugs: DEFENCATH
Coding Clinic: 2024, Q3

D **J0945** Injection, brompheniramine maleate, per 10 mg K5 ASC E2
BETOS: O1E Other drugs

D **J1000** Injection, depo-estradiol cypionate, up to 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DEPO-ESTRADIOL

● D **J1010** Injection, methylprednisolone acetate, 1 mg N
BETOS: O1E Other drugs
Drugs: DEPO-MEDROL, METHYLPREDNISOLONE ACETATE, METHYLPREDNISOLONE ACETATE USP
Coding Clinic: 2024, Q2

C **J1050** Injection, medroxyprogesterone acetate, 1 mg N1 ♀ ASC N
BETOS: O1E Other drugs

D **J1071** Injection, testosterone cypionate, 1 mg N1 ♂ ASC N
BETOS: O1E Other drugs
Drugs: DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE

D **J1094** Injection, dexamethasone acetate, 1 mg N1 ASC N
BETOS: O1E Other drugs

D **J1095** Injection, dexamethasone 9 percent, intraocular, 1 microgram N1 ASC N
BETOS: O1E Other drugs
Statute: 1833T
Coding Clinic: 2019, Q1

C **J1096** Dexamethasone, lacrimal ophthalmic insert, 0.1 mg K2 ASC N
BETOS: O1E Other drugs
Drugs: DEXTENZA
Coding Clinic: 2019, Q4

C **J1097** phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml K2 ASC N
BETOS: O1E Other drugs
Drugs: OMIDRIA
Coding Clinic: 2019, Q4

D **J1100** Injection, dexamethasone sodium phosphate, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DEXAMETHASONE SODIUM PHOSPHATE

I **J1105** Dexmedetomidine, oral, 1 mcg K2 ASC K
BETOS: O1E Other drugs
Drugs: IGALMI
Coding Clinic: 2024, Q1

D **J1110** Injection, dihydroergotamine mesylate, per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DIHYDROERGOTAMINE MESYLATE

D **J1120** Injection, acetazolamide sodium, up to 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ACETAZOLAMIDE SODIUM
Coding Clinic: 2005, Q4

C **J1130** Injection, diclofenac sodium, 0.5 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2017, Q1

D **J1160** Injection, digoxin, up to 0.5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DIGOXIN, LANOXIN

D **J1162** Injection, digoxin immune FAB(Ovine), per vial K2 ASC K
BETOS: O1E Other drugs
Drugs: DIGIFAB

D **J1165** Injection, phenytoin sodium, per 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PHENYTOIN SODIUM

● D **J1171** Injection, hydromorphone, 0.1 mg N
BETOS: O1E Other drugs
Drugs: DILAUDID, HYDROMORPHONE HCL

D **J1180** Injection, dyphylline, up to 500 mg K5 ASC E2
BETOS: O1E Other drugs

D **J1190** Injection, dexrazoxane hydrochloride, per 250 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: DEXRAZOXANE

D **J1200** Injection, diphenhydramine HCl, up to 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BENADRYL, DIPHENHYDRAMINE HCL
Coding Clinic: 2002, Q1

C **J1201** Injection, cetirizine hydrochloride, 0.5 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: QUZYTTIR
Coding Clinic: 2020, Q2

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● I **J1202** Miglustat, oral, 65 mg Ⓐ E1
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **J1203** Injection, cipaglucosidase alfa-atga, 5 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: POMBILITI
Coding Clinic: 2024, Q2

D **J1205** Injection, chlorothiazide sodium, per 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CHLOROTHIAZIDE SODIUM

D **J1212** Injection, DMSO, dimethyl sulfoxide, 50%, 50 ml K2 ASC K
BETOS: O1E Other drugs
Drugs: RIMSO-50

D **J1230** Injection, methadone HCl, up to 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: METHADONE HCL

D **J1240** Injection, dimenhydrinate, up to 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DIMENHYDRINATE

D **J1245** Injection, dipyridamole, per 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DIPYRIDAMOLE

D **J1250** Injection, Dobutamine hydrochloride, per 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DOBUTAMINE HCL

D **J1260** Injection, dolasetron mesylate, 10 mg N1 ASC N
BETOS: O1D Chemotherapy

C **J1265** Injection, dopamine HCl, 40 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DOPAMINE, DOPAMINE IN D5W
Coding Clinic: 2005, Q4

C **J1267** Injection, doripenem, 10 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4

C **J1270** Injection, doxercalciferol, 1 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: DOXERCALCIFEROL, HECTOROL
Coding Clinic: 2002, Q1

C **J1290** Injection, ecallantide, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KALBITOR
Coding Clinic: 2011, Q1

C **J1300** Injection, eculizumab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SOLIRIS
Coding Clinic: 2008, Q1

C **J1301** Injection, edaravone, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RADICAVA
Coding Clinic: 2019, Q1

C **J1302** Injection, sutimlimab-jome, 10 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ENJAYMO
Coding Clinic: 2022, Q4

C **J1303** Injection, ravulizumab-cwvz, 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ULTOMIRIS
Coding Clinic: 2019, Q4

C **J1304** Injection, tofersen, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: QALSODY
Coding Clinic: 2024, Q1

C **J1305** Injection, evinacumab-dgnb, 5mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: EVKEEZA
Coding Clinic: 2021, Q4

C **J1306** Injection, inclisiran, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: LEQVIO
Coding Clinic: 2022, Q3

● C **J1307** Injection, crovalimab-akkz, 10 mg Ⓐ
BETOS: O1E Other drugs

D **J1320** Injection, amitriptyline HCl, up to 20 mg N1 ASC N
BETOS: O1E Other drugs

C **J1322** Injection, elosulfase alfa, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VIMIZIM

● C **J1323** Injection, elranatamab-bcmm, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: ELREXFIO
Coding Clinic: 2024, Q2

C **J1324** Injection, enfuvirtide, 1 mg K5 ASC E2
BETOS: O1E Other drugs

D **J1325** Injection, epoprostenol, 0.5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: EPOPROSTENOL, FLOLAN, VELETRI

D **J1327** Injection, eptifibatide, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: EPTIFIBATIDE

D **J1330** Injection, ergonovine maleate, up to 0.2 mg K5 ♀ ASC E2
BETOS: O1E Other drugs

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **J1335** Injection, ertapenem sodium, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ERTAPENEM, INVANZ

D **J1364** Injection, erythromycin lactobionate, per 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ERYTHROMYCIN LACTOBIONATE

D **J1380** Injection, estradiol valerate, up to 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DELESTROGEN, ESTRADIOL VALERATE
Coding Clinic: 2011, Q1

D **J1410** Injection, estrogen conjugated, per 25 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PREMARIN

C **J1411** Injection, etranacogene dezaparvovec-drlb, per therapeutic dose Ⓐ G
BETOS: O1E Other drugs
Drugs: HEMGENIX
Coding Clinic: 2023, Q2

C **J1412** Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^{13} vector genomes Ⓐ G
BETOS: O1E Other drugs
Drugs: ROCTAVIAN
Coding Clinic: 2024, Q1

C **J1413** Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose Ⓐ G
BETOS: O1E Other drugs
Drugs: ELEVIDYS
Coding Clinic: 2024, Q1

● C **J1414** Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose Ⓐ
BETOS: O1E Other drugs

C **J1426** Injection, casimersen, 10 mg K2 ASC K
BETOS: O1E Other drugs
Coding Clinic: 2021, Q4

C **J1427** Injection, viltolarsen, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VILTEPSO
Coding Clinic: 2021, Q1

C **J1428** Injection, eteplirsen, 10 mg K5 ASC E2
BETOS: O1E Other drugs

C **J1429** Injection, golodirsen, 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: VYONDYS 53
Coding Clinic: 2020, Q2

D **J1430** Injection, ethanolamine oleate, 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ETHANOLAMINE OLEATE

● C **J1434** Injection, fosaprepitant (focinvez), 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: FOCINVEZ
Coding Clinic: 2024, Q2

D **J1435** Injection, estrone, per 1 mg K5 ♀ ASC E2
BETOS: O1E Other drugs

D **J1436** Injection, etidronate disodium, per 300 mg E1
BETOS: O1E Other drugs

C **J1437** Injection, ferric derisomaltose, 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: MONOFERRIC
Coding Clinic: 2020, Q4

D **J1438** Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) K2 ASC K
BETOS: O1E Other drugs
Drugs: ENBREL

C **J1439** Injection, ferric carboxymaltose, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: INJECTAFER

C **J1440** Fecal microbiota, live - jslm, 1 ml K2 ASC G
BETOS: T2D Other tests - other
Price established by carriers
Drugs: REBYOTA
Coding Clinic: 2014, Q1; 2023, Q3

D **J1442** Injection, filgrastim (G-CSF), excludes biosimilars, 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: NEUPOGEN
Coding Clinic: 2014, Q1

C **J1443** Injection, ferric pyrophosphate citrate solution (triferic), 0.1 mg of iron K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2016, Q1

C **J1444** Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q3

C **J1445** Injection, ferric pyrophosphate citrate solution (triferic avnu), 0.1 mg of iron K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2021, Q4

D **J1447** Injection, tbo-filgrastim, 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: GRANIX
Coding Clinic: 2016, Q1

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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J1448 Injection, trilaciclib, 1mg K2 ASC K
BETOS: O1E Other drugs
Drugs: COSELA
Coding Clinic: 2021, Q4

J1449 Injection, eflapegrastim-xnst, 0.1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ROLVEDON
Coding Clinic: 2023, Q2

J1450 Injection fluconazole, 200 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: FLUCONAZOLE IN SODIUM CHLORIDE

J1451 Injection, fomepizole, 15 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FOMEPIZOLE

J1452 Injection, fomivirsen sodium, intraocular, 1.65 mg K5 ASC E2
BETOS: O1E Other drugs

J1453 Injection, fosaprepitant, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: EMEND, FOSAPREPITANT
Coding Clinic: 2008, Q4; 2023, Q1

J1454 Injection, fosnetupitant 235 mg and palonosetron 0.25 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AKYNZEO
Coding Clinic: 2018, Q4; 2019, Q1

J1455 Injection, foscarnet sodium, per 1000 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FOSCARNET SODIUM

J1456 Injection, fosaprepitant (teva), not therapeutically equivalent to J1453, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: FOSAPREPITANT
Coding Clinic: 2023, Q1

J1457 Injection, gallium nitrate, 1 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2005, Q2

J1458 Injection, galsulfase, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: NAGLAZYME

J1459 Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PRIVIGEN
Coding Clinic: 2008, Q4

J1460 Injection, gamma globulin, intramuscular, 1 cc K2 ASC K
BETOS: O1E Other drugs
Drugs: GAMASTAN
Coding Clinic: 2011, Q1

J1551 Injection, immune globulin (cutaquig), 100 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CUTAQUIG
Coding Clinic: 2022, Q3

● **J1552** Injection, immune globulin (alyglo), 500 mg Ⓐ
BETOS: O1E Other drugs

J1554 Injection, immune globulin (asceniv), 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ASCENIV
Coding Clinic: 2021, Q1

J1555 Injection, immune globulin (cuvitru), 100 mg K2 ASC K
BETOS: D1G Drugs Administered through DME
Drugs: CUVITRU
Coding Clinic: 2018, Q1

J1556 Injection, immune globulin (bivigam), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BIVIGAM
Coding Clinic: 2013, Q4

J1557 Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GAMMAPLEX

J1558 Injection, immune globulin (xembify), 100 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: XEMBIFY
Coding Clinic: 2020, Q2

J1559 Injection, immune globulin (Hizentra), 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: HIZENTRA
Coding Clinic: 2011, Q1

J1560 Injection, gamma globulin, intramuscular, over 10 cc K2 ASC K
BETOS: O1E Other drugs
Drugs: GAMASTAN

J1561 Injection, immune globulin, (Gamunex-C/ Gammaked), non-lyophilized (e.g., liquid), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GAMMAKED, GAMUNEX-C
Coding Clinic: 2002, Q2; 2007, Q4; 2008, Q1; 2012, Q1

J1562 Injection, immune globulin (Vivaglobin), 100 mg K5 ASC E2
BETOS: O1E Other drugs

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **J1566** Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GAMMAGARD S/D
Coding Clinic: 2006, Q1

C **J1568** Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: OCTAGAM
Coding Clinic: 2007, Q4; 2008, Q1

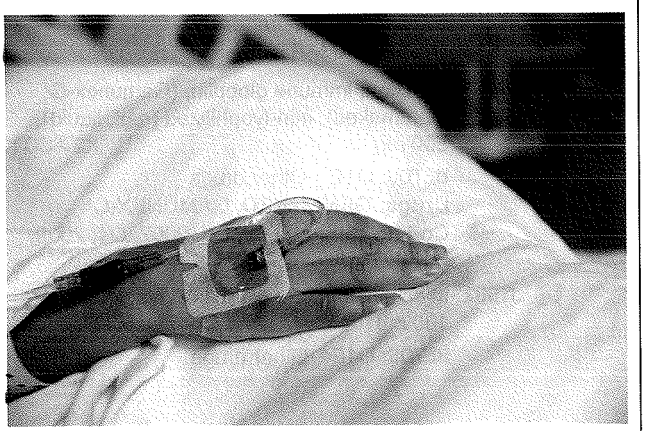
D **J1569** Injection, immune globulin, (Gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GAMMAGARD LIQUID
Coding Clinic: 2007, Q4; 2008, Q1

D **J1570** Injection, ganciclovir sodium, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CYTOVENE, GANCICLOVIR
Coding Clinic: 2023, Q1

D **J1571** Injection, hepatitis B immune globulin (HepaGam B), intramuscular, 0.5 ml K2 ASC K
BETOS: O1E Other drugs
Drugs: HEPAGAM B
Coding Clinic: 2007, Q4; 2008, Q1; 2008, Q3

D **J1572** Injection, immune globulin, (Flebogamma/ Flebogamma Dif), intravenous, non-lyophilized (e.g., liquid), 500 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FLEBOGAMMA DIF
Coding Clinic: 2007, Q4; 2008, Q1

C **J1573** Injection, hepatitis B immune globulin (HepaGam B), intravenous, 0.5 ml K2 ASC K
BETOS: O1E Other drugs
Drugs: HEPAGAM B
Coding Clinic: 2008, Q1; 2008, Q3



Intravenous (IV) access

▲ D **J1574** Injection, ganciclovir sodium (exela), not therapeutically equivalent to J1570, 500 mg K5 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q1

C **J1575** Injection, immune globulin/hyaluronidase, (HYQVIA), 100 mg immunoglobulin K2 ASC K
BETOS: O1E Other drugs
Drugs: HYQVIA
Coding Clinic: 2016, Q1

D **J1576** Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: PANZYGA
Coding Clinic: 2023, Q3

D **J1580** Injection, garamycin, gentamicin, up to 80 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: GENTAMICIN SULFATE

D **J1595** Injection, glatiramer acetate, 20 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: COPAXONE

C **J1596** Injection, glycopyrrolate, 0.1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: GLYCOPYRROLATE INJECTION
Coding Clinic: 2024, Q1; 2024, Q3

● C **J1597** Injection, glycopyrrolate (glyrx-pf), 0.1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **J1598** Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to J1596, 0.1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: GLYCOPYRROLATE
Coding Clinic: 2024, Q3

C **J1599** Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2011, Q1

D **J1600** Injection, gold sodium thiomalate, up to 50 mg K5 ASC E2
BETOS: O1E Other drugs

C **J1602** Injection, golimumab, 1 mg, for intravenous use K2 ASC K
BETOS: O1E Other drugs
Drugs: SIMPONI ARIA
Coding Clinic: 2014, Q1

D **J1610** Injection, glucagon hydrochloride, per 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GLUCAGEN, GLUCAGON, GLUCAGON EMERGENCY
Coding Clinic: 2023, Q1

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D **J1611** Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to J1610, per 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: GLUCAGEN, GLUCAGON, GLUCAGON EMERGENCY
Coding Clinic: 2023, Q1

D **J1620** Injection, gonadorelin hydrochloride, per 100 mcg K5 ASC E2
BETOS: O1E Other drugs

D **J1626** Injection, granisetron hydrochloride, 100 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: GRANISETRON HCL

C **J1627** Injection, granisetron, extended-release, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SUSTOL

C **J1628** Injection, guselkumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TREMFYA
Coding Clinic: 2019, Q1

D **J1630** Injection, haloperidol, up to 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: HALOPERIDOL LACTATE

D **J1631** Injection, haloperidol decanoate, per 50 mg N1 ASC N MIPS
BETOS: O1E Other drugs
Drugs: HALDOL DECANOATE, HALOPERIDOL DECANOATE

C **J1632** Injection, brexanolone, 1 mg K2 ♀ Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ZULRESSO
Coding Clinic: 2020, Q4

D **J1640** Injection, hemin, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PANHEMATIN

D **J1642** Injection, heparin sodium, (heparin lock flush), per 10 units N1 ASC N
BETOS: O1E Other drugs
Drugs: HEPARIN (PORCINE) LOCK FLUSH
Coding Clinic: 2005, Q4

D **J1643** Injection, heparin sodium (pfizer), not therapeutically equivalent to J1644, per 1000 units K2 ASC K
BETOS: O1E Other drugs
Drugs: HEPARIN SODIUM (PORCINE)
Coding Clinic: 2023, Q1

D **J1644** Injection, heparin sodium, per 1000 units N1 ASC N
BETOS: O1E Other drugs
Drugs: HEPARIN (PORCINE) IN D5W, HEPARIN (PORCINE) IN NACL, HEPARIN SODIUM, HEPARIN SODIUM (PORCINE), HEPARIN SODIUM IN NACL
Coding Clinic: 2023, Q1

D **J1645** Injection, dalteparin sodium, per 2500 IU N1 ASC N
BETOS: O1E Other drugs
Drugs: FRAGMIN

C **J1650** Injection, enoxaparin sodium, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ENOXAPARIN SODIUM, LOVENOX

D **J1652** Injection, fondaparinux sodium, 0.5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ARIXTRA, FONDAPARINUX SODIUM

C **J1655** Injection, tinzaparin sodium, 1000 IU K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2002, Q1

D **J1670** Injection, tetanus immune globulin, human, up to 250 units K2 ASC K
BETOS: O1E Other drugs
Drugs: HYPERTET

D **J1675** Injection, histrelin acetate, 10 micrograms B
BETOS: O1E Other drugs

D **J1700** Injection, hydrocortisone acetate, up to 25 mg N1 ASC N
BETOS: O1E Other drugs

D **J1710** Injection, hydrocortisone sodium phosphate, up to 50 mg N1 ASC N
BETOS: O1E Other drugs

D **J1720** Injection, hydrocortisone sodium succinate, up to 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: SOLU-CORTEF

C **J1726** Injection, hydroxyprogesterone caproate, (makena), 10 mg K2 ♀ ASC K
BETOS: O1E Other drugs
Drugs: HYDROXYPROGESTERONE CAPROATE, MAKENA, MAKENA AUTO INJECTOR

C **J1729** Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg K2 ♀ ASC K
BETOS: O1E Other drugs

D **J1730** Injection, diazoxide, up to 300 mg K5 ASC E2
BETOS: O1E Other drugs

C **J1738** Injection, meloxicam, 1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q4

C **J1740** Injection, ibandronate sodium, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: IBANDRONATE SODIUM
Coding Clinic: 2006, Q4

C **J1741** Injection, ibuprofen, 100 mg N1 ASC N
BETOS: O1E Other drugs

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **J1742** Injection, ibutilide fumarate, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CORVERT, IBUTILIDE FUMARATE

C **J1743** Injection, idursulfase, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ELAPRASE
Coding Clinic: 2008, Q1

C **J1744** Injection, icatibant, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ICATIBANT

D **J1745** Injection, infliximab, excludes biosimilar, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: INFLIXIMAB, REMICADE

C **J1746** Injection, ibalizumab-uiyk, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TROGARZO
Coding Clinic: 2019, Q1

C **J1747** Injection, spesolimab-sbzo, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: SPEVIGO
Coding Clinic: 2023, Q2

● C **J1748** Injection, infliximab-dyyb (zymfentra), 10 mg Ⓐ N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **J1749** Injection, iloprost, 0.1 mcg Ⓐ E2
BETOS: O1E Other drugs

D **J1750** Injection, iron dextran, 50 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: INFED

C **J1756** Injection, iron sucrose, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: VENOFER

D **J1786** Injection, imiglucerase, 10 units K2 ASC K
BETOS: O1E Other drugs
Drugs: CEREZYME
Coding Clinic: 2011, Q1

D **J1790** Injection, droperidol, up to 5 mg N1 ASC N
BETOS: O1E Other drugs

D **J1800** Injection, propranolol HCl, up to 1 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2005, Q4

C **J1805** Injection, esmolol hydrochloride, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BREVIBLOC, BREVIBLOC IN NACL, ESMOLOL HCL
Coding Clinic: 2023, Q3

▲ C **J1806** Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to J1805, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ESMOLOL HCL
Coding Clinic: 2023, Q3

D **J1810** Injection, droperidol and fentanyl Citrate, up to 2 ml ampule E1
BETOS: O1E Other drugs
Coding Clinic: 2002, Q2

C **J1811** Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units K2 Ⓐ ASC K
BETOS: D1G Drugs Administered through DME
Drugs: FIASP, FIASP PUMPCART
Coding Clinic: 2023, Q3

D **J1812** Insulin (fiasp), per 5 units N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **J1813** Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units K2 Ⓐ ASC K
BETOS: D1G Drugs Administered through DME
Drugs: LYUMJEV
Coding Clinic: 2023, Q3

D **J1814** Insulin (lyumjev), per 5 units N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

D **J1815** Injection, insulin, per 5 units N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2005, Q4

C **J1817** Insulin for administration through DME (i.e., insulin pump) per 50 units N1 ASC N
BETOS: D1G Drugs Administered through DME
Drugs: HUMALOG, HUMALOG KWIKPEN, HUMALOG TEMPO PEN, HUMILIN®, HUMULIN N, HUMULIN R, INSULIN ASPART, INSULIN LISPRO, INSULIN LISPRO JUNIOR KWIKPEN, INSULIN LISPRO KWIKPEN, NOVOLIN N, NOVOLIN®, NOVOLOG, NOVOLOG FLEXPEN, NOVOLOG PENFILL
Coding Clinic: 2005, Q4

C **J1823** Injection, inebilizumab-cdon, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: UPLIZNA
Coding Clinic: 2021, Q1

C **J1826** Injection, interferon beta-1a, 30 mcg K2 ASC K
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2011, Q1; 2011, Q2; 2011, Q2; 2014, Q4

D **J1830** Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) K5 ASC E2
BETOS: O1E Other drugs

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C **J1833** Injection, isavuconazonium, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CRESEMBA
Coding Clinic: 2016, Q1

C **J1835** Injection, itraconazole, 50 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2002, Q1

C **J1836** Injection, metronidazole, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: METRONIDAZOLE
Coding Clinic: 2023, Q3

D **J1885** Injection, ketorolac tromethamine, per 15 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: KETOROLAC TROMETHAMINE , KETOROLAC TROMETHAMINE

D **J1890** Injection, cephalothin sodium, up to 1 gram K5 ASC E2
BETOS: O1E Other drugs

C **J1920** Injection, labetalol hydrochloride, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LABETALOL HCL
Coding Clinic: 2023, Q3; 2023, Q4

▲ C **J1921** Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to J1920, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LABETALOL HCL
Coding Clinic: 2023, Q3; 2023, Q4

C **J1930** Injection, lanreotide, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LANREOTIDE ACETATE, SOMATULINE DEPOT
Coding Clinic: 2008, Q4

C **J1931** Injection, laronidase, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ALDURAZYME
Coding Clinic: 2005, Q1; 2005, Q2

C **J1932** Injection, lanreotide, (cipla), 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: LANREOTIDE
Coding Clinic: 2022, Q4

D **J1939** Injection, bumetanide, 0.5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BUMETANIDE
Coding Clinic: 2024, Q1

D **J1940** Injection, furosemide, up to 20 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: FUROSEMIDE
Coding Clinic: 2005, Q4

C **J1941** Injection, furosemide (furoscix), 20 mg E1
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **J1943** Injection, aripiprazole lauroxil, (aristada initio), 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ARISTADA INITIO
Coding Clinic: 2019, Q4

C **J1944** Injection, aripiprazole lauroxil, (aristada), 1 mg K2 Ⓐ ASC K MIPS
BETOS: O1E Other drugs
Drugs: ARISTADA
Coding Clinic: 2019, Q4

D **J1945** Injection, lepirudin, 50 mg K5 ASC E2
BETOS: O1E Other drugs

D **J1950** Injection, leuprolide acetate (for depot suspension), per 3.75 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LUPRON DEPOT
Coding Clinic: 2019, Q2

C **J1951** Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: FENSOLVI
Coding Clinic: 2021, Q3

C **J1952** Leuprolide injectable, camcevi, 1 mg K2 ♂ ASC G
BETOS: O1D Chemotherapy
Drugs: CAMCEVI
Coding Clinic: 2022, Q1

C **J1953** Injection, levetiracetam, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: KEPPRA, LEVETIRACETAM
Coding Clinic: 2008, Q4

C **J1954** Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg K2 ASC G
BETOS: O1D Chemotherapy
Drugs: LEUPROLIDE ACETATE
Coding Clinic: 2023, Q1; 2023, Q2

D **J1955** Injection, levocarnitine, per 1 gm B
BETOS: O1E Other drugs
Drugs: CARNITOR, LEVOCARNITINE

D **J1956** Injection, levofloxacin, 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: LEVOFLOXACIN

D **J1960** Injection, levorphanol tartrate, up to 2 mg N1 ASC N
BETOS: O1E Other drugs

C **J1961** Injection, lenacapavir, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: SUNLENCA
Coding Clinic: 2023, Q3

D **J1980** Injection, hyoscyamine sulfate, up to 0.25 mg N1 ASC N
BETOS: O1E Other drugs

D **J1990** Injection, chlordiazepoxide HCl, up to 100 mg K5 ASC E2
BETOS: O1E Other drugs

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● D **J2002** Injection, lidocaine hcl in 5% dextrose, 1 mg N
BETOS: O1E Other drugs
Drugs: LIDOCAINE IN D5W

● D **J2003** Injection, lidocaine hydrochloride, 1 mg N
BETOS: O1E Other drugs

● D **J2004** Injection, lidocaine hcl with epinephrine, 1 mg N
BETOS: O1E Other drugs

D **J2010** Injection, lincomycin HCl, up to 300 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: LINCOCIN, LINCOMYCIN, LINCOMYCIN HCL

C **J2020** Injection, linezolid, 200 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: LINEZOLID, ZYVOX
Coding Clinic: 2002, Q1; 2002, Q2; 2023, Q1

▲ C **J2021** Injection, linezolid (hospira), not therapeutically equivalent to J2020, 200 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: LINEZOLID
Coding Clinic: 2023, Q1

D **J2060** Injection, lorazepam, 2 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ATIVAN, LORAZEPAM

C **J2062** Loxapine for inhalation, 1 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

D **J2150** Injection, mannitol, 25% in 50 ml N1 ASC N
BETOS: O1E Other drugs
Drugs: MANNITOL

C **J2170** Injection, mecasermin, 1 mg N1 ASC N
BETOS: O1E Other drugs

D **J2175** Injection, meperidine hydrochloride, per 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DEMEROL, MEPERIDINE HCL

D **J2180** Injection, meperidine and promethazine HCl, up to 50 mg N1 ASC N
BETOS: O1E Other drugs

C **J2182** Injection, mepolizumab, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: NUCALA

● C **J2183** Injection, meropenem (wg critical care), not therapeutically equivalent to J2185, 100 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: MEROPENEM
Coding Clinic: 2024, Q3

▲ C **J2184** Injection, meropenem (b. braun), not therapeutically equivalent to J2185, 100 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: MEROPENEM
Coding Clinic: 2023, Q1

C **J2185** Injection, meropenem, 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MEROPENEM
Coding Clinic: 2005, Q2; 2023, Q1; 2024, Q3

C **J2186** Injection, meropenem and vaborbactam, 10mg/10mg (20mg) K2 ASC K
BETOS: O1E Other drugs
Drugs: VABOMERE
Coding Clinic: 2019, Q1

D **J2210** Injection, methylergonovine maleate, up to 0.2 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: METHYLERGONOVINE MALEATE

C **J2212** Injection, methylnaltrexone, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RELISTOR

● C **J2246** Injection, micafungin in sodium (baxter), not therapeutically equivalent to J2248, 1 mg K5 Ⓐ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

C **J2247** Injection, micafungin sodium (par pharm) not therapeutically equivalent to J2248, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: MICAFUNGIN
Coding Clinic: 2023, Q1

C **J2248** Injection, micafungin sodium, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MICAFUNGIN, MICAFUNGIN SODIUM, MYCAMINE
Coding Clinic: 2006, Q4; 2023, Q1; 2024, Q3

C **J2249** Injection, remimazolam, 1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

D **J2250** Injection, midazolam hydrochloride, per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MIDAZOLAM, MIDAZOLAM HCL
Coding Clinic: 2023, Q1

▲ D **J2251** Injection, midazolam in 0.9% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: MIDAZOLAM HCL
Coding Clinic: 2023, Q1

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● D **J2252** Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg Ⓐ N
BETOS: O1E Other drugs

● D **J2253** Injection, midazolam (seizalam), 1 mg Ⓐ N
BETOS: O1E Other drugs

D **J2260** Injection, milrinone lactate, 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MILRINONE IN DEXTROSE, MILRINONE LACTATE

C **J2265** Injection, minocycline hydrochloride, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: MINOCIN

● C **J2267** Injection, mirikizumab-mrkz, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: OMVOH
Coding Clinic: 2024, Q3

D **J2270** Injection, morphine sulfate, up to 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MORPHINE SULFATE
Coding Clinic: 2005, Q4; 2023, Q1

▲ D **J2272** Injection, morphine sulfate (fresenius kabi), not therapeutically equivalent to J2270, up to 10 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Drugs: MORPHINE SULFATE
Coding Clinic: 2023, Q1

D **J2274** Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DURAMORPH, INFUMORPH 200, INFUMORPH 500, MITIGO, MORPHINE SULFATE

● C **J2277** Injection, motixafortide, 0.25 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: APHEXDA
Coding Clinic: 2024, Q2

D **J2278** Injection, ziconotide, 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: PRIALT

C **J2280** Injection, moxifloxacin, 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MOXIFLOXACIN HCL
Coding Clinic: 2005, Q2; 2023, Q1

▲ C **J2281** Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to J2280, 100 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: MOXIFLOXACIN HCL
Coding Clinic: 2023, Q1

● D **J2290** Injection, nafcillin sodium, 20 mg Ⓐ
BETOS: O1E Other drugs

D **J2300** Injection, nalbuphine hydrochloride, per 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: NALBUPHINE HCL

C **J2305** Injection, nitroglycerin, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: NITROGLYCERIN, NITROGLYCERIN IN D5W
Coding Clinic: 2023, Q3

D **J2310** Injection, naloxone hydrochloride, per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: NALOXONE HCL

D **J2311** Injection, naloxone hydrochloride (zimhi), 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ZIMHI
Coding Clinic: 2023, Q1

C **J2315** Injection, naltrexone, depot form, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VIVITROL

D **J2320** Injection, nandrolone decanoate, up to 50 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2011, Q1

C **J2323** Injection, natalizumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TYSABRI
Coding Clinic: 2008, Q1

D **J2325** Injection, nesiritide, 0.1 mg E1
BETOS: O1E Other drugs

C **J2326** Injection, nusinersen, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SPINRAZA
Coding Clinic: 2020, Q1; 2021, Q1

C **J2327** Injection, risankizumab-rzaa, intravenous, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: SKYRIZI
Coding Clinic: 2023, Q1

C **J2329** Injection, ublituximab-xiiy, 1mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: BRIUMVI
Coding Clinic: 2023, Q3

C **J2350** Injection, ocrelizumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: OCREVUS

C **J2353** Injection, octreotide, depot form for intramuscular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SANDOSTATIN LAR DEPOT

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **J2354** Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: OCTREOTIDE ACETATE, SANDOSTATIN

D **J2355** Injection, oprelvekin, 5 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2005, Q2

C **J2356** Injection, tezepelumab-ekko, 1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: TEZSPIRE
Coding Clinic: 2022, Q3

C **J2357** Injection, omalizumab, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: XOLAIR
Coding Clinic: 2005, Q2

C **J2358** Injection, olanzapine, long-acting, 1 mg K2 ASC K MPS
BETOS: O1E Other drugs
Drugs: ZYPREXA RELPREVV
Coding Clinic: 2011, Q1

C **J2359** Injection, olanzapine, 0.5 mg K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: OLANZAPINE
Coding Clinic: 2023, Q4

D **J2360** Injection, orphenadrine citrate, up to 60 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ORPHENADRINE CITRATE INJECTION

C **J2371** Injection, phenylephrine hydrochloride, 20 micrograms N1 ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **J2372** Injection, phenylephrine hydrochloride (biorphen), 20 micrograms K2 ASC K
BETOS: O1E Other drugs
Drugs: BIORPHEN
Coding Clinic: 2023, Q3

● C **J2373** Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms N1 ⓐ ASC N
BETOS: O1E Other drugs
Drugs: IMMPHENTIV
Coding Clinic: 2024, Q3

D **J2401** Injection, chloroprocaine hydrochloride, per 1 mg K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CHLOROPROCAINE HCL, NESACAINE, NESACAINE-MPF, NESCAINE
Coding Clinic: 2023, Q1

D **J2402** Injection, chloroprocaine hydrochloride (clorotekal), per 1 mg K5 ⓐ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2023, Q1

C **J2403** Chloroprocaine hcl ophthalmic, 3% gel, 1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: IHEEZO
Coding Clinic: 2023, Q2

D **J2404** Injection, nicardipine, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: NICARDIPINE
Coding Clinic: 2024, Q1

D **J2405** Injection, ondansetron hydrochloride, per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ONDANSETRON HCL

C **J2406** Injection, oritavancin (kimyrsa), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KIMYRSA
Coding Clinic: 2021, Q4

~~D~~ ~~J2407~~ ~~Injection, oritavancin (orbactiv),~~ 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ORBACTIV
Coding Clinic: 2016, Q1

D **J2410** Injection, oxymorphone HCl, up to 1 mg K5 ASC E2
BETOS: O1E Other drugs

C **J2425** Injection, palifermin, 50 micrograms K2 ASC K
BETOS: O1E Other drugs
Drugs: KEPIVANCE

C **J2426** Injection, paliperidone palmitate extended release (invega sustenna), 1 mg K2 ASC K MPS
BETOS: O1E Other drugs
Drugs: INVEGA SUSTENNA
Coding Clinic: 2011, Q1; 2023, Q3

C **J2427** Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: INVEGA HAFYERA, INVEGA TRINZA
Coding Clinic: 2023, Q3

D **J2430** Injection, pamidronate disodium, per 30 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PAMIDRONATE DISODIUM

D **J2440** Injection, papaverine HCl, up to 60 mg N1 ASC N
BETOS: O1E Other drugs

D **J2460** Injection, oxytetracycline HCl, up to 50 mg K5 ASC E2
BETOS: O1E Other drugs

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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● ▲ C **J2468*** Injection, palonosetron hydrochloride (posfrea), 25 micrograms K5 Ⓐ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

C **J2469** Injection, palonosetron HCl, 25 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: ALOXI, PALONOSETRON
Coding Clinic: 2005, Q1; 2005, Q2; 2024, Q3

● C **J2470** Injection, pantoprazole sodium, 40 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **J2471** Injection, pantoprazole (hikma), not therapeutically equivalent to J2470, 40 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **J2472** Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg Ⓐ
BETOS: O1E Other drugs

D **J2501** Injection, paricalcitol, 1 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: PARICALCITOL, ZEMPLAR

C **J2502** Injection, pasireotide long acting, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SIGNIFOR LAR
Coding Clinic: 2016, Q1

C **J2503** Injection, pegaptanib sodium, 0.3 mg K5 ASC E2
BETOS: O1E Other drugs

D **J2504** Injection, pegademase bovine, 25 IU K5 ASC E2
BETOS: O1E Other drugs

C **J2506** Injection, pegfilgrastim, excludes biosimilar, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: NEULASTA
Coding Clinic: 2022, Q1

C **J2507** Injection, pegloticase, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KRYSTEXXA

C **J2508** Injection, pegunigalsidase alfa-iwxj, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ELFABRIO
Coding Clinic: 2024, Q1

D **J2510** Injection, penicillin G procaine, aqueous, up to 600,000 units K2 ASC K
BETOS: O1E Other drugs
Drugs: PENICILLIN G PROCAINE

D **J2513** Injection, pentastarch, 10% solution, 100 ml K5 ASC E2
BETOS: O1E Other drugs

D **J2515** Injection, pentobarbital sodium, per 50 mg N1 ASC N
BETOS: O1E Other drugs

D **J2540** Injection, penicillin G potassium, up to 600,000 units N1 ASC N
BETOS: O1E Other drugs
Drugs: PENICILLIN G POT IN DEXTROSE, PENICILLIN G POTASSIUM, PFIZERPEN, PFIZERPEN-G

D **J2543** Injection, piperacillin sodium/tazobactam sodium, 1 gram/0.125 grams (1.125 grams) N1 ASC N
BETOS: O1E Other drugs
Drugs: PIPERACILLIN SODIUM-TAZOBACTAM SODIUM, PIPERACILLIN SODIUM/TAZOBACTAM SODIUM, ZOSYN

D **J2545** Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg B
BETOS: D1G Drugs Administered through DME
Drugs: NEBUPENT, PENTAMIDINE ISETHIONATE

C **J2547** Injection, peramivir, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RAPIVAB
Coding Clinic: 2016, Q1

D **J2550** Injection, promethazine HCl, up to 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PHENERGAN, PROMETHAZINE HCL

D **J2560** Injection, phenobarbital sodium, up to 120 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PHENOBARBITAL SODIUM

C **J2561** Injection, phenobarbital sodium (sezaby), 1 mg N1 Ⓐ ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **J2562** Injection, plerixafor, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PLERIXAFOR

D **J2590** Injection, oxytocin, up to 10 units N1 ♀ ASC N
BETOS: O1E Other drugs

D **J2597** Injection, desmopressin acetate, per 1 mcg K2 ASC K
BETOS: O1E Other drugs
Drugs: DDAVP, DESMOPRESSIN ACETATE

* Code J2468 was added by CMS mid-year and revised in the January 2025 code set release. The official descriptor shown here is the most recent revised descriptor.

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ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **J2598** Injection, vasopressin, 1 unit K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: VASOPRESSIN, VASOSTRICT
Coding Clinic: 2023, Q3

▲ C **J2599** Injection, vasopressin (american regent), not therapeutically equivalent to J2598, 1 unit N1 ⓐ ASC N
BETOS: O1E Other drugs
Drugs: VASOPRESSIN (AMERICAN REGENT)
Coding Clinic: 2023, Q3

● C **J2601** Injection, vasopressin (baxter), 1 unit K2 ⓐ ASC K
BETOS: O1E Other drugs
Drugs: VASOPRESSIN

D **J2650** Injection, prednisolone acetate, up to 1 ml K5 ASC E2
BETOS: O1E Other drugs

D **J2670** Injection, tolazoline HCl, up to 25 mg K5 ASC E2
BETOS: O1E Other drugs

D **J2675** Injection, progesterone, per 50 mg N1 ♀ ASC N
BETOS: O1E Other drugs
Drugs: PROGESTERONE

D **J2679** Injection, fluphenazine hcl, 1.25 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: FLUPHENAZINE HCL
Coding Clinic: 2024, Q1

D **J2680** Injection, fluphenazine decanoate, up to 25 mg N1 ASC N MIPS
BETOS: O1E Other drugs
Drugs: FLUPHENAZINE DECANOATE

D **J2690** Injection, procainamide HCl, up to 1 gm K2 ASC K
BETOS: O1E Other drugs
Drugs: PROCAINAMIDE HCL

D **J2700** Injection, oxacillin sodium, up to 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: BACTOCILL IN DEXTROSE, OXACILLIN SODIUM

C **J2704** Injection, propofol, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DIPRIVAN, PROPOFOL
Coding Clinic: 2014, Q4

D **J2710** Injection, neostigmine methylsulfate, up to 0.5 mg N1 ASC N
BETOS: O1E Other drugs

D **J2720** Injection, protamine sulfate, per 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PROTAMINE SULFATE

C **J2724** Injection, protein C concentrate, intravenous, human, 10 IU K2 ASC K
BETOS: O1E Other drugs
Drugs: CEPROTIN
Coding Clinic: 2008, Q1

D **J2725** Injection, protirelin, per 250 mcg K5 ASC E2
BETOS: O1E Other drugs

D **J2730** Injection, pralidoxime chloride, up to 1 gm N1 ASC N
BETOS: O1E Other drugs

D **J2760** Injection, phentolamine mesylate, up to 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PHENTOLAMINE MESYLATE

D **J2765** Injection, metoclopramide HCl, up to 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: METOCLOPRAMIDE HCL

D **J2770** Injection, quinupristin/dalfopristin, 500 mg (150/350) K2 ASC K
BETOS: O1E Other drugs

C ~~J2777~~ injection, faricimab-svoa, 0.1 mg K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: VABYSMO
Coding Clinic: 2022, Q4

C **J2778** Injection, ranibizumab, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: LUCENTIS, LUCENTIS PFS
Coding Clinic: 2008, Q1

C **J2779** Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: SUSVIMO
Coding Clinic: 2022, Q3

C **J2781** Injection, pegcetacoplan, intravitreal, 1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: SYFOVRE
Coding Clinic: 2023, Q4

● C **J2782** Injection, avacincaptad pegol, 0.1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: IZERVAY
Coding Clinic: 2024, Q2

C **J2783** Injection, rasburicase, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ELITEK
Coding Clinic: 2004, Q2; 2005, Q2

C **J2785** Injection, regadenoson, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: LEXICAN, REGADENOSON
Coding Clinic: 2008, Q4

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C **J2786** Injection, reslizumab, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: CINQAIR

C **J2787** Riboflavin 5'-phosphate, ophthalmic solution, up to 3 ml N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

D **J2788** Injection, Rho D immune globulin, human, minidose, 50 micrograms (250 IU) N1 ASC N
BETOS: O1E Other drugs
Drugs: HYPERRHO S/D, MICRHOGAM

D **J2790** Injection, Rho D immune globulin, human, full dose, 300 micrograms (1500 IU) N1 ASC N
BETOS: O1E Other drugs
Drugs: HYPERRHO S/D, RHOGAM

D **J2791** Injection, Rho D immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 IU N1 ASC N
BETOS: O1E Other drugs
Drugs: RHOPHYLAC
Coding Clinic: 2007, Q4; 2008, Q1

D **J2792** Injection, Rho D immune globulin, intravenous, human, solvent detergent, 100 IU K2 ASC K
BETOS: O1E Other drugs
Drugs: WINRHO SDF

D **J2793** Injection, rilonacept, 1 mg K5 ASC E2
BETOS: O1E Other drugs

C **J2794** Injection, risperidone (risperdal consta), 0.5 mg K2 ASC K MIPS
BETOS: O1E Other drugs
Drugs: RISPERDAL CONSTA, RISPERIDONE ER
Coding Clinic: 2005, Q1; 2005, Q2

C **J2795** Injection, ropivacaine hydrochloride, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: NAROPIN, ROPIVACAINE, ROPIVACAINE HCL

D **J2797** Injection, rolapitant, 0.5 mg E1
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **J2798** Injection, risperidone, (perseris), 0.5 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: PERSERIS
Coding Clinic: 2019, Q4

C **J2799** Injection, risperidone (uzedy), 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: UZEDY
Coding Clinic: 2024, Q1

D **J2800** Injection, methocarbamol, up to 10 ml N1 ASC N
BETOS: O1E Other drugs
Drugs: METHOCARBAMOL, ROBAXIN

● C **J2801** Injection, risperidone (rykindo), 0.5 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: RYKINDO
Coding Clinic: 2024, Q2

● C **J2802** Injection, romiplostim, 1 microgram Ⓐ
BETOS: O1E Other drugs

C **J2805** Injection, sincalide, 5 micrograms N1 ASC N
BETOS: O1E Other drugs
Drugs: SINCALIDE, SINCALIDE INJ
Coding Clinic: 2005, Q4; 2023, Q3

D **J2810** Injection, theophylline, per 40 mg K5 ASC E2
BETOS: O1E Other drugs

D **J2820** Injection, sargramostim (GM-CSF), 50 mcg K2 ASC K
BETOS: O1E Other drugs
Drugs: LEUKINE

C **J2840** Injection, sebelipase alfa, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KANUMA

D **J2850** Injection, secretin, synthetic, human, 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: CHIRHOSTIM

C **J2860** Injection, siltuximab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SYLVANT
Coding Clinic: 2016, Q1

D **J2910** Injection, aurothioglucose, up to 50 mg K5 ASC E2
BETOS: O1E Other drugs

D **J2916** Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: FERRLECIT, SODIUM FERRIC GLUCONATE

● D **J2919** Injection, methylprednisolone sodium succinate, 5 mg N
BETOS: O1E Other drugs
Drugs: METHYLPREDNISOLONE SODIUM SUCC, SOLU-MEDROL
Coding Clinic: 2024, Q2

D **J2940** Injection, somatrem, 1 mg K5 ASC E2
BETOS: O1E Other drugs
Statute: 1861s2b
Coding Clinic: 2002, Q1; 2002, Q2

D **J2941** Injection, somatropin, 1 mg K2 ASC K
BETOS: O1E Other drugs
Statute: 1861s2b
Coding Clinic: 2002, Q1; 2002, Q2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **J2950** Injection, promazine HCl, up to 25 mg N1 ASC N
BETOS: O1E Other drugs

D **J2993** Injection, reteplase, 18.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RETAVASE
Coding Clinic: 2021, Q3

D **J2995** Injection, streptokinase, per 250,000 IU K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2021, Q3

D **J2997** Injection, alteplase recombinant, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ACTIVASE, CATHFLO ACTIVASE
Coding Clinic: 2021, Q3

C **J2998** Injection, plasminogen, human-tvmh, 1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: RYPLAZIM
Coding Clinic: 2022, Q3

D **J3000** Injection, streptomycin, up to 1 gm N1 ASC N
BETOS: O1E Other drugs
Drugs: STREPTOMYCIN SULFATE

D **J3010** Injection, fentanyl citrate, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: FENTANYL CITRATE

D **J3030** Injection, sumatriptan succinate, 6 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) N1 ASC N
BETOS: O1E Other drugs

C **J3031** Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered) K2 ⓪ ASC K
BETOS: O1E Other drugs
Drugs: AJOVY
Coding Clinic: 2019, Q4

C **J3032** Injection, eptinezumab-jjmr, 1 mg K2 ⓪ ASC K
BETOS: O1E Other drugs
Drugs: VYEPTI
Coding Clinic: 2020, Q4

● C **J3055** Injection, talquetamab-tgvs, 0.25 mg K2 ⓪ ASC G
BETOS: O1E Other drugs
Drugs: TALVEY
Coding Clinic: 2024, Q2

C **J3060** Injection, taliglucerase alfa, 10 units K2 ASC K
BETOS: O1E Other drugs
Drugs: ELELYSO
Coding Clinic: 2013, Q4

D **J3070** Injection, pentazocine, 30 mg N1 ASC N
BETOS: O1E Other drugs

C **J3090** Injection, tedizolid phosphate, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SIVEXTRO
Coding Clinic: 2016, Q1

C **J3095** Injection, telavancin, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VIBATIV
Coding Clinic: 2011, Q1

C **J3101** Injection, tenecteplase, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TNKASE
Coding Clinic: 2008, Q4; 2020, Q3; 2021, Q3

D **J3105** Injection, terbutaline sulfate, up to 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: TERBUTALINE SULFATE

D **J3110** Injection, teriparatide, 10 mcg B
BETOS: O1E Other drugs

C **J3111** Injection, romosozumab-aqqg, 1 mg K2 ♀ ASC K
BETOS: O1E Other drugs
Drugs: EVENITY

D **J3121** Injection, testosterone enanthate, 1 mg N1 ♂ ASC N
BETOS: O1E Other drugs
Drugs: TESTOSTERONE ENANTHATE

D **J3145** Injection, testosterone undecanoate, 1 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: AVEED

D **J3230** Injection, chlorpromazine HCl, up to 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CHLORPROMAZINE HCL

D **J3240** Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial K2 ASC K
BETOS: O1E Other drugs
Drugs: THYROGEN
Coding Clinic: 2005, Q2; 2005, Q4

C **J3241** Injection, teprotumumab-trbw, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TEPEZZA
Coding Clinic: 2020, Q4

C **J3243** Injection, tigecycline, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: TIGECYCLINE
Coding Clinic: 2006, Q4; 2023, Q1

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▲ C **J3244** Injection, tigecycline (accord), not therapeutically equivalent to J3243, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: TIGECYCLINE
Coding Clinic: 2023, Q1

C **J3245** Injection, tildrakizumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ILUMYA
Coding Clinic: 2005, Q1

C **J3246** Injection, tirofiban HCl, 0.25mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AGGRASTAT, TIROFIBAN
Coding Clinic: 2005, Q1

● C **J3247** Injection, secukinumab, intravenous, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: COSENTYX
Coding Clinic: 2024, Q3

D **J3250** Injection, trimethobenzamide HCl, up to 200 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: TIGAN

D **J3260** Injection, tobramycin sulfate, up to 80 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: TOBRAMYCIN SULFATE

C **J3262** Injection, tocilizumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ACTEMRA
Coding Clinic: 2011, Q1

● C **J3263** Injection, toripalimab-tpzi, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: LOQTORZI
Coding Clinic: 2024, Q3

D **J3265** Injection, torsemide, 10 mg/ml K5 ASC E2
BETOS: O1E Other drugs

D **J3280** Injection, thiethylperazine maleate, up to 10 mg K5 ASC E2
BETOS: O1E Other drugs

C **J3285** Injection, treprostinil, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: REMODULIN, TREPROSTINIL INJECTION

C **J3299** Injection, triamcinolone acetonide (xipere), 1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: XIPERE
Coding Clinic: 2022, Q3

D **J3300** Injection, triamcinolone acetonide, preservative free, 1 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4; 2009, Q1

D **J3301** Injection, triamcinolone acetonide, not otherwise specified, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: KENALOG-40, KENALOG-80, TRIAMCINOLONE ACETONIDE, TRIAMCINOLONE ACETONIDE
Coding Clinic: 2017, Q3; 2018, Q4; 2024, Q1

D **J3302** Injection, triamcinolone diacetate, per 5 mg N1 ASC N
BETOS: O1E Other drugs

D **J3303** Injection, triamcinolone hexacetonide, per 5 mg N1 ASC N
BETOS: O1E Other drugs

D **J3304** Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ZILRETTA
Coding Clinic: 2019, Q1

D **J3305** Injection, trimetrexate glucuronate, per 25 mg K5 ASC E2
BETOS: O1E Other drugs

D **J3310** Injection, perphenazine, up to 5 mg N1 ASC N
BETOS: O1E Other drugs

D **J3315** Injection, triptorelin pamoate, 3.75 mg K2 ♂ ASC K
BETOS: O1E Other drugs
Drugs: TRELSTAR

D **J3316** Injection, triptorelin, extended-release, 3.75 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TRIPTODUR
Coding Clinic: 2019, Q1

D **J3320** Injection, spectinomycin dihydrochloride, up to 2 gm K5 ASC E2
BETOS: O1E Other drugs

D **J3350** Injection, urea, up to 40 gm K5 ♀ ASC E2
BETOS: O1E Other drugs

D **J3355** Injection, urofollitropin, 75 IU K5 ♀ ASC E2
BETOS: O1E Other drugs

C **J3357** Ustekinumab, for subcutaneous injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: STELARA
Coding Clinic: 2011, Q1; 2016, Q4; 2017, Q1

C **J3358** Ustekinumab, for intravenous injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: STELARA

D **J3360** Injection, diazepam, up to 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DIAZEPAM
Coding Clinic: 2007, Q2

D **J3364** Injection, urokinase, 5000 IU vial K5 ASC E2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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BETOS: O1E Other drugs
Coding Clinic: 2021, Q3

D **J3365** Injection, IV, urokinase, 250,000 IU vial K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2021, Q3

D **J3370** Injection, vancomycin HCl, 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: VANCOMYCIN HCL
Coding Clinic: 2023, Q1

▲ D **J3371** Injection, vancomycin hcl (mylan), not therapeutically equivalent to J3370, 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: VANCOMYCIN HCL
Coding Clinic: 2023, Q1

▲ D **J3372** Injection, vancomycin hcl (xellia), not therapeutically equivalent to J3370, 500 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: VANCOMYCIN HCL
Coding Clinic: 2023, Q1

▲ D **J3380** Injection, vedolizumab, intravenous, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ENTYVIO
Coding Clinic: 2016, Q1; 2024, Q2

C **J3385** Injection, velaglucerase alfa, 100 units K2 ASC K
BETOS: O1E Other drugs
Drugs: VPRIV
Coding Clinic: 2011, Q1

● C **J3392** Injection, exagamglogene autotemcel, per treatment Ⓐ
BETOS: O1E Other drugs

● C **J3393** Injection, betibeglogene autotemcel, per treatment B5 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ZYNTEGLO
Coding Clinic: 2024, Q3

● C **J3394** Injection, lovotibeglogene autotemcel, per treatment B5 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: LYFGENIA
Coding Clinic: 2024, Q3

D **J3396** Injection, verteporfin, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VISUDYNE
Coding Clinic: 2005, Q1; 2020, Q1
Pub: 100-4, Chapter-32, 300.1; 100-4, Chapter-32, 300.2

C **J3397** Injection, vestronidase alfa-vjbk, 1 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **J3398** Injection, voretigene neparvovec-rzyl, 1 billion vector genomes K2 ASC K
BETOS: O1E Other drugs
Drugs: LUXTURNA
Coding Clinic: 2019, Q1

C **J3399** Injection, onasemnogene abeparvovec-xioi, per treatment, up to $5x10^{15}$ vector genomes Ⓐ K
BETOS: O1E Other drugs
Drugs: ZOLGENSMA
Coding Clinic: 2020, Q2

D **J3400** Injection, triflupromazine HCl, up to 20 mg K5 ASC E2
BETOS: O1E Other drugs

C **J3401** Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: VYJUVEK
Coding Clinic: 2024, Q1

D **J3410** Injection, hydroxyzine HCl, up to 25 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: HYDROXYZINE HCL

C **J3411** Injection, thiamine HCl, 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: THIAMINE HCL
Coding Clinic: 2005, Q2

C **J3415** Injection, pyridoxine HCl, 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PYRIDOXINE HCL
Coding Clinic: 2005, Q2

D **J3420** Injection, vitamin B-12 cyanocobalamin, up to 1000 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: CYANOCOBALAMIN, DODEX

● C **J3424** Injection, hydroxocobalamin, intravenous, 25 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CYANOKIT
Coding Clinic: 2024, Q2

▲ D **J3425** Injection, hydroxocobalamin, intramuscular, 10 mcg N1 ASC N
BETOS: O1E Other drugs
Drugs: HYDROXOCOBALAMIN IM
Coding Clinic: 2024, Q1; 2024, Q2

D **J3430** Injection, phytonadione (vitamin K), per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PHYTONADIONE, VITAMIN K1

D **J3465** Injection, voriconazole, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: VFEND IV, VORICONAZOLE
Coding Clinic: 2005, Q2

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D **J3470** Injection, hyaluronidase, up to 150 units N1 ASC N
BETOS: O1E Other drugs

D **J3471** Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units) N1 ASC N
BETOS: O1E Other drugs

D **J3472** Injection, hyaluronidase, ovine, preservative free, per 1000 USP units N1 ASC N
BETOS: O1E Other drugs

D **J3473** Injection, hyaluronidase, recombinant, 1 USP unit N1 ASC N
BETOS: O1E Other drugs
Drugs: HYLENEX

D **J3475** Injection, magnesium sulfate, per 500 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MAGNESIUM SULFATE, MAGNESIUM SULFATE-DEXTROSE

D **J3480** Injection, potassium chloride, per 2 mEq N1 ASC N
BETOS: O1E Other drugs
Drugs: POTASSIUM CHLORIDE, POTASSIUM CHLORIDE IN DEXTROSE, POTASSIUM CHLORIDE IN SODIUM CHLORIDE

D **J3485** Injection, zidovudine, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: RETROVIR

C **J3486** Injection, ziprasidone mesylate, 10 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: GEODON, ZIPRASIDONE MESYLATE
Coding Clinic: 2005, Q2

C **J3489** Injection, zoledronic acid, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: RECLAST, ZOLEDRONIC ACID
Coding Clinic: 2013, Q4

D **J3490** Unclassified drugs N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2005, Q4; 2008, Q1; 2009, Q2; 2010, Q3; 2012, Q4; 2013, Q1; 2014, Q2; 2014, Q4; 2017, Q1; 2017, Q1; 2021, Q3; 2023, Q3
Pub: 100-4, Chapter-8, 60.2.1.1; 100-4, Chapter-32, 280.2

M **J3520** Edetate disodium, per 150 mg E1
BETOS: O1E Other drugs
Service not separately priced by Part B

D **J3530** Nasal vaccine inhalation N1 ASC N
BETOS: O1E Other drugs

M **J3535** Drug administered through a metered dose inhaler E1
BETOS: O1E Other drugs
Service not separately priced by Part B

M **J3570** Laetrile, amygdalin, vitamin B17 E1
BETOS: O1E Other drugs
Service not separately priced by Part B

C **J3590** Unclassified biologics N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2012, Q4; 2016, Q4; 2017, Q1; 2023, Q3
Pub: 100-4, Chapter-32, 280.2

C **J3591** Unclassified drug or biological used for esrd on dialysis B
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

D **J7030** Infusion, normal saline solution, 1000 cc N1 ASC N
BETOS: O1E Other drugs
Drugs: SODIUM CHLORIDE

D **J7040** Infusion, normal saline solution, sterile (500 ml=1 unit) N1 ASC N
BETOS: O1E Other drugs
Drugs: SODIUM CHLORIDE

D **J7042** 5% dextrose/normal saline (500 ml = 1 unit) N1 ASC N
BETOS: O1E Other drugs
Drugs: DEXTROSE-NACL

D **J7050** Infusion, normal saline solution, 250 cc N1 ASC N
BETOS: O1E Other drugs
Drugs: SODIUM CHLORIDE

D **J7060** 5% dextrose/water (500 ml = 1 unit) N1 ASC N
BETOS: O1E Other drugs
Drugs: DEXTROSE, DEXTROSE 5%

D **J7070** Infusion, D5W, 1000 cc N1 ASC N
BETOS: O1E Other drugs
Drugs: DEXTROSE, DEXTROSE 5%

D **J7100** Infusion, dextran 40, 500 ml N1 ASC N
BETOS: O1E Other drugs

D **J7110** Infusion, dextran 75, 500 ml N1 ASC N
BETOS: O1E Other drugs

D **J7120** Ringers lactate infusion, up to 1000 cc N1 ASC N
BETOS: O1E Other drugs
Drugs: LACTATED RINGER'S, LACTATED RINGERS

D **J7121** 5% dextrose in lactated ringers infusion, up to 1000 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2016, Q1

D **J7131** Hypertonic saline solution, 1 ml N1 ASC N
BETOS: O1E Other drugs

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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● C **J7165** Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: BALFAXAR
Coding Clinic: 2024, Q2

C **J7168** Prothrombin complex concentrate (human), kcentra, per i.u. of factor IX activity K2 ASC K
BETOS: O1E Other drugs
Drugs: KCENTRA
Coding Clinic: 2021, Q3

C **J7169** Injection, coagulation factor xa (recombinant), inactivated-zhzo (andexxa), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ANDEXXA
Coding Clinic: 2020, Q2

C **J7170** Injection, emicizumab-kxwh, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: HEMLIBRA
Coding Clinic: 2019, Q1

● C **J7171** Injection, adamts13, recombinant-krhn, 10 iu K2 ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ADZYNMA
Coding Clinic: 2024, Q3

C **J7175** Injection, factor x, (human), 1 i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: COAGADEX
Coding Clinic: 2017, Q1

CLOTTING FACTORS (J7177-J7214)

C **J7177** Injection, human fibrinogen concentrate (fibryga), 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FIBRYGA
Coding Clinic: 2019, Q1

C **J7178** Injection, human fibrinogen concentrate, not otherwise specified, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RIASTAP

D **J7179** Injection, von willebrand factor (recombinant), (vonvendi), 1 i.u. vwf:rco K2 ASC K
BETOS: O1E Other drugs
Drugs: VONVENDI
Coding Clinic: 2017, Q1

C **J7180** Injection, factor XIII (antihemophilic factor, human), 1 IU K2 ASC K
BETOS: O1E Other drugs
Drugs: CORIFACT
Coding Clinic: 2012, Q1

C **J7181** Injection, factor XIII a-subunit, (recombinant), per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: TRETTEN

C **J7182** Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: NOVOEIGHT
Coding Clinic: 2014, Q4

D **J7183** Injection, von Willebrand factor complex (human), wilate, 1 IU VWF:RCo K2 ASC K
BETOS: O1E Other drugs
Drugs: WILATE

C **J7185** Injection, factor VIII (antihemophilic factor, recombinant) (XYNTHA), per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: XYNTHA

D **J7186** Injection, antihemophilic factor VIII/ von Willebrand factor complex (human), per factor VIII IU K2 ASC K
BETOS: O1E Other drugs
Drugs: ALPHANATE
Coding Clinic: 2008, Q4

D **J7187** Injection, von Willebrand factor complex (Humate-P), per IU VWF:RCo K2 ASC K
BETOS: O1E Other drugs
Drugs: HUMATE-P LOW DILUENT

D **J7188** Injection, factor VIII (antihemophilic factor, recombinant), (OBIZUR), per i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: OBIZUR
Coding Clinic: 2016, Q1

D **J7189** Factor viia (antihemophilic factor, recombinant), (novoseven rt), 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: NOVOSEVEN RT

D **J7190** Factor VIII (antihemophilic factor, human) per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: HEMOFIL M, KOATE, KOATE-DVI

D **J7191** Factor VIII (antihemophilic factor (porcine)), per IU K5 ASC E2
BETOS: O1E Other drugs

D **J7192** Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified K2 ASC K
BETOS: O1E Other drugs
Drugs: ADVATE, KOGENATE FS, RECOMBINATE

D **J7193** Factor IX (antihemophilic factor, purified, non-recombinant) per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: ALPHANINE SD
Coding Clinic: 2002, Q2

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D **J7194** Factor IX, complex, per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: PROFILNINE

D **J7195** Injection, factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified K2 ASC K
BETOS: O1E Other drugs
Drugs: BENEFIX
Coding Clinic: 2002, Q1; 2002, Q2

C **J7196** Injection, antithrombin recombinant, 50 IU K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2011, Q1

D **J7197** Antithrombin III (human), per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: THROMBATE III

D **J7198** Anti-inhibitor, per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: FEIBA NF

D **J7199** Hemophilia clotting factor, not otherwise classified B
BETOS: O1E Other drugs

D **J7200** Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: RIXUBIS

D **J7201** Injection, factor ix, fc fusion protein, (recombinant), alprolix, 1 i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: ALPROLIX

D **J7202** Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: IDELVION

D **J7203** Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu K2 ASC K
BETOS: O1E Other drugs
Drugs: REBINYN, RECOMBI
Coding Clinic: 2019, Q1

C **J7204** Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ESPEROCT
Coding Clinic: 2020, Q2

D **J7205** Injection, factor VIII Fc fusion protein (recombinant), per IU K2 ASC K
BETOS: O1E Other drugs
Drugs: ELOCTATE
Coding Clinic: 2016, Q1

D **J7207** Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: ADYNOVATE

D **J7208** Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: JIVI
Coding Clinic: 2019, Q3

C **J7209** Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u. K2 ASC K
BETOS: O1E Other drugs
Drugs: NUWIQ

C **J7210** Injection, factor VIII, (antihemophilic factor, recombinant), (afstyla), 1 I.U. K2 ASC K
BETOS: O1E Other drugs
Drugs: AFSTYLA

C **J7211** Injection, factor VIII, (antihemophilic factor, recombinant), (kovaltry), 1 I.U. K2 ASC K
BETOS: O1E Other drugs
Drugs: KOVALTRY
Coding Clinic: 2018, Q1

C **J7212** Factor VIIa (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: SEVENFACT
Coding Clinic: 2021, Q1

D **J7213** Injection, coagulation factor IX (recombinant), ixinity, 1 i.u. K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: IXINITY
Coding Clinic: 2023, Q3

C **J7214** Injection, factor VIII/von willebrand factor complex, recombinant (altuviiio), per factor VIII i.u. K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: ALTUVIIIO
Coding Clinic: 2023, Q4

CONTRACEPTIVE SYSTEMS (J7294-J7307)

S **J7294** Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each ♀ Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1862(a)(1)
Coding Clinic: 2021, Q4

S **J7295** Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each ♀ Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1862(a)(1)
Coding Clinic: 2021, Q4

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S J7296 Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg ♀ E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Statute: 1862(a)(1)

S J7297 Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg ♀ Ⓐ E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Statute: 1862(a)(1)
Coding Clinic: 2016, Q1

S J7298 Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg ♀ Ⓐ E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Statute: 1862(a)(1)
Coding Clinic: 2016, Q1; 2023, Q1

S J7300 Intrauterine copper contraceptive ♀ Ⓐ E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Statute: 1862A1

S J7301 Levonorgestrel-releasing intrauterine contraceptive system (skyla), 13.5 mg ♀ E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Statute: 1862(a)(1)
Coding Clinic: 2014, Q4

S J7304 Contraceptive supply, hormone containing patch, each ♀ Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1862.1

I J7306 Levonorgestrel (contraceptive) implant system, including implants and supplies E1
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B

I J7307 Etonogestrel (contraceptive) implant system, including implant and supplies E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS DRUGS (J7308-J7402)

C J7308 Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg) K2 ASC K
BETOS: O1E Other drugs
Drugs: LEVULAN KERASTICK
Coding Clinic: 2002, Q1; 2005, Q2; 2020, Q1

D J7309 Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2011, Q1; 2020, Q1

D J7310 Ganciclovir, 4.5 mg, long-acting implant K5 ASC E2
BETOS: O1E Other drugs

C J7311 Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RETISERT

C J7312 Injection, dexamethasone, intravitreal implant, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: OZURDEX
Coding Clinic: 2011, Q1

C J7313 Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ILUVIEN
Coding Clinic: 2016, Q1

C J7314 Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: YUTIQ
Coding Clinic: 2019, Q4

C J7315 Mitomycin, ophthalmic, 0.2 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2002, Q2; 2014, Q2; 2016, Q4

C J7316 Injection, ocriplasmin, 0.125 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2002, Q1; 2002, Q2; 2013, Q4

C J7318 Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: DUROLANE
Coding Clinic: 2019, Q1

C J7320 Hyaluronan or derivitive, genvisc 850, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GENVISC 850
Coding Clinic: 2006, Q1

C J7321 Hyaluronan or derivative, hyalgan, supartz or visco-3, for intra-articular injection, per dose N1 ASC N
BETOS: O1E Other drugs
Drugs: HYALGAN, SUPARTZ FX, VISCO-3
Coding Clinic: 2008, Q1; 2012, Q4; 2020, Q2; 2021, Q1

C J7322 Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: HYMOVIS
Coding Clinic: 2008, Q1

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C **J7323** Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose K2 ASC K
BETOS: O1E Other drugs
Drugs: EUFLEXXA
Coding Clinic: 2008, Q1; 2012, Q4

C **J7324** Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose K2 ASC K
BETOS: O1E Other drugs
Drugs: ORTHOVISC
Coding Clinic: 2008, Q1; 2012, Q4

C **J7325** Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SYNVISC, SYNVISCONE
Coding Clinic: 2012, Q4

C **J7326** Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose K2 ASC K
BETOS: O1E Other drugs
Drugs: GEL-ONE
Coding Clinic: 2012, Q1; 2012, Q4

C **J7327** Hyaluronan or derivative, monovisc, for intra-articular injection, per dose K2 ASC K
BETOS: O1E Other drugs
Drugs: MONOVISC
Coding Clinic: 2014, Q4

C **J7328** Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: GELSYN-3
Coding Clinic: 2016, Q1

C **J7329** Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TRIVISC
Coding Clinic: 2019, Q1

C **J7330** Autologous cultured chondrocytes, implant B
BETOS: O1E Other drugs
Other carrier priced
Coding Clinic: 2010, Q4

C **J7331** Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SYNOJOYNT
Coding Clinic: 2019, Q4

C **J7332** Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TRILURON
Coding Clinic: 2019, Q4

C **J7336** Capsaicin 8% patch, per square centimeter K2 ASC K
BETOS: O1E Other drugs
Drugs: QUTENZA

C **J7340** Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml K2 ASC K
BETOS: O1E Other drugs
Drugs: DUOPA
Coding Clinic: 2002, Q1; 2006, Q4; 2008, Q4; 2016, Q1

C **J7342** Instillation, ciprofloxacin otic suspension, 6 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: OTIPRIO
Coding Clinic: 2008, Q4

D **J7345** Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AMELUZ GEL, AMINOLEVULINIC ACID HYDROCHLORIDE
Coding Clinic: 2008, Q1; 2017, Q4; 2018, Q1; 2020, Q1

C **J7351** Injection, bimatoprost, intracameral implant, 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: DURYSTA
Coding Clinic: 2020, Q4

C **J7352** Afamelanotide implant, 1 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: SCENESSE
Coding Clinic: 2021, Q1

C **J7353** Anacaulase-bcdb, 8.8% gel, 1 gram K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: NEXOBRID
Coding Clinic: 2023, Q4

● C **J7354** Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg) K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: YCANTH
Coding Clinic: 2024, Q2

● C **J7355** Injection, travoprost, intracameral implant, 1 microgram K2 ASC G
BETOS: O1E Other drugs
Drugs: IDOSE TR
Coding Clinic: 2024, Q3

C **J7402** Mometasone furoate sinus implant, (sinuva), 10 micrograms K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: SINUVA
Coding Clinic: 2021, Q1

IMMUNOSUPPRESSIVE DRUGS (J7500-J7599)

D **J7500** Azathioprine, oral, 50 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: AZASAN, AZATHIOPRINE

D **J7501** Azathioprine, parenteral, 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AZATHIOPRINE

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **J7502** Cyclosporine, oral, 100 mg N1 ASC N
BETOS: O1E Other drugs
Other carrier priced
Drugs: CYCLOSPORINE, CYCLOSPORINE MODIFIED, GENGRAF, NEORAL, SANDIMMUNE

D **J7503** Tacrolimus, extended release, (Envarsus XR), oral, 0.25 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ENVARSUS XR
Coding Clinic: 2016, Q1

D **J7504** Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ATGAM

D **J7505** Muromonab-CD3, parenteral, 5 mg K5 ASC E2
BETOS: O1E Other drugs

D **J7507** Tacrolimus, immediate release, oral, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PROGRAF, PROGRAF GRANULES, TACROLIMUS

D **J7508** Tacrolimus, extended release, (Astagraf XL), oral, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ASTAGRAF XL
Coding Clinic: 2014, Q1; 2016, Q1

D **J7509** Methylprednisolone oral, per 4 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MEDROL, MEDROL (PAK), MEDROL DOSEPAK, METHYLPREDNISOLONE, METHYLPREDNISOLONE (PAK)

D **J7510** Prednisolone oral, per 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PREDNISOLONE

C **J7511** Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral, 25 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: THYMOGLOBULIN
Coding Clinic: 2002, Q1; 2002, Q2

D **J7512** Prednisone, immediate release or delayed release, oral, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PREDNISONE, PREDNISONE INTENSOL
Coding Clinic: 2016, Q1

D **J7513** Daclizumab, parenteral, 25 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2005, Q2

● C **J7514** Mycophenolate mofetil (myhibbin), oral suspension, 100 mg A
BETOS: O1E Other drugs

C **J7515** Cyclosporine, oral, 25 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CYCLOSPORINE, CYCLOSPORINE MODIFIED, GENGRAF, NEORAL, SANDIMMUNE

▲ C **J7516** Injection, cyclosporine, 250 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

C **J7517** Mycophenolate mofetil, oral, 250 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CELLCEPT, MYCOPHENOLATE MOFETIL

D **J7518** Mycophenolic acid, oral, 180 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: MYCOPHENOLIC ACID, MYCOPHENOLIC ACID DR, MYFORTIC
Coding Clinic: 2005, Q2

C **J7519** Injection, mycophenolate mofetil, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CELLCEPT - IV, MYCOPHENOLATE MOFETIL IV
Coding Clinic: 2023, Q4

D **J7520** Sirolimus, oral, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: RAPAMUNE, SIROLIMUS

D **J7525** Tacrolimus, parenteral, 5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PROGRAF

D **J7527** Everolimus, oral, 0.25 mg N1 ASC N
BETOS: O1G Immunizations/Vaccinations
Drugs: EVEROLIMUS, ZORTRESS

D **J7599** Immunosuppressive drug, not otherwise classified N1 ASC N
BETOS: O1E Other drugs

INHALATION SOLUTIONS (J7601-J7686)

● C **J7601** Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg A
BETOS: D1G Drugs Administered through DME

C **J7604** Acetylcysteine, inhalation solution, compounded product, administered through DME, unit dose form, per gram M
BETOS: D1G Drugs Administered through DME

C **J7605** Arformoterol, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 15 micrograms M
BETOS: D1G Drugs Administered through DME
Drugs: ARFORMOTEROL, ARFORMOTEROL TARTRATE, BROVANA

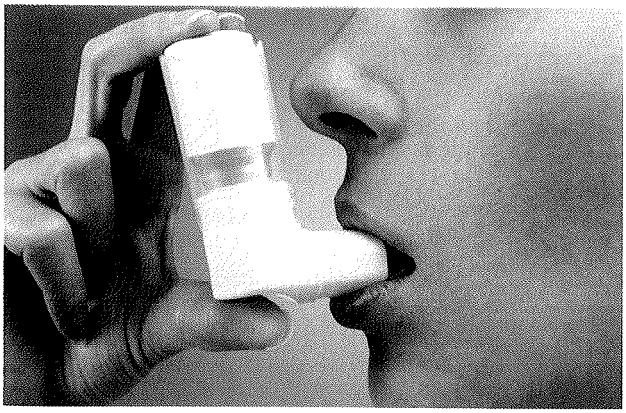
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C **J7606** Formoterol fumarate, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms M
BETOS: D1G Drugs Administered through DME
Drugs: FORMORTEROL FUMARATE, FORMOTEROL FUMARATE, PERFOROMIST
Coding Clinic: 2008, Q4

C **J7607** Levalbuterol, inhalation solution, compounded product, administered through DME, concentrated form, 0.5 mg M
BETOS: D1G Drugs Administered through DME

D **J7608** Acetylcysteine, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per gram M
BETOS: D1G Drugs Administered through DME
Drugs: ACETYLCYSTEINE

C **J7609** Albuterol, inhalation solution, compounded product, administered through DME, unit dose, 1 mg M
BETOS: D1G Drugs Administered through DME



Inhaler

C **J7610** Albuterol, inhalation solution, compounded product, administered through DME, concentrated form, 1 mg M
BETOS: D1G Drugs Administered through DME

D **J7611** Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg M
BETOS: D1G Drugs Administered through DME
Service not separately priced by Part B
Drugs: ALBUTEROL SULFATE
Coding Clinic: 2007, Q2; 2008, Q2; 2009, Q3

D **J7612** Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg M
BETOS: D1G Drugs Administered through DME
Service not separately priced by Part B
Drugs: LEVALBUTEROL, LEVALBUTEROL INHALATION SOLUTION CONCENTRATED
Coding Clinic: 2007, Q2; 2008, Q2; 2009, Q3

D **J7613** Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg M
BETOS: D1G Drugs Administered through DME
Service not separately priced by Part B
Drugs: ALBUTEROL SULFATE
Coding Clinic: 2007, Q2; 2008, Q2; 2009, Q3

D **J7614** Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg M
BETOS: D1G Drugs Administered through DME
Service not separately priced by Part B
Drugs: LEVALBUTEROL, LEVALBUTEROL HYDROCHLORIDE
Coding Clinic: 2007, Q2; 2008, Q2; 2009, Q3

C **J7615** Levalbuterol, inhalation solution, compounded product, administered through DME, unit dose, 0.5 mg M
BETOS: D1G Drugs Administered through DME

D **J7620** Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME M
BETOS: D1G Drugs Administered through DME
Drugs: ALBUTEROL IPRATROPIUM

C **J7622** Beclomethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME
Coding Clinic: 2002, Q1

C **J7624** Betamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME
Coding Clinic: 2002, Q1

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **J7626** Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 0.5 mg M
BETOS: D1G Drugs Administered through DME
Drugs: BUDESONIDE, PULMICORT
Coding Clinic: 2002, Q1

C **J7627** Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg M
BETOS: D1G Drugs Administered through DME

D **J7628** Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7629** Bitolterol mesylate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7631** Cromolyn sodium, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 milligrams M
BETOS: D1G Drugs Administered through DME
Drugs: CROMOLYN SODIUM

C **J7632** Cromolyn sodium, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligrams M
BETOS: D1G Drugs Administered through DME

C **J7633** Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 0.25 milligram M
BETOS: D1G Drugs Administered through DME

C **J7634** Budesonide, inhalation solution, compounded product, administered through DME, concentrated form, per 0.25 milligram M
BETOS: D1G Drugs Administered through DME

D **J7635** Atropine, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7636** Atropine, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7637** Dexamethasone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7638** Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7639** Dornase alfa, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME
Drugs: PULMOZYME

C **J7640** Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 micrograms E1
BETOS: D1G Drugs Administered through DME
Service not separately priced by Part B
Coding Clinic: 2006, Q1

C **J7641** Flunisolide, inhalation solution, compounded product, administered through DME, unit dose, per milligram M
BETOS: D1G Drugs Administered through DME
Coding Clinic: 2002, Q1

D **J7642** Glycopyrrolate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7643** Glycopyrrolate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7644** Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME
Drugs: IPRATROPIUM BROMIDE

C **J7645** Ipratropium bromide, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

C **J7647** Isoetharine HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

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D **J7648** Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7649** Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

C **J7650** Isoetharine HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

C **J7657** Isoproterenol HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7658** Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7659** Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

C **J7660** Isoproterenol HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

C **J7665** Mannitol, administered through an inhaler, 5 mg N1 ASC N
BETOS: O1E Other drugs

C **J7667** Metaproterenol sulfate, inhalation solution, compounded product, concentrated form, per 10 milligrams M
BETOS: D1G Drugs Administered through DME

D **J7668** Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 10 milligrams M
BETOS: D1G Drugs Administered through DME

D **J7669** Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 milligrams M
BETOS: D1G Drugs Administered through DME

C **J7670** Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligrams M
BETOS: D1G Drugs Administered through DME

C **J7674** Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PROVOCHOLINE, PROVOCHOLINE INHALATION SOLUTION
Coding Clinic: 2005, Q2

C **J7676** Pentamidine isethionate, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg M
BETOS: D1G Drugs Administered through DME

C **J7677** Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram M
BETOS: D1G Drugs Administered through DME
Drugs: YUPELRI

D **J7680** Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7681** Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7682** Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligrams M
BETOS: D1G Drugs Administered through DME
Drugs: BETHKIS, KITABIS PAK, TOBI, TOBRAMYCIN, TOBRAMYCIN INHALATION

D **J7683** Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram M
BETOS: D1G Drugs Administered through DME

D **J7684** Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram M
BETOS: D1G Drugs Administered through DME

C **J7685** Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 milligrams M
BETOS: D1G Drugs Administered through DME

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C **J7686** Treprostinil, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1.74 mg M
BETOS: D1G Drugs Administered through DME
Drugs: TYVASO

DRUGS, NOT OTHERWISE CLASSIFIED (J7699-J8499)

D **J7699** Noc drugs, inhalation solution administered through DME M
BETOS: D1G Drugs Administered through DME

D **J7799** Noc drugs, other than inhalation drugs, administered through DME N1 ASC N
BETOS: D1G Drugs Administered through DME

D **J7999** Compounded drug, not otherwise classified N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2016, Q1; 2016, Q4; 2017, Q1

D **J8498** Antiemetic drug, rectal/suppository, not otherwise specified B
BETOS: O1D Chemotherapy
Statute: 1861s2T

M **J8499** Prescription drug, oral, non chemotherapeutic, NOS E1
BETOS: O1E Other drugs
Service not separately priced by Part B

CHEMOTHERAPY DRUGS, ORAL ADMINISTRATION (J8501-J8999), SEE ALSO CHEMOTHERAPY DRUGS, ADMINISTERED BY INJECTION (J9000-J9999)

D **J8501** Aprepitant, oral, 5 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: APREPITANT, EMEND
Coding Clinic: 2005, Q3

D **J8510** Busulfan; oral, 2 mg N1 ASC N
BETOS: O1D Chemotherapy

M **J8515** Cabergoline, oral, 0.25 mg E1
BETOS: O1E Other drugs
Service not separately priced by Part B

● D **J8522** Capecitabine, oral, 50 mg N
BETOS: O1D Chemotherapy
Drugs: CAPECITABINE, XELODA

D **J8530** Cyclophosphamide; oral, 25 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: CYCLOPHOSPHAMIDE
Coding Clinic: 2002, Q1

D **J8540** Dexamethasone, oral, 0.25 mg N1 ASC N
BETOS: O1E Other drugs
Statute: 1861(s)2T
Drugs: DEXAMETHASONE

● C **J8541** Dexamethasone (hemady), oral, 0.25 mg ⓪ N
BETOS: O1E Other drugs

D **J8560** Etoposide; oral, 50 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ETOPOSIDE

C **J8562** Fludarabine phosphate, oral, 10 mg K5 ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2011, Q1

D **J8565** Gefitinib, oral, 250 mg K5 ASC E2
BETOS: O1E Other drugs
Service not separately priced by Part B
Coding Clinic: 2014, Q4

D **J8597** Antiemetic drug, oral, not otherwise specified N1 ASC N
BETOS: O1D Chemotherapy
Statute: 1861s2T

D **J8600** Melphalan; oral, 2 mg K5 ASC E2
BETOS: O1D Chemotherapy

D **J8610** Methotrexate; oral, 2.5 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: METHOTREXATE, TREXALL

● D **J8611** Methotrexate (jylamvo), oral, 2.5 mg K2 ⓪ ASC K
BETOS: O1D Chemotherapy
Drugs: JYLAMVO
Coding Clinic: 2024, Q3

● D **J8612** Methotrexate (xatmep), oral, 2.5 mg K2 ⓪ ASC K
BETOS: O1D Chemotherapy
Drugs: XATMEP
Coding Clinic: 2024, Q3

C **J8650** Nabilone, oral, 1 mg K5 ASC E2
BETOS: O1E Other drugs

D **J8655** Netupitant 300 mg and palonosetron 0.5 mg, oral K2 ASC K
BETOS: O1E Other drugs
Drugs: AKYNZEO
Coding Clinic: 2016, Q1

D **J8670** Rolapitant, oral, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VARUBI ORAL

D **J8700** Temozolomide, oral, 5 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: TEMODAR, TEMOZOLOMIDE

C **J8705** Topotecan, oral, 0.25 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: HYCAMTIN
Coding Clinic: 2008, Q4; 2009, Q1

D **J8999** Prescription drug, oral, chemotherapeutic, NOS B
BETOS: O1D Chemotherapy

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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CHEMOTHERAPY DRUGS (J9000-J9999)

CHEMOTHERAPY DRUGS, ADMINISTERED BY INJECTION (J9000-J9999), SEE ALSO CHEMOTHERAPY DRUGS, ORAL ADMINISTRATION (J8501-J8999)

D **J9000** Injection, doxorubicin hydrochloride, 10 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: ADRIAMYCIN, DOXORUBICIN HCL
Coding Clinic: 2007, Q4

D **J9015** Injection, aldesleukin, per single use vial K2 ASC K
BETOS: O1D Chemotherapy
Coding Clinic: 2005, Q2

C **J9017** Injection, arsenic trioxide, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ARSENIC TRIOXIDE, TRISENOX
Coding Clinic: 2002, Q1; 2002, Q2; 2005, Q2

D **J9019** Injection, asparaginase (Erwinaze), 1,000 IU K5 ASC E2
BETOS: O1D Chemotherapy

D **J9020** Injection, asparaginase, not otherwise specified, 10,000 units K5 ASC E2
BETOS: O1D Chemotherapy

C **J9021** Injection, asparaginase, recombinant, (rylaze), 0.1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: RYLAZE
Coding Clinic: 2022, Q1

C **J9022** Injection, atezolizumab, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: TECENTRIQ

C **J9023** Injection, avelumab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BAVENCIO

C **J9025** Injection, azacitidine, 1 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: AZACITIDINE, VIDAZA

● C **J9026** Injection, tarlatamab-dlle, 1 mg Ⓐ
BETOS: O1D Chemotherapy

C **J9027** Injection, clofarabine, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: CLOFARABINE, CLOLAR

● C **J9028** Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram Ⓐ
BETOS: O1D Chemotherapy

▲ C **J9029** Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: ADSTILADRIN
Coding Clinic: 2023, Q3; 2024, Q2

D **J9030** BCG live intravesical instillation, 1 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: TICE BCG
Coding Clinic: 2019, Q3

C **J9032** Injection, belinostat, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BELEODAQ
Coding Clinic: 2016, Q1

▲ C **J9033** Injection, bendamustine hydrochloride, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BENDAMUSTINE, BENDAMUSTINE HYDROCHLORIDE, TREANDA
Coding Clinic: 2008, Q4

C **J9034** Injection, bendamustine HCL (bendeka), 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BENDEKA
Coding Clinic: 2017, Q1

C **J9035** Injection, bevacizumab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: AVASTIN
Coding Clinic: 2005, Q2; 2013, Q1; 2013, Q3

C **J9036** Injection, bendamustine hydrochloride, (belrapzo/ bendamustine), 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BELRAPZO, BENDAMUSTINE, BENDAMUSTINE HYDROCHLORIDE
Coding Clinic: 2019, Q3

C **J9037** Injection, belantamab mafodotin-blmf, 0.5 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: BLENREP
Coding Clinic: 2021, Q1

C **J9039** Injection, blinatumomab, 1 microgram K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BLINCYTO
Coding Clinic: 2016, Q1

D **J9040** Injection, bleomycin sulfate, 15 units N1 ASC N
BETOS: O1D Chemotherapy
Drugs: BLEOMYCIN SULFATE

C **J9041** Injection, bortezomib, 0.1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BORTEZOMIB, VELCADE
Coding Clinic: 2005, Q1; 2005, Q2; 2023, Q1; 2023, Q4

C **J9042** Injection, brentuximab vedotin, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ADCETRIS

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **J9043** Injection, cabazitaxel, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: JEVTANA
Coding Clinic: 2023, Q4

D **J9045** Injection, carboplatin, 50 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: CARBOPLATIN, PARAPLATIN

▲ C **J9046** Injection, bortezomib (dr. reddy's), not therapeutically equivalent to J9041, 0.1 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: BORTEZOMIB
Coding Clinic: 2023, Q1

C **J9047** Injection, carfilzomib, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: KYPROLIS
Coding Clinic: 2013, Q4

C **J9048** Injection, bortezomib (fresenius kabi), not therapeutically equivalent to J9041, 0.1 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Coding Clinic: 2023, Q1

C **J9049** Injection, bortezomib (hospira), not therapeutically equivalent to J9041, 0.1 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: BORTEZOMIB
Coding Clinic: 2023, Q1

D **J9050** Injection, carmustine, 100 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: BICNU, CARMUSTINE
Coding Clinic: 2024, Q1

C **J9051** Injection, bortezomib (maia), not therapeutically equivalent to J9041, 0.1 mg K5 Ⓐ ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2023, Q4

D **J9052** Injection, carmustine (accord), not therapeutically equivalent to J9050, 100 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: CARMUSTINE
Coding Clinic: 2024, Q1

C **J9055** Injection, cetuximab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ERBITUX
Coding Clinic: 2005, Q2

C **J9056** Injection, bendamustine hydrochloride (vivimusta), 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: VIVIMUSTA
Coding Clinic: 2023, Q3

C **J9057** Injection, copanlisib, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ALIQOPA
Coding Clinic: 2019, Q1

D **J9060** Injection, cisplatin, powder or solution, 10 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: CISPLATIN
Coding Clinic: 2011, Q1

C **J9061** Injection, amivantamab-vmjw, 2 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: RYBREVANT
Coding Clinic: 2022, Q1

C **J9063** Injection, mirvetuximab soravtansine-gynx, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: ELAHERE
Coding Clinic: 2023, Q3

C **J9064** Injection, cabazitaxel (sandoz), not therapeutically equivalent to J9043, 1 mg K5 ♂ ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2023, Q4

D **J9065** Injection, cladribine, per 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: CLADRIBINE

▲ D **J9071** Injection, cyclophosphamide (auromedics), 5 mg K2 ASC G
BETOS: O1D Chemotherapy
Drugs: CYCLOPHOSPHAMIDE
Coding Clinic: 2022, Q2

▲ D **J9072** Injection, cyclophosphamide (avyxa), 5 mg K5 Ⓐ ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2024, Q1

● D **J9073** Injection, cyclophosphamide (ingenus), 5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: CYCLOPHOSPHAMIDE, CYCLOPHOSPHAMIDE (INGENUS)
Coding Clinic: 2024, Q2

● D **J9074** Injection, cyclophosphamide (sandoz), 5 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: CYCLOPHOSPHAMIDE
Coding Clinic: 2024, Q2

● D **J9075** Injection, cyclophosphamide, not otherwise specified, 5 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: CYCLOPHOSPHAMIDE
Coding Clinic: 2024, Q2

● D **J9076** Injection, cyclophosphamide (baxter), 5 mg Ⓐ
BETOS: O1D Chemotherapy

C **J9098** Injection, cytarabine liposome, 10 mg K5 ASC E2
BETOS: O1E Other drugs

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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D **J9100** Injection, cytarabine, 100 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: CYTARABINE
Coding Clinic: 2011, Q1

C **J9118** Injection, calaspargase pegol-mknl, 10 units K5 Ⓐ ASC E2
BETOS: O1D Chemotherapy
Drugs: ASPARLAS
Coding Clinic: 2019, Q4

C **J9119** Injection, cemiplimab-rwlc, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: LIBTAYO
Coding Clinic: 2019, Q4

D **J9120** Injection, dactinomycin, 0.5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: COSMEGEN, DACTINOMYCIN

D **J9130** Dacarbazine, 100 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: DACARBAZINE
Coding Clinic: 2008, Q1; 2011, Q1

C **J9144** Injection, daratumumab, 10 mg and hyaluronidase-fihj K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: DARZALEX FASPRO
Coding Clinic: 2021, Q1

D **J9145** Injection, daratumumab, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: DARZALEX

D **J9150** Injection, daunorubicin, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: DAUNORUBICIN HCL

D **J9151** Injection, daunorubicin Citrate, liposomal formulation, 10 mg K5 ASC E2
BETOS: O1D Chemotherapy

C **J9153** Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine K2 ASC K
BETOS: O1D Chemotherapy
Drugs: VYXEOS
Coding Clinic: 2019, Q1

C **J9155** Injection, degarelix, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FIRMAGON

D **J9165** Injection, diethylstilbestrol diphosphate, 250 mg K5 ♂ ASC E2
BETOS: O1D Chemotherapy

D **J9171** Injection, docetaxel, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: DOCETAXEL
Coding Clinic: 2024, Q1

▲ C **J9172** Injection, docetaxel (docivyx), 1 mg K2 ASC G
BETOS: O1D Chemotherapy
Drugs: DOCIVYX
Coding Clinic: 2024, Q1

C **J9173** Injection, durvalumab, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: IMFINZI
Coding Clinic: 2019, Q1

D **J9175** Injection, Elliotts' B solution, 1 ml N1 ASC N
BETOS: O1E Other drugs

C **J9176** Injection, elotuzumab, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: EMPLICITI

C **J9177** Injection, enfortumab vedotin-ejfv, 0.25 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: PADCEV
Coding Clinic: 2020, Q2

C **J9178** Injection, epirubicin HCl, 2 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ELLENCE, EPIRUBICIN

C **J9179** Injection, eribulin mesylate, 0.1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ERIBULIN MESYLATE, HALAVEN

D **J9181** Injection, etoposide, 10 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: ETOPOPHOS, ETOPOSIDE

D **J9185** Injection, fludarabine phosphate, 50 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: FLUDARABINE PHOSPHATE

D **J9190** Injection, fluorouracil, 500 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: FLUOROURACIL

D **J9196** Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: GEMCITABINE
Coding Clinic: 2023, Q2

C **J9198** Injection, gemcitabine hydrochloride, (infugem), 100 mg K2 ♀ Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: INFUGEM
Coding Clinic: 2020, Q2; 2020, Q2

D **J9200** Injection, floxuridine, 500 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: FLOXURIDINE

D **J9201** Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: GEMCITABINE
Coding Clinic: 2023, Q2

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D **J9202** Goserelin acetate implant, per 3.6 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ZOLADEX

C **J9203** Injection, gemtuzumab ozogamicin, 0.1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: MYLOTARG
Coding Clinic: 2017, Q4; 2018, Q1

C **J9204** Injection, mogamulizumab-kpkc, 1 mg K2 ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: POTELIGEO
Coding Clinic: 2019, Q4

D **J9205** Injection, irinotecan liposome, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ONIVYDE

D **J9206** Injection, irinotecan, 20 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: CAMPTOSAR, IRINOTECAN HCL

C **J9207** Injection, ixabepilone, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: IXEMPRA KIT
Coding Clinic: 2008, Q4

D **J9208** Injection, ifosfamide, 1 gram N1 ASC N
BETOS: O1D Chemotherapy
Drugs: IFEX, IFOSFAMIDE

D **J9209** Injection, mesna, 200 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: MESNA, MESNEX

C **J9210** Injection, emapalumab-lzsg, 1 mg K2 ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: GAMIFANT
Coding Clinic: 2019, Q4

D **J9211** Injection, idarubicin hydrochloride, 5 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: IDAMYCIN PFS, IDARUBICIN

D **J9212** Injection, interferon alfacon-1, recombinant, 1 microgram K5 ASC E2
BETOS: O1E Other drugs

D **J9213** Injection, interferon, alfa-2a, recombinant, 3 million units K5 ASC E2
BETOS: O1D Chemotherapy

D **J9214** Injection, interferon, alfa-2b, recombinant, 1 million units K2 ASC K
BETOS: O1D Chemotherapy

D **J9215** Injection, interferon, alfa-N3, (human leukocyte derived), 250,000 IU K5 ASC E2
BETOS: O1D Chemotherapy

D **J9216** Injection, interferon, gamma 1-b, 3 million units K5 ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2005, Q2

D **J9217** Leuprolide acetate (for depot suspension), 7.5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ELIGARD, LUPRON DEPOT
Coding Clinic: 2019, Q2

D **J9218** Leuprolide acetate, per 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: LEUPROLIDE ACETATE
Coding Clinic: 2019, Q2

D **J9219** Leuprolide acetate implant, 65 mg K5 ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2001, Q4

C **J9223** Injection, lurbinectedin, 0.1 mg K2 ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: ZEPZELCA
Coding Clinic: 2021, Q1

D **J9225** Histrelin implant (Vantas), 50 mg K2 ASC K
BETOS: O1D Chemotherapy

D **J9226** Histrelin implant (Supprelin LA), 50 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: SUPPRELIN LA IMPLANT
Coding Clinic: 2008, Q1

C **J9227** Injection, isatuximab-irfc, 10 mg K2 ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: SARCLISA
Coding Clinic: 2020, Q4

C **J9228** Injection, ipilimumab, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: YERVOY

C **J9229** Injection, inotuzumab ozogamicin, 0.1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: BESPONSA
Coding Clinic: 2019, Q1

D **J9230** Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg N1 ASC N
BETOS: O1D Chemotherapy

D **J9245** Injection, melphalan hydrochloride, not otherwise specified, 50 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ALKERAN, MELPHALAN
Coding Clinic: 2020, Q2

C **J9246** Injection, melphalan (evomela), 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: EVOMELA
Coding Clinic: 2020, Q2

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C **J9247** Injection, melphalan flufenamide, 1mg K5 ASC E1
BETOS: O1E Other drugs
Coding Clinic: 2021, Q4

● C **J9248** Injection, melphalan (hepzato), 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: HEPZATO KIT
Coding Clinic: 2024, Q2

● C **J9249** Injection, melphalan (apotex), 1 mg E2
BETOS: O1D Chemotherapy
Coding Clinic: 2024, Q2

▲ D **J9255** Injection, methotrexate (accord), not therapeutically equivalent to J9260, 50 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1; 2024, Q2

▲ D **J9260** Injection, methotrexate sodium, 50 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: METHOTREXATE SODIUM
Coding Clinic: 2024, Q1; 2024, Q2

C **J9261** Injection, nelarabine, 50 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ARRANON, NELARABINE

C **J9262** Injection, omacetaxine mepesuccinate, 0.01 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: SYNRIBO
Coding Clinic: 2013, Q4

C **J9263** Injection, oxaliplatin, 0.5 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: OXALIPLATIN
Coding Clinic: 2009, Q1

C **J9264** Injection, paclitaxel protein-bound particles, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ABRAXANE, PACLITAXEL PROTEIN-BOUND
Coding Clinic: 2023, Q3; 2024, Q1

D **J9266** Injection, pegaspargase, per single dose vial K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ONCASPAR
Coding Clinic: 2002, Q2

D **J9267** Injection, paclitaxel, 1 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: PACLITAXEL

D **J9268** Injection, pentostatin, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: NIPENT

C **J9269** Injection, tagraxofusp-erzs, 10 micrograms K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: ELZONRIS
Coding Clinic: 2019, Q4

D **J9270** Injection, plicamycin, 2.5 mg K5 ASC E2
BETOS: O1D Chemotherapy

C **J9271** Injection, pembrolizumab, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: KEYTRUDA
Coding Clinic: 2016, Q1

C **J9272** Injection, dostarlimab-gxly, 10 mg K2 ♀ ASC K
BETOS: O1D Chemotherapy
Drugs: JEMPERLI
Coding Clinic: 2022, Q1

C **J9273** Injection, tisotumab vedotin-tftv, 1 mg K2 ♀ Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: TIVDAK
Coding Clinic: 2022, Q2

C **J9274** Injection, tebentafusp-tebn, 1 microgram K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: KIMMTRAK
Coding Clinic: 2022, Q4

D **J9280** Injection, mitomycin, 5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: MITOMYCIN
Coding Clinic: 2011, Q1; 2014, Q2; 2016, Q4; 2017, Q4

C **J9281** Mitomycin pyelocalyceal instillation, 1 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: JELMYTO
Coding Clinic: 2021, Q1

C **J9285** Injection, olaratumab, 10 mg K5 ASC E2
BETOS: O1D Chemotherapy

C **J9286** Injection, glofitamab-gxbm, 2.5 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: COLUMVI
Coding Clinic: 2024, Q1

● C **J9292** Injection, pemetrexed (avyxa), not therapeutically equivalent to J9305, 10 mg
BETOS: O1E Other drugs

D **J9293** Injection, mitoxantrone hydrochloride, per 5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: MITOXANTRONE HYDROCHLORIDE

▲ C **J9294** Injection, pemetrexed (hospira), not therapeutically equivalent to J9305, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PEMETREXED
Coding Clinic: 2023, Q2

C **J9295** Injection, necitumumab, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: PORTRAZZA

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
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▲ C **J9296** Injection, pemetrexed (accord), not therapeutically equivalent to J9305, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PEMETREXED
Coding Clinic: 2023, Q2

C **J9297** Injection, pemetrexed (sandoz), not therapeutically equivalent to J9305, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: PEMETREXED
Coding Clinic: 2023, Q2

C **J9298** Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg K2 ⓪ ASC G
BETOS: O1D Chemotherapy
Drugs: OPDUALAG
Coding Clinic: 2022, Q4

D **J9299** Injection, nivolumab, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: OPDIVO
Coding Clinic: 2016, Q1

C **J9301** Injection, obinutuzumab, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: GAZYVA

C **J9302** Injection, ofatumumab, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ARZERRA
Coding Clinic: 2011, Q1

C **J9303** Injection, panitumumab, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: PANITUMUMAB
Coding Clinic: 2008, Q1

C **J9304** Injection, pemetrexed (pemfexy), 10 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: PEMFEXY
Coding Clinic: 2020, Q4

C **J9305** Injection, pemetrexed, not otherwise specified, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ALIMTA, PEMETREXED
Coding Clinic: 2005, Q2; 2020, Q4; 2023, Q1; 2023, Q2; 2023, Q3

C **J9306** Injection, pertuzumab, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: PERJETA
Coding Clinic: 2013, Q4

C **J9307** Injection, pralatrexate, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FOLOTYN, PRALATREXATE
Coding Clinic: 2011, Q1

C **J9308** Injection, ramucirumab, 5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: CYRAMZA
Coding Clinic: 2016, Q1

C **J9309** Injection, polatuzumab vedotin-piiq, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: POLIVY

D **J9311** Injection, rituximab 10 mg and hyaluronidase K2 ASC K
BETOS: O1D Chemotherapy
Drugs: RITUXAN HYCELA
Coding Clinic: 2019, Q1

D **J9312** Injection, rituximab, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: RITUXAN
Coding Clinic: 2019, Q1

C **J9313** Injection, moxetumomab pasudotox-tdfk, 0.01 mg K2 ⓪ ASC K
BETOS: O1D Chemotherapy
Drugs: LUMOXITI
Coding Clinic: 2019, Q4

▲ C **J9314** Injection, pemetrexed (teva), not therapeutically equivalent to J9305, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: PEMETREXED
Coding Clinic: 2023, Q1; 2023, Q2

C **J9316** Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg K2 ⓪ ASC K
BETOS: O1D Chemotherapy
Drugs: PHESGO
Coding Clinic: 2021, Q1

C **J9317** Injection, sacituzumab govitecan-hziy, 2.5 mg K2 ⓪ ASC K
BETOS: O1D Chemotherapy
Drugs: TRODELVY
Coding Clinic: 2021, Q1

C **J9318** Injection, romidepsin, non-lyophilized, 0.1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ROMIDEPSIN NON-LYOPHILIZED
Coding Clinic: 2021, Q4

C **J9319** Injection, romidepsin, lyophilized, 0.1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ISTODAX LYOPHILIZED, ROMIDEPSIN LYOPHILIZED
Coding Clinic: 2021, Q4

D **J9320** Injection, streptozocin, 1 gram K2 ASC K
BETOS: O1D Chemotherapy
Drugs: ZANOSAR

C **J9321** Injection, epcoritamab-bysp, 0.16 mg K2 ⓪ ASC G
BETOS: O1D Chemotherapy
Drugs: EPKINLY
Coding Clinic: 2024, Q1

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▲ C **J9322** Injection, pemetrexed (bluepoint), not therapeutically equivalent to J9305, 10 mg K5 ASC E2
BETOS: O1D Chemotherapy
Coding Clinic: 2023, Q3

C **J9323** Injection, pemetrexed ditromethamine, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: PEMETREXED DITROMETHAMINE
Coding Clinic: 2023, Q3

C **J9324** Injection, pemetrexed (pemrydi rtu), 10 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: PEMRYDI RTU
Coding Clinic: 2024, Q1

C **J9325** Injection, talimogene laherparepvec, per 1 million plaque forming units K2 ASC K
BETOS: O1E Other drugs
Drugs: IMLYGIC
Coding Clinic: 2019, Q2

C **J9328** Injection, temozolomide, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: TEMODAR IV

● C **J9329** Injection, tislelizumab-jsgr, 1mg Ⓐ E2
BETOS: O1D Chemotherapy

C **J9330** Injection, temsirolimus, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: TEMSIROLIMUS
Coding Clinic: 2008, Q4

C **J9331** Injection, sirolimus protein-bound particles, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: FYARRO
Coding Clinic: 2022, Q3

C **J9332** Injection, efgartigimod alfa-fcab, 2mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: VYVGART
Coding Clinic: 2022, Q3

C **J9333** Injection, rozanolixizumab-noli, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: RYSTIGGO
Coding Clinic: 2024, Q1

C **J9334** Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: VYVGART HYTRULO
Coding Clinic: 2024, Q1

D **J9340** Injection, thiotepa, 15 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: THIOTEPA

C **J9345** Injection, retifanlimab-dlwr, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: ZYNYZ
Coding Clinic: 2023, Q4

C **J9347** Injection, tremelimumab-actl, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: IMJUDO
Coding Clinic: 2023, Q3

C **J9348** Injection, naxitamab-gqgk, 1 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: DANYELZA
Coding Clinic: 2021, Q3

C **J9349** Injection, tafasitamab-cxix, 2 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: MONJUVI
Coding Clinic: 2021, Q1

C **J9350** Injection, mosunetuzumab-axgb, 1 mg K2 Ⓐ ASC G
BETOS: O1D Chemotherapy
Drugs: LUNSUMIO
Coding Clinic: 2011, Q1; 2023, Q3

C **J9351** Injection, topotecan, 0.1 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: HYCAMTIN, TOPOTECAN
Coding Clinic: 2011, Q1

C **J9352** Injection, trabectedin, 0.1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: YONDELIS

C **J9353** Injection, margetuximab-cmkb, 5 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: MARGENZA
Coding Clinic: 2021, Q3

C **J9354** Injection, ado-trastuzumab emtansine, 1 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: KADCYLA
Coding Clinic: 2013, Q4

C **J9355** Injection, trastuzumab, excludes biosimilar, 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: HERCEPTIN
Coding Clinic: 2006, Q2; 2019, Q3

C **J9356** Injection, trastuzumab, 10 mg and Hyaluronidase-oysk K2 ASC K
BETOS: O1E Other drugs
Drugs: HERCEPTIN HYLECTA
Coding Clinic: 2019, Q3

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **J9357** Injection, valrubicin, intravesical, 200 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: VALRUBICIN, VALSTAR

C **J9358** Injection, fam-trastuzumab deruxtecan-nxki, 1 mg K2 ♀ Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ENHERTU
Coding Clinic: 2020, Q2

C **J9359** Injection, loncastuximab tesirine-lpyl, 0.075 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: ZYNLONTA
Coding Clinic: 2022, Q2

D **J9360** Injection, vinblastine sulfate, 1 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: VINBLASTINE SULFATE

● C **J9361** Injection, efbemalenograstim alfa-vuxw, 0.5 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

D **J9370** Vincristine sulfate, 1 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: VINCRISTINE SULFATE
Coding Clinic: 2011, Q1

● C **J9376** Injection, pozelimab-bbfg, 1 mg Ⓐ E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

C **J9380** Injection, teclistamab-cqyv, 0.5 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: TECVAYLI
Coding Clinic: 2011, Q1; 2023, Q3

C **J9381** Injection, teplizumab-mzwv, 5 mcg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: TZIELD
Coding Clinic: 2023, Q3

D **J9390** Injection, vinorelbine tartrate, 10 mg N1 ASC N
BETOS: O1D Chemotherapy
Drugs: VINORELBINE TARTRATE
Coding Clinic: 2005, Q2

▲ C **J9393** Injection, fulvestrant (teva), not therapeutically equivalent to J9395, 25 mg K2 ♀ ASC K
BETOS: O1E Other drugs
Drugs: FULVESTRANT
Coding Clinic: 2023, Q1

C **J9394** Injection, fulvestrant (fresenius kabi) not therapeutically equivalent to J9395, 25 mg K2 ♀ ASC K
BETOS: O1E Other drugs
Drugs: FULVESTRANT
Coding Clinic: 2023, Q1

C **J9395** Injection, fulvestrant, 25 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FASLODEX, FULVESTRANT
Coding Clinic: 2023, Q1

C **J9400** Injection, ziv-aflibercept, 1 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ZALTRAP
Coding Clinic: 2013, Q4

D **J9600** Injection, porfimer sodium, 75 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: PHOTOFRIN
Coding Clinic: 2020, Q1

D **J9999** Not otherwise classified, antineoplastic drugs N1 ASC N
BETOS: O1D Chemotherapy
Coding Clinic: 2002, Q1; 2008, Q1; 2009, Q2; 2010, Q3; 2012, Q4; 2013, Q1; 2017, Q1

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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DURABLE MEDICAL EQUIPMENT (DME) (K0001-K1037)

WHEELCHAIRS, COMPONENTS, AND ACCESSORIES (K0001-K0195)

C **K0001** Standard wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR



Wheelchair

C **K0002** Standard hemi (low seat) wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0003** Lightweight wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0004** High strength, lightweight wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0005** Ultralightweight wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0006** Heavy duty wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0007** Extra heavy duty wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **K0008** Custom manual wheelchair/base Y
BETOS: D1D Wheelchairs

C **K0009** Other manual wheelchair/base DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0010** Standard - weight frame motorized/power wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0011** Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking DME Y
BETOS: D1D Wheelchairs
DME Modifier: KF, RR

C **K0012** Lightweight portable motorized/power wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

D **K0013** Custom motorized/power wheelchair base Y
BETOS: D1D Wheelchairs

C **K0014** Other motorized/power wheelchair base Y
BETOS: D1D Wheelchairs

C **K0015** Detachable, non-adjustable height armrest, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

C **K0017** Detachable, adjustable height armrest, base, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0018** Detachable, adjustable height armrest, upper portion, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0019** Arm pad, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0020** Fixed, adjustable height armrest, pair DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0037** High mount flip-up footrest, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0038** Leg strap, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0039** Leg strap, H style, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0040** Adjustable angle footplate, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

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C **K0041** Large size footplate, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0042** Standard size footplate, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0043** Footrest, lower extension tube, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0044** Footrest, upper hanger bracket, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0045** Footrest, complete assembly, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0046** Elevating legrest, lower extension tube, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0047** Elevating legrest, upper hanger bracket, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0050** Ratchet assembly, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0051** Cam release assembly, footrest or legrest, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0052** Swingaway, detachable footrests, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0053** Elevating footrests, articulating (telescoping), each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0056** Seat height less than 17 inch or equal to or greater than 21 inch for a high strength, lightweight, or ultralightweight wheelchair DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0065** Spoke protectors, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0069** Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0070** Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, RR

C **K0071** Front caster assembly, complete, with pneumatic tire, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0072** Front caster assembly, complete, with semi-pneumatic tire, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0073** Caster pin lock, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0077** Front caster assembly, complete, with solid tire, replacement only, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

C **K0098** Drive belt for power wheelchair, replacement only DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0105** IV hanger, each DME Y
BETOS: D1D Wheelchairs
DME Modifier: KU, NU, RR, UE

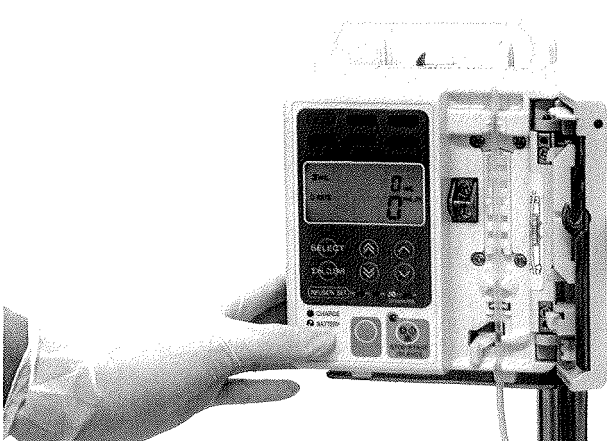
C **K0108** Wheelchair component or accessory, not otherwise specified Y
BETOS: D1D Wheelchairs

D **K0195** Elevating leg rests, pair (for use with capped rental wheelchair base) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, RR

INFUSION PUMPS AND SUPPLIES (K0455-K0605)

D **K0455** Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol) DME Y
BETOS: D1E Other DME
DME Modifier: RR

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Infusion pump

D **K0462** Temporary replacement for patient owned equipment being repaired, any type Y
BETOS: D1E Other DME

D **K0552** Supplies for external non-insulin drug infusion pump, syringe type cartridge, sterile, each DME Y
BETOS: D1E Other DME

C **K0601** Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Coding Clinic: 2003, Q2

C **K0602** Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Coding Clinic: 2003, Q2

C **K0603** Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Coding Clinic: 2003, Q2

C **K0604** Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Coding Clinic: 2003, Q2

C **K0605** Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each DME Y
BETOS: D1E Other DME
DME Modifier: NU
Coding Clinic: 2003, Q2

AUTOMATED EXTERNAL DEFIBRILLATOR AND SUPPLIES (K0606-K0609)

C **K0606** Automatic external defibrillator, with integrated electrocardiogram analysis, garment type DME Y
BETOS: D1E Other DME
DME Modifier: KF, RR

C **K0607** Replacement battery for automated external defibrillator, garment type only, each DME Y
BETOS: D1E Other DME
DME Modifier: KF, RR

C **K0608** Replacement garment for use with automated external defibrillator, each DME Y
BETOS: D1E Other DME
DME Modifier: KF, NU, RR, UE

C **K0609** Replacement electrodes for use with automated external defibrillator, garment type only, each DME Y
BETOS: D1E Other DME
DME Modifier: KF

MISCELLANEOUS DME AND ACCESSORIES (K0669-K0746)

C **K0669** Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from DME PDAC Y
BETOS: D1D Wheelchairs

C **K0672** Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **K0730** Controlled dose inhalation drug delivery system DME Y
BETOS: D1E Other DME
DME Modifier: RR

C **K0733** Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) DME Y
BETOS: D1D Wheelchairs
DME Modifier: KE, KU, NU, RR, UE

C **K0738** Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing DME Y
BETOS: D1C Oxygen and supplies
DME Modifier: QB, QF, RR

C **K0739** Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes Y
BETOS: D1E Other DME

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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M **K0740** Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes E1
BETOS: D1C Oxygen and supplies
Service not separately priced by Part B

C **K0743** Suction pump, home model, portable, for use on wounds Y
BETOS: D1E Other DME

C **K0744** Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less A
BETOS: D1E Other DME

C **K0745** Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches A
BETOS: D1E Other DME

C **K0746** Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches A
BETOS: D1E Other DME

POWER OPERATED VEHICLES (K0800-K0812)

C **K0800** Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0801** Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0802** Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0806** Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0807** Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0808** Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: NU, RR, UE

C **K0812** Power operated vehicle, not otherwise classified Y
BETOS: D1D Wheelchairs

WHEELCHAIRS, POWER OPERATED (K0813-K0899)

C **K0813** Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0814** Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0815** Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0816** Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0820** Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0821** Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0822** Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0823** Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0824** Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

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K0825 Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0826 Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0827 Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0828 Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0829 Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0830 Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

K0831 Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

K0835 Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0836 Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0837 Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0838 Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0839 Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0840 Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0841 Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0842 Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0843 Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0848 Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0849 Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0850 Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0851 Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

K0852 Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **K0853** Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0854** Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0855** Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0856** Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0857** Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0858** Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0859** Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0860** Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0861** Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0862** Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0863** Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0864** Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more DME Y
BETOS: D1D Wheelchairs
DME Modifier: RR

C **K0868** Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

C **K0869** Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

C **K0870** Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds Y
BETOS: D1D Wheelchairs

C **K0871** Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds Y
BETOS: D1D Wheelchairs

C **K0877** Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

C **K0878** Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

C **K0879** Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds Y
BETOS: D1D Wheelchairs

C **K0880** Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds Y
BETOS: D1D Wheelchairs

C **K0884** Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

C **K0885** Power wheelchair, group 4 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds Y
BETOS: D1D Wheelchairs

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C **K0886** Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds Y
BETOS: D1D Wheelchairs

C **K0890** Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds A Y
BETOS: D1D Wheelchairs

C **K0891** Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds A Y
BETOS: D1D Wheelchairs

C **K0898** Power wheelchair, not otherwise classified Y
BETOS: D1D Wheelchairs

C **K0899** Power mobility device, not coded by DME PDAC or does not meet criteria Y
BETOS: D1D Wheelchairs
Service not separately priced by Part B

CUSTOMIZED DME, OTHER THAN WHEELCHAIR (K0900)

D **K0900** Customized durable medical equipment, other than wheelchair Y
BETOS: D1E Other DME

COMPONENTS, ACCESSORIES AND SUPPLIES (K1004-K1037)

S **K1004** Low frequency ultrasonic diathermy treatment device for home use E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2023, Q4

C **K1007** Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors DME Y
BETOS: D1F Prosthetic/Orthotic devices

C **K1027** Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment Y
BETOS: Z2 Undefined codes
Value not established

C **K1030** External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only Y
BETOS: Z2 Undefined codes
Value not established

C **K1034** Provision of covid-19 test, nonprescription self-administered and self-collected use, fda approved, authorized or cleared, one test count A E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2022, Q3

C **K1035** Molecular diagnostic test reader, nonprescription self-administered and self-collected use, fda approved, authorized or cleared E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q2

S **K1036** Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1861(n)
Coding Clinic: 2023, Q4

● C **K1037** Docking station for use with oral device/appliance used to reduce upper airway collapsibility A E1
BETOS: Z2 Undefined codes
Value not established

♂ Male only ♀ Female only A Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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NOTES

ORTHOTIC PROCEDURES AND SERVICES (L0112-L4631)

CERVICAL ORTHOTICS (L0112-L0174)

C **L0112** Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0113** Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

C **L0120** Cervical, flexible, non-adjustable, prefabricated, off-the-shelf (foam collar) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0130** Cervical, flexible, thermoplastic collar, molded to patient DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0140** Cervical, semi-rigid, adjustable (plastic collar) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0150** Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0160** Cervical, semi-rigid, wire frame occipital/mandibular support, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0170** Cervical, collar, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0172** Cervical, collar, semi-rigid thermoplastic foam, two-piece, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0174** Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

CERVICAL ORTHOTICS MULTI-POST COLLAR (L0180-L0200)

C **L0180** Cervical, multiple post collar, occipital/mandibular supports, adjustable DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0190** Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (SOMI, Guilford, Taylor types) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0200** Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension DME A
BETOS: D1F Prosthetic/Orthotic devices

THORACIC RIB BELT (L0220)

C **L0220** Thoracic, rib belt, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

THORACIC-LUMBAR-SACRAL ORTHOTIC (TLSO) (L0450-L0492), SEE ALSO LOW-PROFILE ADDITIONS, THORACIC-LUMBAR-SACRAL ORTHOTICS (L1200-L1290)

C **L0450** Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0452** Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0454** Thoracic-lumbar-sacral orthosis (TLSO) flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0455** Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L0456** Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary

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pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0457** Thoracic-lumbar-sacral orthosis (TLSO), flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0458** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0460** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0462** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0464** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0466** Thoracic-lumbar-sacral orthosis (TLSO), sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0467** Thoracic-lumbar-sacral orthosis (TLSO), sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0468** Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0469** Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal

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planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0470** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, provides intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0472** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0480** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0482** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0484** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0486** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0488** Thoracic-lumbar-sacral orthosis (TLSO), triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0490** Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0491** Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral

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strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0492** Thoracic-lumbar-sacral orthosis (TLSO), sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

SACRAL ORTHOTICS (L0621-L0624)

C **L0621** Sacroiliac orthosis (SO), flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0622** Sacroiliac orthosis (SO), flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0623** Sacroiliac orthosis (SO), provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

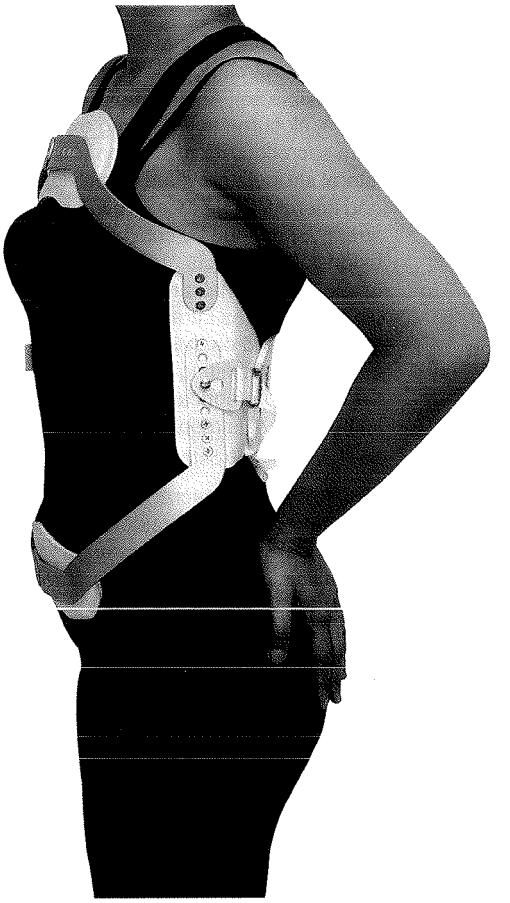
C **L0624** Sacroiliac orthosis (SO), provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

LUMBAR ORTHOTICS (L0625-L0627), SEE ALSO LUMBAR ORTHOTICS SAGITTAL CONTROL (L0641, L0642)

C **L0625** Lumbar orthosis (LO), flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices



Thoracic-lumbar-sacral orthosis

C **L0626** Lumbar orthosis (LO), sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0627** Lumbar orthosis (LO), sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

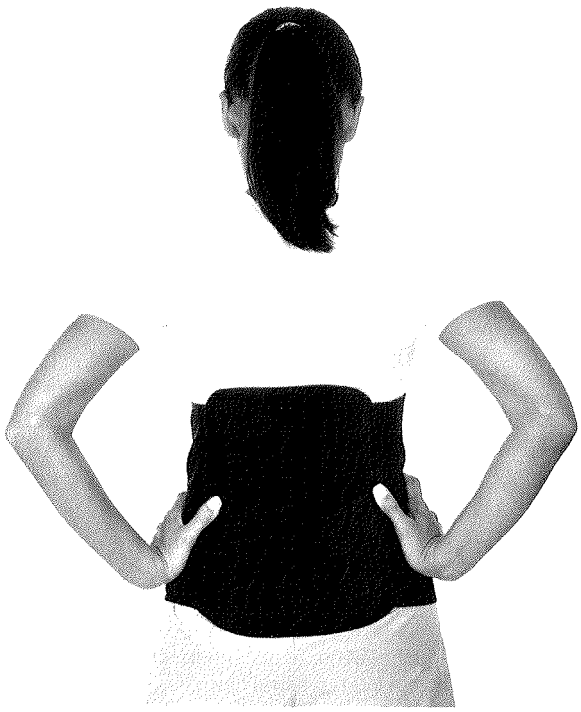
BETOS: D1F Prosthetic/Orthotic devices

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LUMBAR-SACRAL ORTHOTICS (L0628-L0640), SEE ALSO LUMBAR-SACRAL ORTHOTICS SAGITTAL CONTROL (L0643-L0651)

C **L0628** Lumbar-sacral orthosis (LSO), flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices



Lumbar-sacral orthosis

C **L0629** Lumbar-sacral orthosis (LSO), flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0630** Lumbar-sacral orthosis (LSO), sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0631** Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0632** Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0633** Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0634** Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0635** Lumbar-sacral orthosis (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

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C **L0636** Lumbar-sacral orthosis (LSO), sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0637** Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0638** Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0639** Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0640** Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

LUMBAR ORTHOTICS SAGITTAL CONTROL (L0641, L0642), SEE ALSO LUMBAR ORTHOTICS (L0625-L0627)

C **L0641** Lumbar orthosis (LO), sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0642** Lumbar orthosis (LO), sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

LUMBAR-SACRAL ORTHOTICS SAGITTAL CONTROL (L0643-L0651), SEE ALSO LUMBAR-SACRAL ORTHOTICS (L0628-L0640)

C **L0643** Lumbar-sacral orthosis (LSO), sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0648** Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L0649** Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder

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straps, pendulous abdomen design, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

L0650 Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

L0651 Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOTICS (L0700, L0710)

L0700 Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model (Minerva type) DME A
BETOS: D1F Prosthetic/Orthotic devices

L0710 Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral-control, molded to patient model, with interface material (Minerva type) DME A
BETOS: D1F Prosthetic/Orthotic devices

CERVICAL HALO PROCEDURES (L0810-L0861)

L0810 Halo procedure, cervical halo incorporated into jacket vest DME A
BETOS: D1F Prosthetic/Orthotic devices

L0820 Halo procedure, cervical halo incorporated into plaster body jacket DME A
BETOS: D1F Prosthetic/Orthotic devices

L0830 Halo procedure, cervical halo incorporated into Milwaukee type orthosis DME A
BETOS: D1F Prosthetic/Orthotic devices

L0859 Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material DME A
BETOS: D1F Prosthetic/Orthotic devices

L0861 Addition to halo procedure, replacement liner/interface material DME A
BETOS: D1F Prosthetic/Orthotic devices

ACCESSORIES FOR SPINAL ORTHOTICS (L0970-L0999)

L0970 Thoracic-lumbar-sacral orthosis (TLSO), corset front DME A
BETOS: D1F Prosthetic/Orthotic devices

L0972 Lumbar-sacral orthosis (LSO), corset front DME A
BETOS: D1F Prosthetic/Orthotic devices

L0974 Thoracic-lumbar-sacral orthosis (TLSO), full corset DME A
BETOS: D1F Prosthetic/Orthotic devices

L0976 Lumbar-sacral orthotic (LSO), full corset DME A
BETOS: D1F Prosthetic/Orthotic devices

L0978 Axillary crutch extension DME A
BETOS: D1F Prosthetic/Orthotic devices

L0980 Peroneal straps, prefabricated, off-the-shelf, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

L0982 Stocking supporter grips, prefabricated, off-the-shelf, set of four (4) DME A
BETOS: D1F Prosthetic/Orthotic devices

L0984 Protective body sock, prefabricated, off-the-shelf, each DME A
BETOS: D1F Prosthetic/Orthotic devices

L0999 Addition to spinal orthosis, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

SCOLIOSIS ORTHOTIC DEVICES (L1000-L1120)

L1000 Cervical-thoracic-lumbar-sacral orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosis, including model DME A
BETOS: D1F Prosthetic/Orthotic devices

L1001 Cervical-thoracic-lumbar-sacral orthosis (CTLSO), immobilizer, infant size, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

L1005 Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

● **L1006** Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME
BETOS: D1F Prosthetic/Orthotic devices

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C **L1010** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, axilla sling DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1020** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, kyphosis pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1025** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, kyphosis pad, floating DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1030** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar bolster pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1040** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar or lumbar rib pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1050** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, sternal pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1060** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, thoracic pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1070** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, trapezius sling DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1080** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, outrigger DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1085** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, outrigger, bilateral with vertical extensions DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1090** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, lumbar sling DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1100** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, ring flange, plastic or leather DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1110** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, ring flange, plastic or leather, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1120** Addition to Cervical-thoracic-lumbar-sacral orthosis (CTLSO), scoliosis orthosis, cover for upright, each DME A
BETOS: D1F Prosthetic/Orthotic devices

LOW-PROFILE ADDITIONS, THORACIC-LUMBAR-SACRAL ORTHOTICS (L1200-L1290), SEE ALSO THORACIC-LUMBAR-SACRAL (TLSO) ORTHOTICS (L0450-L0492)

C **L1200** Thoracic-lumbar-sacral-orthosis (TLSO), inclusive of furnishing initial orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1210** Addition to Thoracic-lumbar-sacral-orthosis (TLSO), (low profile), lateral thoracic extension DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1220** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior thoracic extension DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1230** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), Milwaukee type superstructure DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1240** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), lumbar derotation pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1250** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior asis pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1260** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), anterior thoracic derotation pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1270** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), abdominal pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1280** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), rib gusset (elastic), each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1290** Addition to Thoracic-lumbar-sacral orthosis (TLSO), (low profile), lateral trochanteric pad DME A
BETOS: D1F Prosthetic/Orthotic devices

OTHER SCOLIOSIS AND SPINAL ORTHOTICS AND PROCEDURES (L1300-L1499)

C **L1300** Other scoliosis procedure, body jacket molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1310** Other scoliosis procedure, post-operative body jacket DME A
BETOS: D1F Prosthetic/Orthotic devices

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● C **L1320** Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated A
BETOS: D1F Prosthetic/Orthotic devices

C **L1499** Spinal orthosis, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

HIP ORTHOTICS (L1600-L1690)

C **L1600** Hip orthosis, abduction control of hip joints, flexible, Frejka type with cover, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1610** Hip orthosis, abduction control of hip joints, flexible, (Frejka cover only), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1620** Hip orthosis, abduction control of hip joints, flexible, (Pavlik harness), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1630** Hip orthosis (HO), abduction control of hip joints, semi-flexible (Von Rosen type), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1640** Hip orthosis (HO), abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1650** Hip orthosis (HO), abduction control of hip joints, static, adjustable, (Ilfled type), prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

▲ C **L1652** Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

● C **L1653** Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, off the shelf DME Ⓐ
BETOS: D1F Prosthetic/Orthotic devices

C **L1660** Hip orthosis (HO), abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1680** Hip orthosis (HO), abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1681** Hip orthosis, bilateral hip joints and thigh cuffs, adjustable flexion, extension, abduction control of hip joint, postoperative hip abduction type, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2023, Q4

C **L1685** Hip orthosis (HO), abduction control of hip joint, postoperative hip abduction type, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1686** Hip orthosis (HO), abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1690** Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

LEGG PERTHES ORTHOTICS (L1700-L1755)

C **L1700** Legg perthes orthosis, (Toronto type), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1710** Legg perthes orthosis, (Newington type), custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1720** Legg perthes orthosis, trilateral, (Tachdijan type), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1730** Legg perthes orthosis, (Scottish Rite type), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L1755** Legg perthes orthosis, (Patten bottom type), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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KNEE ORTHOTICS (L1810-L1860)

C **L1810** Knee orthosis (KO), elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1812** Knee orthosis (KO), elastic with joints, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

▲ C **L1820** Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

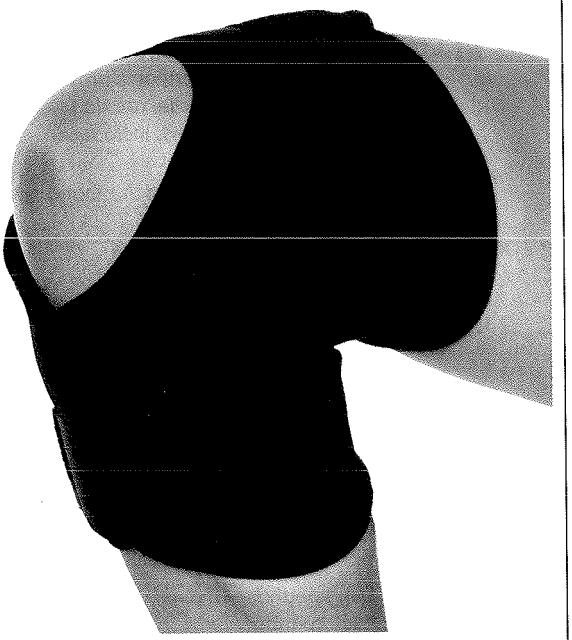
BETOS: D1F Prosthetic/Orthotic devices

● C **L1821** Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, off the shelf DME

BETOS: D1F Prosthetic/Orthotic devices

C **L1830** Knee orthosis (KO), immobilizer, canvas longitudinal, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices



Knee orthosis

C **L1831** Knee orthosis (KO), locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1832** Knee orthosis (KO), adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1833** Knee orthosis (KO), adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1834** Knee orthosis (KO), without knee joint, rigid, custom-fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1836** Knee orthosis (KO), rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1840** Knee orthosis (KO), derotation, medial-lateral, anterior cruciate ligament, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1843** Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1844** Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1845** Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1846** Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1847** Knee orthosis (KO), double upright with adjustable joint, with inflatable air support chamber(s), prefabricated item that has been trimmed, bent, molded, assembled, or

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otherwise customized to fit a specific patient by an individual with expertise DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1848** Knee orthosis (KO), double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1850** Knee orthosis (KO), swedish type, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1851** Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1852** Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1860** Knee orthosis (KO), modification of supracondylar prosthetic socket, custom-fabricated (SK) DME A

BETOS: D1F Prosthetic/Orthotic devices

ANKLE-FOOT ORTHOTICS (L1900-L1990), SEE ALSO ANKLE-FOOT ORTHOTICS (L2106-L2116)

C **L1900** Ankle foot orthosis (AFO), spring wire, dorsiflexion assist calf band, custom-fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1902** Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1904** Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1906** Ankle foot orthosis, multiligamentous ankle support, prefabricated, off-the-shelf DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1907** Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1910** Ankle foot orthosis (AFO), posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices



Ankle-foot orthosis

C **L1920** Ankle foot orthosis (AFO), single upright with static or adjustable stop (phelps or perlstein type), custom-fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1930** Ankle foot orthosis (AFO), plastic or other material, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1932** Ankle foot orthosis (AFO), rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1940** Ankle foot orthosis (AFO), plastic or other material, custom-fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1945** Ankle foot orthosis (AFO), plastic, rigid anterior tibial section (floor reaction), custom-fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

C **L1950** Ankle foot orthosis (AFO), spiral, (institute of rehabilitative medicine type), plastic, custom-fabricated DME A

BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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L1951 Ankle foot orthosis (AFO), spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

L1960 Ankle foot orthosis (AFO), posterior solid ankle, plastic, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L1970 Ankle foot orthosis (AFO), plastic with ankle joint, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L1971 Ankle foot orthosis (AFO), plastic or other material with ankle joint, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

L1980 Ankle foot orthosis (AFO), single upright free plantar dorsiflexion, solid stirrup, calf band/ cuff (single bar 'BK' orthosis), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L1990 Ankle foot orthosis (AFO), double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar 'BK' orthosis), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

KNEE-ANKLE-FOOT ORTHOTICS (L2000-L2038), SEE ALSO KNEE-ANKLE-FOOT ORTHOTICS (L2126-L2136)

L2000 Knee ankle foot orthosis (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'AK' orthosis), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2005 Knee ankle foot orthosis (KAFO), any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2006 Knee ankle foot device, any material, single or double upright, swing and stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2010 Knee ankle foot orthosis (KAFO), single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'AK' orthosis), without knee joint, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2020 Knee ankle foot orthosis (KAFO), double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar 'AK' orthosis), custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2030 Knee ankle foot orthosis (KAFO), double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar 'AK' orthosis), without knee joint, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2034 Knee ankle foot orthosis (KAFO), full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2035 Knee ankle foot orthosis (KAFO), full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

L2036 Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2037 Knee ankle foot orthosis (KAFO), full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2038 Knee ankle foot orthosis (KAFO), full plastic, with or without free motion knee, multi-axis ankle, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

HIP-KNEE-ANKLE-FOOT ORTHOTICS (L2040-L2090)

L2040 Hip knee ankle foot orthosis (HKAFO), torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2050 Hip knee ankle foot orthosis (HKAFO), torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2060 Hip knee ankle foot orthosis (HKAFO), torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/ belt, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

L2070 Hip knee ankle foot orthosis (HKAFO), torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L2080** Hip knee ankle foot orthosis (HKAFO), torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2090** Hip knee ankle foot orthosis (HKAFO), torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/ belt, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

ANKLE-FOOT ORTHOTICS (L2106-L2116), SEE ALSO ANKLE-FOOT ORTHOTICS (L1900-L1990)

C **L2106** Ankle foot orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2108** Ankle foot orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2112** Ankle foot orthosis (AFO), fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2114** Ankle foot orthosis (AFO), fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2116** Ankle foot orthosis (AFO), fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

KNEE-ANKLE-FOOT ORTHOTICS (L2126-L2136), SEE ALSO KNEE-ANKLE-FOOT ORTHOTICS (L2000-L2038)

C **L2126** Knee ankle foot orthosis (KAFO), fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2128** Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2132** Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2134** Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2136** Knee ankle foot orthosis(KAFO), fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

ADDITIONS, LOWER EXTREMITY, FRACTURE ORTHOTICS (L2180-L2192)

C **L2180** Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2182** Addition to lower extremity fracture orthosis, drop lock knee joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2184** Addition to lower extremity fracture orthosis, limited motion knee joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2186** Addition to lower extremity fracture orthosis, adjustable motion knee joint, lerman type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2188** Addition to lower extremity fracture orthosis, quadrilateral brim DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2190** Addition to lower extremity fracture orthosis, waist belt DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2192** Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt DME A
BETOS: D1F Prosthetic/Orthotic devices

ADDITIONS, LOWER EXTREMITY ORTHOTICS (L2200-L2397)

C **L2200** Addition to lower extremity, limited ankle motion, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2210** Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2220** Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2230** Addition to lower extremity, split flat caliper stirrups and plate attachment DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **L2232** Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis (AFO), for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2240** Addition to lower extremity, round caliper and plate attachment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2250** Addition to lower extremity, foot plate, molded to patient model, stirrup attachment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2260** Addition to lower extremity, reinforced solid stirrup (Scott-Craig type) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2265** Addition to lower extremity, long tongue stirrup DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2270** Addition to lower extremity, varus/valgus correction ('T') strap, padded/lined or malleolus pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2275** Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2280** Addition to lower extremity, molded inner boot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2300** Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2310** Addition to lower extremity, abduction bar-straight DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2320** Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2330** Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2335** Addition to lower extremity, anterior swing band DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2340** Addition to lower extremity, pre-tibial shell, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2350** Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for 'PTB' 'AFO' orthoses) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2360** Addition to lower extremity, extended steel shank DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2370** Addition to lower extremity, Patten bottom DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2375** Addition to lower extremity, torsion control, ankle joint and half solid stirrup DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2380** Addition to lower extremity, torsion control, straight knee joint, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2385** Addition to lower extremity, straight knee joint, heavy duty, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2387** Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis (KAFO), each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2390** Addition to lower extremity, offset knee joint, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2395** Addition to lower extremity, offset knee joint, heavy duty, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2397** Addition to lower extremity orthosis, suspension sleeve DME A
BETOS: D1F Prosthetic/Orthotic devices

ORTHOTIC ADDITIONS TO KNEE JOINTS (L2405-L2492)

C **L2405** Addition to knee joint, drop lock, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2415** Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2425** Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2430** Addition to knee joint, ratchet lock for active and progressive knee extension, each joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2492** Addition to knee joint, lift loop for drop lock ring DME A
BETOS: D1F Prosthetic/Orthotic devices

ADDITIONS, WEIGHT-BEARING, LOWER EXTREMITIES (L2500-L2550)

C **L2500** Addition to lower extremity, thigh/weight bearing, gluteal/ ischial weight bearing, ring DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L2510** Addition to lower extremity, thigh/weight bearing, quadri- lateral brim, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2520** Addition to lower extremity, thigh/ weight bearing, quadri- lateral brim, custom fitted DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2525** Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2526** Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2530** Addition to lower extremity, thigh-weight bearing, lacer, non-molded DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2540** Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2550** Addition to lower extremity, thigh/weight bearing, high roll cuff DME A
BETOS: D1F Prosthetic/Orthotic devices

ADDITIONS, PELVIC AND/OR THORACIC CONTROL, LOWER EXTREMITIES (L2570-L2680)

C **L2570** Addition to lower extremity, pelvic control, hip joint, Clevis type two position joint, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2580** Addition to lower extremity, pelvic control, pelvic sling DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2600** Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2610** Addition to lower extremity, pelvic control, hip joint, Clevis type or thrust bearing, lock, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2620** Addition to lower extremity, pelvic control, hip joint, heavy duty, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2622** Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2624** Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2627** Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2628** Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2630** Addition to lower extremity, pelvic control, band and belt, unilateral DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2640** Addition to lower extremity, pelvic control, band and belt, bilateral DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2650** Addition to lower extremity, pelvic and thoracic control, gluteal pad, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2660** Addition to lower extremity, thoracic control, thoracic band DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2670** Addition to lower extremity, thoracic control, paraspinal uprights DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2680** Addition to lower extremity, thoracic control, lateral support uprights DME A
BETOS: D1F Prosthetic/Orthotic devices

OTHER LOWER EXTREMITY ADDITIONS (L2750-L2999)

C **L2750** Addition to lower extremity orthosis, plating chrome or nickel, per bar DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2755** Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2760** Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2768** Orthotic side bar disconnect device, per bar DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L2780** Addition to lower extremity orthosis, non-corrosive finish, per bar DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2785** Addition to lower extremity orthosis, drop lock retainer, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2795** Addition to lower extremity orthosis, knee control, full kneecap DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L2800** Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2810** Addition to lower extremity orthosis, knee control, condylar pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2820** Addition to lower extremity orthosis, soft interface for molded plastic, below knee section DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2830** Addition to lower extremity orthosis, soft interface for molded plastic, above knee section DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2840** Addition to lower extremity orthosis, tibial length sock, fracture or equal, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L2850** Addition to lower extremity orthosis, femoral length sock, fracture or equal, each DME A
BETOS: D1F Prosthetic/Orthotic devices

I ~~L2861~~ Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **L2999** Lower extremity orthoses, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

FOOT INSERTS, REMOVABLE (L3000-L3031)

D **L3000** Foot, insert, removable, molded to patient model, 'UCB' type, Berkeley Shell, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3001** Foot, insert, removable, molded to patient model, Spenco, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3002** Foot, insert, removable, molded to patient model, Plastazote or equal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3003** Foot, insert, removable, molded to patient model, silicone gel, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3010** Foot, insert, removable, molded to patient model, longitudinal arch support, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

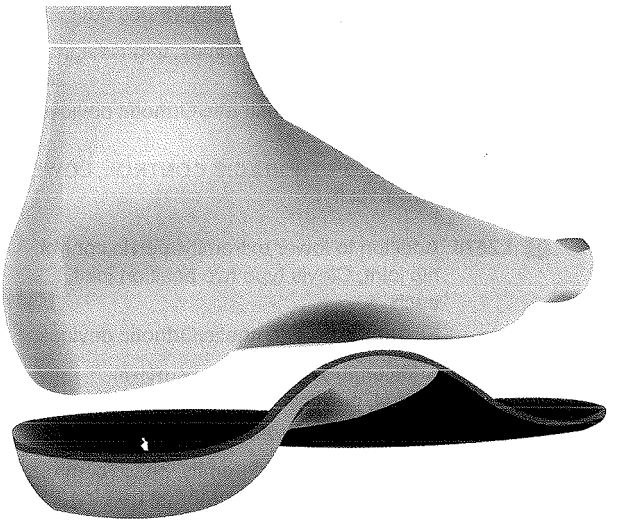
D **L3020** Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3030** Foot, insert, removable, formed to patient foot, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **L3031** Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

FOOT ARCH SUPPORTS (L3040-L3090)

D **L3040** Foot, arch support, removable, premolded, longitudinal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B



Arch support

D **L3050** Foot, arch support, removable, premolded, metatarsal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3060** Foot, arch support, removable, premolded, longitudinal/ metatarsal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3070** Foot, arch support, non-removable attached to shoe, longitudinal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3080** Foot, arch support, non-removable attached to shoe, metatarsal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

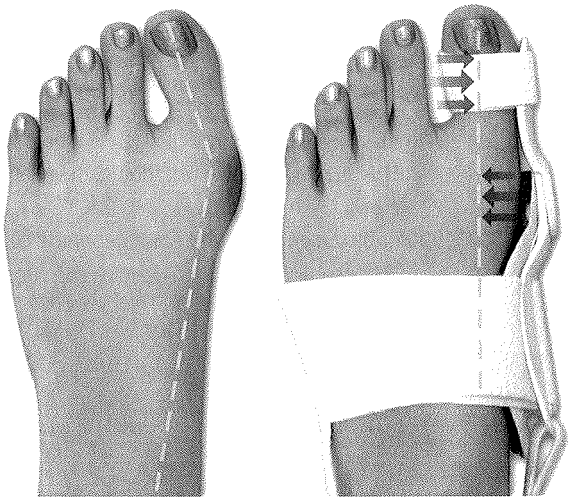
● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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D **L3090** Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

REPOSITIONING FOOT ORTHOTICS (L3100-L3170)

D **L3100** Hallux-valgus night dynamic splint, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B



Hallux valgus splint

D **L3140** Foot, abduction rotation bar, including shoes DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3150** Foot, abduction rotation bar, without shoes DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **L3160** Foot, adjustable shoe-styled positioning device A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **L3161** Foot, adductus positioning device, adjustable A
BETOS: Z2 Undefined codes

D **L3170** Foot, plastic, silicone or equal, heel stabilizer, prefabricated, off-the-shelf, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

ORTHOPEDIC SHOES (L3201-L3207)

D **L3201** Orthopedic shoe, Oxford with supinator or pronator, infant A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3202** Orthopedic shoe, Oxford with supinator or pronator, child Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3203** Orthopedic shoe, Oxford with supinator or pronator, junior A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3204** Orthopedic shoe, hightop with supinator or pronator, infant A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3206** Orthopedic shoe, hightop with supinator or pronator, child Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3207** Orthopedic shoe, hightop with supinator or pronator, junior A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

SURGICAL BOOTS (L3208-L3211)

D **L3208** Surgical boot, each, infant Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3209** Surgical boot, each, child Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3211** Surgical boot, each, junior A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

BENESCH BOOTS (L3212-L3214)

D **L3212** Benesch boot, pair, infant A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3213** Benesch boot, pair, child Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3214** Benesch boot, pair, junior A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

OTHER ORTHOPEDIC FOOTWEAR (L3215-L3265)

S **L3215** Orthopedic footwear, ladies shoe, Oxford, each ♀ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862A8

S **L3216** Orthopedic footwear, ladies shoe, depth inlay, each ♀ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862A8

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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S **L3217** Orthopedic footwear, ladies shoe, hightop, depth inlay, each ♀ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862A8

S **L3219** Orthopedic footwear, mens shoe, Oxford, each ♂ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862A8

S **L3221** Orthopedic footwear, mens shoe, depth inlay, each ♂ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862A8

S **L3222** Orthopedic footwear, mens shoe, hightop, depth inlay, each E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862A8

D **L3224** Orthopedic footwear, woman's shoe, Oxford, used as an integral part of a brace (orthosis) ♀ DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L3225** Orthopedic footwear, man's shoe, Oxford, used as an integral part of a brace (orthosis) ♂ DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L3230** Orthopedic footwear, custom shoe, depth inlay, each A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3250** Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3251** Foot, shoe molded to patient model, silicone shoe, each A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3252** Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3253** Foot, molded shoe Plastazote (or similar) custom fitted, each A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3254** Non-standard size or width A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3255** Non-standard size or length A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3257** Orthopedic footwear, additional charge for split size A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3260** Surgical boot/shoe, each E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **L3265** Plastazote sandal, each A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

SHOE LIFTS (L3300-L3334)

D **L3300** Lift, elevation, heel, tapered to metatarsals, per inch DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3310** Lift, elevation, heel and sole, neoprene, per inch DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

S **L3320** Lift, elevation, heel and sole, cork, per inch A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3330** Lift, elevation, metal extension (skate) DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3332** Lift, elevation, inside shoe, tapered, up to one-half inch DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3334** Lift, elevation, heel, per inch DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

SHOE WEDGES (L3340-L3420)

D **L3340** Heel wedge, SACH DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3350** Heel wedge DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3360** Sole wedge, outside sole DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3370** Sole wedge, between sole DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3380** Clubfoot wedge DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

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D **L3390** Outflare wedge DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3400** Metatarsal bar wedge, rocker DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3410** Metatarsal bar wedge, between sole DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3420** Full sole and heel wedge, between sole DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

SHOE HEELS (L3430-L3485)

D **L3430** Heel, counter, plastic reinforced DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3440** Heel, counter, leather reinforced DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3450** Heel, SACH cushion type DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3455** Heel, new leather, standard DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3460** Heel, new rubber, standard DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3465** Heel, Thomas with wedge DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3470** Heel, Thomas extended to ball DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3480** Heel, pad and depression for spur DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3485** Heel, pad, removable for spur A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

OTHER ORTHOPEDIC SHOE ADDITIONS (L3500-L3595)

D **L3500** Orthopedic shoe addition, insole, leather DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3510** Orthopedic shoe addition, insole, rubber DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3520** Orthopedic shoe addition, insole, felt covered with leather DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3530** Orthopedic shoe addition, sole, half DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3540** Orthopedic shoe addition, sole, full DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3550** Orthopedic shoe addition, toe tap standard DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3560** Orthopedic shoe addition, toe tap, horseshoe DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3570** Orthopedic shoe addition, special extension to instep (leather with eyelets) DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3580** Orthopedic shoe addition, convert instep to velcro closure DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3590** Orthopedic shoe addition, convert firm shoe counter to soft counter DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3595** Orthopedic shoe addition, March bar DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

ORTHOSIS TRANSFERS (L3600-L3649)

D **L3600** Transfer of an orthosis from one shoe to another, caliper plate, existing DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3610** Transfer of an orthosis from one shoe to another, caliper plate, new DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3620** Transfer of an orthosis from one shoe to another, solid stirrup, existing DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3630** Transfer of an orthosis from one shoe to another, solid stirrup, new DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **L3640** Transfer of an orthosis from one shoe to another, dennis browne splint (Riveton), both shoes DME A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L3649** Orthopedic shoe, modification, addition or transfer, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

SHOULDER ORTHOTICS (L3650-L3678)

C **L3650** Shoulder orthosis (SO), figure of eight design abduction restrainer, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3660** Shoulder orthosis (SO), figure of eight design abduction restrainer, canvas and webbing, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3670** Shoulder orthosis (SO), acromio/clavicular (canvas and webbing type), prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3671** Shoulder orthosis (SO), shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3674** Shoulder orthosis (SO), 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 DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3675** Shoulder orthosis (SO), vest type abduction restrainer, canvas webbing type or equal, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L3677** Shoulder orthosis (SO), shoulder joint design, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise A
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

C **L3678** Shoulder orthosis (SO), shoulder joint design, without joints, may include soft interface, straps, prefabricated, off-the-shelf A
BETOS: D1F Prosthetic/Orthotic devices

ELBOW ORTHOTICS (L3702-L3762)

C **L3702** Elbow orthosis (EO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3710** Elbow orthosis (EO), elastic with metal joints, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3720** Elbow orthosis (EO), double upright with forearm/arm cuffs, free motion, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3730** Elbow orthosis (EO), double upright with forearm/arm cuffs, extension/ flexion assist, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3740** Elbow orthosis (EO), double upright with forearm/arm cuffs, adjustable position lock with active control, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3760** Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3761** Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3762** Elbow orthosis (EO), rigid, without joints, includes soft interface material, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

ELBOW-WRIST-HAND-FINGER ORTHOTICS (L3763-L3766)

C **L3763** Elbow wrist hand orthosis (EWHO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3764** Elbow wrist hand orthosis (EWHO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3765** Elbow wrist hand finger orthosis (EWHFO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L3766** Elbow wrist hand finger orthosis (EWHFO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

WRIST-HAND-FINGER ORTHOTICS (L3806-L3904)

C **L3806** Wrist hand finger orthosis (WHFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3807** Wrist hand finger orthosis (WHFO), without joint(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3808** Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3809** Wrist hand finger orthosis (WHFO), without joint(s), prefabricated, off-the-shelf, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

I **L3891** Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **L3900** Wrist hand finger orthosis (WHFO), dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3901** Wrist hand finger orthosis (WHFO), dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3904** Wrist hand finger orthosis (WHFO), external powered, electric, custom-fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

WRIST-HAND ORTHOTICS (L3905-L3908)

C **L3905** Wrist hand orthosis (WHO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3906** Wrist hand orthosis (WHO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3908** Wrist hand orthosis (WHO), wrist extension control cock-up, non molded, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

ADDITIONAL MISCELLANEOUS ORTHOTICS, UPPER EXTREMITIES (L3912-L3956)

C **L3912** Hand finger orthosis (HFO), flexion glove with elastic finger control, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3913** Hand finger orthosis (HFO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3915** Wrist hand orthosis (WHO), includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3916** Wrist hand orthosis (WHO), includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3917** Hand orthosis (HO), metacarpal fracture orthosis, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3918** Hand orthosis (HO), metacarpal fracture orthosis, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3919** Hand orthosis (HO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3921** Hand finger orthosis (HFO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L3923** Hand finger orthosis (HFO), without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3924** Hand finger orthosis (HFO), without joints, may include soft interface, straps, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3925** Finger orthosis (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), non torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3927** Finger orthosis (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3929** Hand finger orthosis (HFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3930** Hand finger orthosis (HFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3931** Wrist hand finger orthosis (WHFO), includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3933** Finger orthosis (FO), without joints, may include soft interface, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3935** Finger orthosis (FO), nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3956** Addition of joint to upper extremity orthosis, any material; per joint DME A
BETOS: D1F Prosthetic/Orthotic devices

SHOULDER-ELBOW-WRIST-HAND ORTHOTICS (L3960-L3973)

C **L3960** Shoulder elbow wrist hand orthosis (SEWHO), abduction positioning, airplane design, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3961** Shoulder elbow wrist hand orthosis (SEWHO), shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3962** Shoulder elbow wrist hand orthosis (SEWHO), abduction positioning, erbs palsy design, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3967** Shoulder elbow wrist hand orthosis (SEWHO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3971** Shoulder elbow wrist hand orthosis (SEWHO), shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3973** Shoulder elbow wrist hand orthosis (SEWHO), abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

SHOULDER-ELBOW-WRIST-HAND-FINGER ORTHOTICS (L3975-L3978)

C **L3975** Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3976** Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L3977** Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3978** Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

FRACTURE, ADDITION, AND UNSPECIFIED ORTHOTICS, UPPER EXTREMITIES (L3980-L3999)

C **L3980** Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3981** Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3982** Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3984** Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3995** Addition to upper extremity orthosis, sock, fracture or equal, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L3999** Upper limb orthosis, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

ORTHOTIC REPLACEMENT PARTS OR REPAIR (L4000-L4210)

C **L4000** Replace girdle for spinal orthosis (Cervical-thoracic-lumbar-sacral orthosis (CTLSO) or Shoulder orthosis (SO)) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4002** Replacement strap, any orthosis, includes all components, any length, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4010** Replace trilateral socket brim DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4020** Replace quadrilateral socket brim, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4030** Replace quadrilateral socket brim, custom fitted DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4040** Replace molded thigh lacer, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4045** Replace non-molded thigh lacer, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4050** Replace molded calf lacer, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4055** Replace non-molded calf lacer, for custom fabricated orthosis only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4060** Replace high roll cuff DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4070** Replace proximal and distal upright for KAFO DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4080** Replace metal bands KAFO, proximal thigh DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4090** Replace metal bands KAFO-AFO, calf or distal thigh DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4100** Replace leather cuff KAFO, proximal thigh DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4110** Replace leather cuff KAFO-AFO, calf or distal thigh DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4130** Replace pretibial shell DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L4205** Repair of orthotic device, labor component, per 15 minutes A
BETOS: D1F Prosthetic/Orthotic devices

D **L4210** Repair of orthotic device, repair or replace minor parts A
BETOS: D1F Prosthetic/Orthotic devices

OTHER LOWER EXTREMITY ORTHOTICS (L4350-L4631)

C **L4350** Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4360** Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **L4361** Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4370** Pneumatic full leg splint, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4386** Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4387** Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4392** Replacement, soft interface material, static AFO DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4394** Replace soft interface material, foot drop splint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4396** Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4397** Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4398** Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L4631** Ankle foot orthosis (AFO), 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 DME A
BETOS: D1F Prosthetic/Orthotic devices

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PROSTHETIC PROCEDURES (L5000-L9900)

PARTIAL FOOT PROSTHETICS (L5000-L5020)

D **L5000** Partial foot, shoe insert with longitudinal arch, toe filler DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L5010** Partial foot, molded socket, ankle height, with toe filler DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L5020** Partial foot, molded socket, tibial tubercle height, with toe filler DME A
BETOS: D1F Prosthetic/Orthotic devices

ANKLE PROSTHETICS (L5050, L5060)

C **L5050** Ankle, Symes, molded socket, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5060** Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot DME A
BETOS: D1F Prosthetic/Orthotic devices

BELOW THE KNEE PROSTHETICS (L5100, L5105)

C **L5100** Below knee, molded socket, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5105** Below knee, plastic socket, joints and thigh lacer, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

KNEE DISARTICULATION PROSTHETICS (L5150, L5160)

C **L5150** Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5160** Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

ABOVE THE KNEE PROSTHETICS (L5200-L5230)

C **L5200** Above knee, molded socket, single axis constant friction knee, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5210** Above knee, short prosthesis, no knee joint ('stubbies'), with foot blocks, no ankle joints, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5220** Above knee, short prosthesis, no knee joint ('stubbies'), with articulated ankle/foot, dynamically aligned, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5230** Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

HIP DISARTICULATION PROSTHETICS (L5250, L5270)

C **L5250** Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5270** Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

ENDOSKELETAL PROSTHETICS, LOWER LIMBS (L5280-L5341)

C **L5280** Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5301** Below knee, molded socket, shin, SACH foot, endoskeletal system DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L5312** Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot, endoskeletal system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5321** Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L5331** Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L5341** Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

PROSTHETIC FITTING, IMMEDIATE POSTSURGICAL OR EARLY, LOWER LIMBS (L5400-L5460)

C **L5400** Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L5410** Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5420** Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change 'AK' or knee disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5430** Immediate post surgical or early fitting, application of initial rigid dressing, incl. fitting, alignment and suspension, 'AK' or knee disarticulation, each additional cast change and realignment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5450** Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, below knee DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5460** Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, above knee DME A
BETOS: D1F Prosthetic/Orthotic devices

SUPPLY, INITIAL PROSTHESIS (L5500-L5505)

C **L5500** Initial, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5505** Initial, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

SUPPLY, PREPARATORY PROSTHESIS (L5510-L5600)

C **L5510** Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5520** Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5530** Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5535** Preparatory, below knee 'PTB' type socket, non-alignable system, no cover, SACH foot, prefabricated, adjustable open end socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5540** Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5560** Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5570** Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5580** Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5585** Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5590** Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon no cover, SACH foot, laminated socket, molded to model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5595** Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5600** Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

ENDOSKELETAL PROSTHETIC ADDITIONS, LOWER EXTREMITIES (L5610-L5617)

C **L5610** Addition to lower extremity, endoskeletal system, above knee, hydracadence system DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L5611** Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with friction swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5613** Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5614** Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5615** Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5616** Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5617** Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

TEST SOCKET PROSTHETIC ADDITIONS, LOWER EXTREMITIES (L5618-L5628)

C **L5618** Addition to lower extremity, test socket, Symes DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5620** Addition to lower extremity, test socket, below knee DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5622** Addition to lower extremity, test socket, knee disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5624** Addition to lower extremity, test socket, above knee DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5626** Addition to lower extremity, test socket, hip disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5628** Addition to lower extremity, test socket, hemipelvectomy DME A
BETOS: D1F Prosthetic/Orthotic devices

VARIOUS PROSTHETIC SOCKETS (L5629-L5653)

C **L5629** Addition to lower extremity, below knee, acrylic socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5630** Addition to lower extremity, Symes type, expandable wall socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5631** Addition to lower extremity, above knee or knee disarticulation, acrylic socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5632** Addition to lower extremity, Symes type, 'PTB' brim design socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5634** Addition to lower extremity, Symes type, posterior opening (Canadian) socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5636** Addition to lower extremity, Symes type, medial opening socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5637** Addition to lower extremity, below knee, total contact DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5638** Addition to lower extremity, below knee, leather socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5639** Addition to lower extremity, below knee, wood socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5640** Addition to lower extremity, knee disarticulation, leather socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5642** Addition to lower extremity, above knee, leather socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5643** Addition to lower extremity, hip disarticulation, flexible inner socket, external frame DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5644** Addition to lower extremity, above knee, wood socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5645** Addition to lower extremity, below knee, flexible inner socket, external frame DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5646** Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5647** Addition to lower extremity, below knee suction socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5648** Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5649** Addition to lower extremity, ischial containment/narrow M-L socket DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L5650** Additions to lower extremity, total contact, above knee or knee disarticulation socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5651** Addition to lower extremity, above knee, flexible inner socket, external frame DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5652** Addition to lower extremity, suction suspension, above knee or knee disarticulation socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5653** Addition to lower extremity, knee disarticulation, expandable wall socket DME A
BETOS: D1F Prosthetic/Orthotic devices

SOCKET INSERT, SUSPENSIONS, AND OTHER PROSTHETIC ADDITIONS (L5654-L5699)

C **L5654** Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5655** Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5656** Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5658** Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5661** Addition to lower extremity, socket insert, multi-durometer Symes DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5665** Addition to lower extremity, socket insert, multi-durometer, below knee DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5666** Addition to lower extremity, below knee, cuff suspension DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5668** Addition to lower extremity, below knee, molded distal cushion DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5670** Addition to lower extremity, below knee, molded supracondylar suspension ('PTS' or similar) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5671** Addition to lower extremity, below knee / above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L5672** Addition to lower extremity, below knee, removable medial brim suspension DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5673** Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5676** Additions to lower extremity, below knee, knee joints, single axis, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5677** Additions to lower extremity, below knee, knee joints, polycentric, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5678** Additions to lower extremity, below knee, joint covers, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5679** Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5680** Addition to lower extremity, below knee, thigh lacer, nonmolded DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5681** Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5682** Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5683** Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5684** Addition to lower extremity, below knee, fork strap DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5685** Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L5686** Addition to lower extremity, below knee, back check (extension control) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5688** Addition to lower extremity, below knee, waist belt, webbing DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5690** Addition to lower extremity, below knee, waist belt, padded and lined DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5692** Addition to lower extremity, above knee, pelvic control belt, light DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5694** Addition to lower extremity, above knee, pelvic control belt, padded and lined DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5695** Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5696** Addition to lower extremity, above knee or knee disarticulation, pelvic joint DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5697** Addition to lower extremity, above knee or knee disarticulation, pelvic band DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5698** Addition to lower extremity, above knee or knee disarticulation, Silesian bandage DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5699** All lower extremity prostheses, shoulder harness DME A
BETOS: D1F Prosthetic/Orthotic devices

REPLACEMENT SOCKETS (L5700-L5703)

C **L5700** Replacement, socket, below knee, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5701** Replacement, socket, above knee/ knee disarticulation, including attachment plate, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5702** Replacement, socket, hip disarticulation, including hip joint, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5703** Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

CUSTOM-SHAPED PROTECTIVE COVERS (L5704-L5707)

C **L5704** Custom shaped protective cover, below knee DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5705** Custom shaped protective cover, above knee DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5706** Custom shaped protective cover, knee disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5707** Custom shaped protective cover, hip disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

EXOSKELETAL KNEE-SHIN SYSTEM ADDITIONS (L5710-L5780)

C **L5710** Addition, exoskeletal knee-shin system, single axis, manual lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5711** Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5712** Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5714** Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5716** Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5718** Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5722** Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5724** Addition, exoskeletal knee-shin system, single axis, fluid swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5726** Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5728** Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5780** Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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VACUUM PUMPS, LOWER LIMB PROSTHETIC ADDITIONS (L5781-L5783)

C **L5781** Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5782** Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty DME A
BETOS: D1F Prosthetic/Orthotic devices

● C **L5783** Addition to lower extremity, user adjustable, mechanical, residual limb volume management system DME A
BETOS: D1F Prosthetic/Orthotic devices

OTHER EXOSKELETAL ADDITIONS (L5785-L5795)

C **L5785** Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5790** Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5795** Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

ENDOSKELETAL KNEE OR HIP SYSTEM ADDITIONS (L5810-L5966)

C **L5810** Addition, endoskeletal knee-shin system, single axis, manual lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5811** Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5812** Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5814** Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5816** Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5818** Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5822** Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5824** Addition, endoskeletal knee-shin system, single axis, fluid swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5826** Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5828** Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5830** Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5840** Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

● C **L5841** Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5845** Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5848** Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5850** Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5855** Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5856** Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5857** Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L5858** Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5859** Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s) DME A
BETOS: D1F Prosthetic/Orthotic devices



Leg prosthesis

C **L5910** Addition, endoskeletal system, below knee, alignable system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5920** Addition, endoskeletal system, above knee or hip disarticulation, alignable system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5925** Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5926** Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5930** Addition, endoskeletal system, high activity knee control frame DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5940** Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5950** Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5960** Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5961** Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5962** Addition, endoskeletal system, below knee, flexible protective outer surface covering system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5964** Addition, endoskeletal system, above knee, flexible protective outer surface covering system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5966** Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system DME A
BETOS: D1F Prosthetic/Orthotic devices

ANKLE AND/OR FOOT PROSTHETICS AND ADDITIONS (L5968-L5999)

C **L5968** Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5969** Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s) A
BETOS: D1F Prosthetic/Orthotic devices

C **L5970** All lower extremity prostheses, foot, external keel, solid ankle cushion heel (SACH) foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5971** All lower extremity prosthesis, solid ankle cushion heel (SACH) foot, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5972** All lower extremity prostheses, foot, flexible keel DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5973** Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L5974** All lower extremity prostheses, foot, single axis ankle/foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5975** All lower extremity prosthesis, combination single axis ankle and flexible keel foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5976** All lower extremity prostheses, energy storing foot (seattle carbon copy II or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5978** All lower extremity prostheses, foot, multiaxial ankle/foot DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5979** All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5980** All lower extremity prostheses, flex foot system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5981** All lower extremity prostheses, flex-walk system or equal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5982** All exoskeletal lower extremity prostheses, axial rotation unit DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5984** All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5985** All endoskeletal lower extremity prostheses, dynamic prosthetic pylon DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5986** All lower extremity prostheses, multi-axial rotation unit ('MCP' or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5987** All lower extremity prosthesis, shank foot system with vertical loading pylon DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5988** Addition to lower limb prosthesis, vertical shock reducing pylon feature DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L5990** Addition to lower extremity prosthesis, user adjustable heel height DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L5991** Addition to lower extremity prostheses, osseointegrated external prosthetic connector DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2023, Q4

C **L5999** Lower extremity prosthesis, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

PARTIAL HAND PROSTHETICS (L6000-L6026)

C **L6000** Partial hand, thumb remaining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6010** Partial hand, little and/or ring finger remaining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6020** Partial hand, no finger remaining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6026** Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s) DME A
BETOS: D1F Prosthetic/Orthotic devices

WRIST DISARTICULATION, HAND PROSTHETICS (L6050-L6055)

C **L6050** Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6055** Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad DME A
BETOS: D1F Prosthetic/Orthotic devices

BELOW ELBOW, FOREARM AND HAND PROSTHETICS (L6100-L6130)

C **L6100** Below elbow, molded socket, flexible elbow hinge, triceps pad DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6110** Below elbow, molded socket, (Muenster or Northwestern suspension types) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6120** Below elbow, molded double wall split socket, step-up hinges, half cuff DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6130** Below elbow, molded double wall split socket, stump activated locking hinge, half cuff DME A
BETOS: D1F Prosthetic/Orthotic devices

ELBOW DISARTICULATION, FOREARM AND HAND PROSTHETICS (L6200-L6205)

C **L6200** Elbow disarticulation, molded socket, outside locking hinge, forearm DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6205** Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm DME A
BETOS: D1F Prosthetic/Orthotic devices

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ABOVE ELBOW, FOREARM AND HAND PROSTHETICS (L6250)

C **L6250** Above elbow, molded double wall socket, internal locking elbow, forearm DME A
BETOS: D1F Prosthetic/Orthotic devices

SHOULDER DISARTICULATION, ARM AND HAND PROSTHETICS (L6300-L6320)

C **L6300** Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6310** Shoulder disarticulation, passive restoration (complete prosthesis) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6320** Shoulder disarticulation, passive restoration (shoulder cap only) DME A
BETOS: D1F Prosthetic/Orthotic devices

INTERSCAPULAR THORACIC, ARM, AND HAND PROSTHETICS (L6350-L6370)

C **L6350** Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6360** Interscapular thoracic, passive restoration (complete prosthesis) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6370** Interscapular thoracic, passive restoration (shoulder cap only) DME A
BETOS: D1F Prosthetic/Orthotic devices

PROSTHETIC FITTING, IMMEDIATE POSTSURGICAL OR EARLY, UPPER LIMBS (L6380-L6388)

C **L6380** Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6382** Immediate post surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6384** Immediate post surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6386** Immediate post surgical or early fitting, each additional cast change and realignment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6388** Immediate post surgical or early fitting, application of rigid dressing only DME A
BETOS: D1F Prosthetic/Orthotic devices

MOLDED SOCKET ENDOSKELETAL PROSTHETIC SYSTEM, UPPER LIMBS (L6400-L6570)

C **L6400** Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6450** Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6500** Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6550** Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6570** Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping DME A
BETOS: D1F Prosthetic/Orthotic devices

PREPARATORY PROSTHETIC, UPPER LIMBS (L6580-L6590)

C **L6580** Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6582** Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6584** Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6586** Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **L6588** Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6590** Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed DME A
BETOS: D1F Prosthetic/Orthotic devices

UPPER EXTREMITY PROSTHETIC ADDITIONS (L6600-L6698)

C **L6600** Upper extremity additions, polycentric hinge, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6605** Upper extremity additions, single pivot hinge, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6610** Upper extremity additions, flexible metal hinge, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6611** Addition to upper extremity prosthesis, external powered, additional switch, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6615** Upper extremity addition, disconnect locking wrist unit DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6616** Upper extremity addition, additional disconnect insert for locking wrist unit, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6620** Upper extremity addition, flexion/extension wrist unit, with or without friction DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6621** Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6623** Upper extremity addition, spring assisted rotational wrist unit with latch release DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6624** Upper extremity addition, flexion/extension and rotation wrist unit DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6625** Upper extremity addition, rotation wrist unit with cable lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6628** Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6629** Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6630** Upper extremity addition, stainless steel, any wrist DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6632** Upper extremity addition, latex suspension sleeve, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6635** Upper extremity addition, lift assist for elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6637** Upper extremity addition, nudge control elbow lock DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6638** Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6640** Upper extremity additions, shoulder abduction joint, pair DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6641** Upper extremity addition, excursion amplifier, pulley type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6642** Upper extremity addition, excursion amplifier, lever type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6645** Upper extremity addition, shoulder flexion-abduction joint, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6646** Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6647** Upper extremity addition, shoulder lock mechanism, body powered actuator DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6648** Upper extremity addition, shoulder lock mechanism, external powered actuator DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6650** Upper extremity addition, shoulder universal joint, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6655** Upper extremity addition, standard control cable, extra DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6660** Upper extremity addition, heavy duty control cable DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L6665** Upper extremity addition, Teflon, or equal, cable lining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6670** Upper extremity addition, hook to hand, cable adapter DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6672** Upper extremity addition, harness, chest or shoulder, saddle type DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6675** Upper extremity addition, harness, (e.g., figure of eight type), single cable design DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6676** Upper extremity addition, harness, (e.g., figure of eight type), dual cable design DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6677** Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6680** Upper extremity addition, test socket, wrist disarticulation or below elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6682** Upper extremity addition, test socket, elbow disarticulation or above elbow DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6684** Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6686** Upper extremity addition, suction socket DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6687** Upper extremity addition, frame type socket, below elbow or wrist disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6688** Upper extremity addition, frame type socket, above elbow or elbow disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6689** Upper extremity addition, frame type socket, shoulder disarticulation DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6690** Upper extremity addition, frame type socket, interscapular-thoracic DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6691** Upper extremity addition, removable insert, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6692** Upper extremity addition, silicone gel insert or equal, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6693** Upper extremity addition, locking elbow, forearm counterbalance DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6694** Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6695** Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6696** Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6697** Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6698** Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert DME A
BETOS: D1F Prosthetic/Orthotic devices

TERMINAL DEVICES AND ADDITIONS (L6703-L6882)

C **L6703** Terminal device, passive hand/mitt, any material, any size DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6704** Terminal device, sport/recreational/work attachment, any material, any size DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6706** Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6707** Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6708** Terminal device, hand, mechanical, voluntary opening, any material, any size DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **L6709** Terminal device, hand, mechanical, voluntary closing, any material, any size DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6711** Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

C **L6712** Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

C **L6713** Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

C **L6714** Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

C **L6715** Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6721** Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

C **L6722** Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2008, Q4

D **L6805** Addition to terminal device, modifier wrist unit DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L6810** Addition to terminal device, precision pinch device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6880** Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6881** Automatic grasp feature, addition to upper limb electric prosthetic terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

D **L6882** Microprocessor control feature, addition to upper limb prosthetic terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

REPLACEMENT SOCKETS, UPPER LIMBS (L6883-L6885)

C **L6883** Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6884** Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6885** Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power DME A
BETOS: D1F Prosthetic/Orthotic devices

HAND RESTORATION PROSTHETICS AND ADDITIONS (L6890-L6915)

C **L6890** Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6895** Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6900** Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6905** Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6910** Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6915** Hand restoration (shading, and measurements included), replacement glove for above DME A
BETOS: D1F Prosthetic/Orthotic devices

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EXTERNAL POWER UPPER LIMB PROSTHETICS (L6920-L6975)

C **L6920** Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6925** Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6930** Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6935** Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6940** Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6945** Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6950** Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6955** Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6960** Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6965** Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6970** Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L6975** Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

ELECTRIC HAND OR HOOK AND ADDITIONS (L7007-L7045)

C **L7007** Electric hand, switch or myoelectric controlled, adult DME Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

C **L7008** Electric hand, switch or myoelectric, controlled, pediatric DME Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

C **L7009** Electric hook, switch or myoelectric controlled, adult DME Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

C **L7040** Prehensile actuator, switch controlled DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7045** Electric hook, switch or myoelectric controlled, pediatric DME Ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

ELECTRONIC ELBOW AND ADDITIONS (L7170-L7259)

C **L7170** Electronic elbow, Hosmer or equal, switch controlled DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **L7180** Electronic elbow, microprocessor sequential control of elbow and terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7181** Electronic elbow, microprocessor simultaneous control of elbow and terminal device DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7185** Electronic elbow, adolescent, Variety Village or equal, switch controlled DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7186** Electronic elbow, child, Variety Village or equal, switch controlled DME ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

C **L7190** Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7191** Electronic elbow, child, Variety Village or equal, myoelectronically controlled DME ⓐ A
BETOS: D1F Prosthetic/Orthotic devices

C **L7259** Electronic wrist rotator, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

BATTERIES AND ACCESSORIES (L7360-L7368)

C **L7360** Six volt battery, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7362** Battery charger, six volt, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7364** Twelve volt battery, each DME A
BETOS: D1F Prosthetic/Orthotic devices

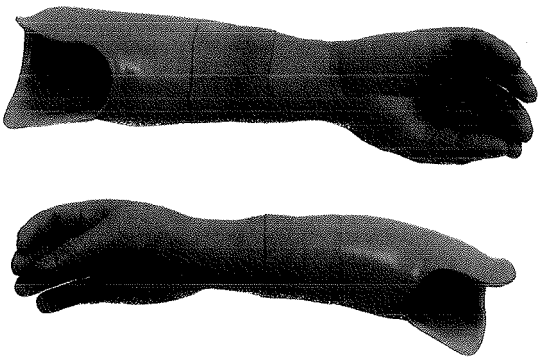
C **L7366** Battery charger, twelve volt, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7367** Lithium ion battery, rechargeable, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7368** Lithium ion battery charger, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

ADDITIONS FOR UPPER EXTREMITY PROSTHETICS (L7400-L7405)

C **L7400** Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultralight material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices



Arm prosthesis

C **L7401** Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7402** Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7403** Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7404** Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L7405** Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material DME A
BETOS: D1F Prosthetic/Orthotic devices

UPPER EXTREMITY PROSTHETICS, NOT OTHERWISE SPECIFIED (NOS) (L7499)

C **L7499** Upper extremity prosthesis, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

PROSTHETIC REPAIR (L7510, L7520)

D **L7510** Repair of prosthetic device, repair or replace minor parts A
BETOS: D1F Prosthetic/Orthotic devices

C **L7520** Repair prosthetic device, labor component, per 15 minutes A
BETOS: D1F Prosthetic/Orthotic devices

PROSTHETIC DONNING SLEEVE (L7600)

S **L7600** Prosthetic donning sleeve, any material, each E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862(1)(a)

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GASKET OR SEAL WITH PROSTHETIC (L7700)

C **L7700** Gasket or seal, for use with prosthetic socket insert, any type, each DME A
BETOS: D1F Prosthetic/Orthotic devices

PENILE PROSTHETICS (L7900, L7902)

S **L7900** Male vacuum erection system ♂ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1834a

S **L7902** Tension ring, for vacuum erection device, any type, replacement only, each ♂ E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1834a

BREAST PROSTHETICS AND ACCESSORIES (L8000-L8039), SEE ALSO PROSTHETIC BREAST IMPLANT (L8600)

D **L8000** Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8001** Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

D **L8002** Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

D **L8010** Breast prosthesis, mastectomy sleeve A
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L8015** External breast prosthesis garment, with mastectomy form, post mastectomy DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8020** Breast prosthesis, mastectomy form DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8030** Breast prosthesis, silicone or equal, without integral adhesive DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8031** Breast prosthesis, silicone or equal, with integral adhesive DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8032** Nipple prosthesis, prefabricated, reusable, any type, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8033** Nipple prosthesis, custom fabricated, reusable, any material, any type, each A
BETOS: D1F Prosthetic/Orthotic devices

D **L8035** Custom breast prosthesis, post mastectomy, molded to patient model DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8039** Breast prosthesis, not otherwise specified A
BETOS: D1F Prosthetic/Orthotic devices

FACIAL AND EXTERNAL EAR PROSTHETICS (L8040-L8049)

C **L8040** Nasal prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8041** Midfacial prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8042** Orbital prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8043** Upper facial prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8044** Hemi-facial prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8045** Auricular prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8046** Partial facial prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8047** Nasal septal prosthesis, provided by a non-physician DME A
BETOS: D1F Prosthetic/Orthotic devices
DME Modifier: KM, KN

C **L8048** Unspecified maxillofacial prosthesis, by report, provided by a non-physician A
BETOS: D1F Prosthetic/Orthotic devices

C **L8049** Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a non-physician A
BETOS: D1F Prosthetic/Orthotic devices

HERNIA TRUSSES (L8300-L8330)

D **L8300** Truss, single with standard pad DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8310** Truss, double with standard pads DME A
BETOS: D1F Prosthetic/Orthotic devices

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D **L8320** Truss, addition to standard pad, water pad DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8330** Truss, addition to standard pad, scrotal pad ♂ DME A
BETOS: D1F Prosthetic/Orthotic devices

PROSTHETIC SHEATHS, SOCKS, AND SHRINKERS (L8400-L8485)

D **L8400** Prosthetic sheath, below knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8410** Prosthetic sheath, above knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8415** Prosthetic sheath, upper limb, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8417** Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8420** Prosthetic sock, multiple ply, below knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8430** Prosthetic sock, multiple ply, above knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8435** Prosthetic sock, multiple ply, upper limb, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8440** Prosthetic shrinker, below knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8460** Prosthetic shrinker, above knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8465** Prosthetic shrinker, upper limb, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8470** Prosthetic sock, single ply, fitting, below knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8480** Prosthetic sock, single ply, fitting, above knee, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8485** Prosthetic sock, single ply, fitting, upper limb, each DME A
BETOS: D1F Prosthetic/Orthotic devices

UNLISTED PROSTHETIC PROCEDURES (L8499)

C **L8499** Unlisted procedure for miscellaneous prosthetic services A
BETOS: D1F Prosthetic/Orthotic devices

VOICE PROSTHETICS AND ACCESSORIES (L8500-L8515)

D **L8500** Artificial larynx, any type DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8501** Tracheostomy speaking valve DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8505** Artificial larynx replacement battery / accessory, any type A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L8507** Tracheo-esophageal voice prosthesis, patient inserted, any type, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L8509** Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

D **L8510** Voice amplifier DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2002, Q1

C **L8511** Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8512** Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10 DME A
BETOS: D1F Prosthetic/Orthotic devices

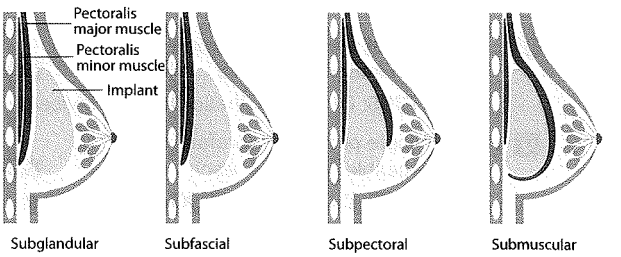
C **L8513** Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8514** Tracheoesophageal puncture dilator, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8515** Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each DME A
BETOS: D1F Prosthetic/Orthotic devices

PROSTHETIC BREAST IMPLANT (L8600), SEE ALSO BREAST PROSTHETICS AND ACCESSORIES (L8000-L8039)

D **L8600** Implantable breast prosthesis, silicone or equal N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices



Breast prosthesis augmentation

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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BULKING AGENTS (L8603-L8607)

D L8603 Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

C L8604 Injectable bulking agent, dextranomer/ hyaluronic acid copolymer implant, urinary tract, 1 ml, includes shipping and necessary supplies N1 ASC N
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Coding Clinic: 2008, Q4

C L8605 Injectable bulking agent, dextranomer/ hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D L8606 Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D L8607 Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

IMPLANTABLE EYE AND EAR PROSTHETICS AND ACCESSORIES (L8608-L8629)

C L8608 Miscellaneous external component, supply or accessory for use with the argus ii retinal prosthesis system N1 ASC N
BETOS: D1F Prosthetic/Orthotic devices

C L8609 Artificial cornea N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D L8610 Ocular implant N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D L8612 Aqueous shunt N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D L8613 Ossicula implant N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D L8614 Cochlear device, includes all internal and external components N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2001, Q1; 2002, Q3; 2003, Q4; 2016, Q3

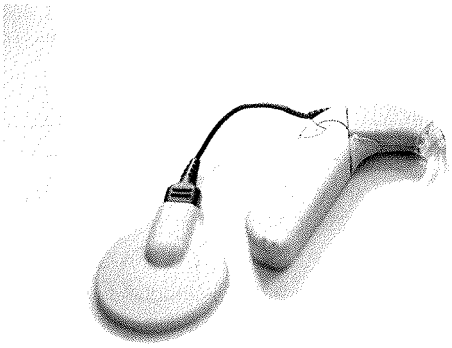
D L8615 Headset/headpiece for use with cochlear implant device, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8616 Microphone for use with cochlear implant device, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8617 Transmitting coil for use with cochlear implant device, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8618 Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8619 Cochlear implant, external speech processor and controller, integrated system, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices



Cochlear device

C L8621 Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C L8622 Alkaline battery for use with cochlear implant device, any size, replacement, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C L8623 Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each DME A
BETOS: D1F Prosthetic/Orthotic devices

C L8624 Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8625 External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8627 Cochlear implant, external speech processor, component, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

D L8628 Cochlear implant, external controller component, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **L8629** Transmitting coil and cable, integrated, for use with cochlear implant device, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

IMPLANTABLE HAND AND FEET PROSTHETICS (L8630-L8659)

D **L8630** Metacarpophalangeal joint implant N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **L8631** Metacarpal phalangeal joint replacement, two or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system) N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **L8641** Metatarsal joint implant N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **L8642** Hallux implant N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **L8658** Interphalangeal joint spacer, silicone or equal, each N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **L8659** Interphalangeal finger joint replacement, 2 or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon) for surgical implantation, any size N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

VASCULAR IMPLANTS (L8670)

D **L8670** Vascular graft material, synthetic, implant N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

IMPLANTABLE NEUROSTIMULATORS AND COMPONENTS (L8678-L8689)

C **L8678** Electrical stimulator supplies (external) for use with implantable neurostimulator, per month N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2023, Q2

D **L8679** Implantable neurostimulator, pulse generator, any type N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

I **L8680** Implantable neurostimulator electrode, each E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L8681** Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8682** Implantable neurostimulator radiofrequency receiver N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **L8683** Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8684** Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement DME A
BETOS: D1F Prosthetic/Orthotic devices

I **L8685** Implantable neurostimulator pulse generator, single array, rechargeable, includes extension E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

I **L8686** Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

I **L8687** Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

I **L8688** Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **L8689** External recharging system for battery (internal) for use with implantable neurostimulator, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

MISCELLANEOUS ORTHOTIC AND PROSTHETIC SERVICES AND SUPPLIES (L8690-L9900)

C **L8690** Auditory osseointegrated device, includes all internal and external components N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2007, Q1; 2016, Q3

C **L8691** Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

S **L8692** Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B
Statute: 1862(a)(7)

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C **L8693** Auditory osseointegrated device abutment, any length, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8694** Auditory osseointegrated device, transducer/actuator, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8695** External recharging system for battery (external) for use with implantable neurostimulator, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8696** Antenna (external) for use with implantable diaphragmatic/phrenic nerve stimulation device, replacement, each DME A
BETOS: D1F Prosthetic/Orthotic devices

D **L8698** Miscellaneous component, supply or accessory for use with total artificial heart system A
BETOS: D1F Prosthetic/Orthotic devices

C **L8699** Prosthetic implant, not otherwise specified N1 ASC N
BETOS: D1F Prosthetic/Orthotic devices

C **L8701** Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

C **L8702** Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated DME A
BETOS: D1F Prosthetic/Orthotic devices

● ▲ C **L8720*** External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg
BETOS: D1F Prosthetic/Orthotic devices

● C **L8721** Receptor sole for use with L8720, replacement, each
BETOS: D1F Prosthetic/Orthotic devices

C **L9900** Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "L" code N1 ASC N
BETOS: D1F Prosthetic/Orthotic devices

* Code L8720 was added by CMS mid-year and revised in the January 2025 code set release. The official descriptor shown here is the most recent revised descriptor.

♂ Male only ♀ Female only Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
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NOTES

MEDICAL SERVICES (M0001-M1425)

MIPS VALUE PATHWAYS (M0001-M0005)

C **M0001** Advancing cancer care mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M0002** Optimal care for kidney health mips value pathways M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M0004** Quality care for patients with neurological conditions mips value pathway M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M0005** Value in primary care mips value pathway M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

EOM (ENHANCING ONCOLOGY MODEL) ENHANCED SERVICES (M0010)

C **M0010** Enhancing oncology model (eom) monthly enhanced oncology services (meos) payment for eom enhanced services M
BETOS: P7B Oncology - other
Price established by carriers
Coding Clinic: 2023, Q2

MISCELLANEOUS MEDICAL SERVICES (M0075-M0301)

M **M0075** Cellular therapy E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

M **M0076** Prolotherapy E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

M **M0100** Intragastric hypothermia using gastric freezing E1
BETOS: P1G Major procedure - other
Service not separately priced by Part B

C **M0201** Administration of pneumococcal, influenza, hepatitis b, and/or covid-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3

C **M0220** Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring Ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2022, Q2

C **M0221** Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency Ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2022, Q2

C **M0222** Intravenous injection, bebtelovimab, includes injection and post administration monitoring Ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2022, Q2

C **M0223** Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency Ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2022, Q2

● C **M0224** Intravenous infusion, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known sars-cov-2 exposure, who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, includes infusion and post administration monitoring Ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2024, Q3

C **M0240** Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses Ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3; 2021, Q4

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C **M0241** Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3; 2021, Q4

C **M0243** Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2020, Q4; 2021, Q1; 2022, Q2

C **M0244** Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3

C **M0245** Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q1

C **M0246** Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider based to the hospital during the covid 19 public health emergency ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3

C **M0247** Intravenous infusion, sotrovimab, includes infusion and post administration monitoring ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3

C **M0248** Intravenous infusion, sotrovimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3

C **M0249** Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q4

C **M0250** Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose ⓐ S
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q4

M **M0300** IV chelation therapy (chemical endarterectomy) E1
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

M **M0301** Fabric wrapping of abdominal aneurysm E1
BETOS: P1G Major procedure - other
Service not separately priced by Part B
Coding Clinic: 2009, Q2

TB SCREENING (M1003-M1005)

C **M1003** Tb screening performed and results interpreted within twelve months prior to initiation of first-time biologic and/or immune response modifier therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1004** Documentation of medical reason for not screening for tb or interpreting results (i.e., patient positive for tb and documentation of past treatment; patient who has recently completed a course of anti-tb therapy) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1005** Tb screening not performed or results not interpreted, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

EVALUATION AND ASSESSMENT (M1006-M1014)

C **M1006** Disease activity not assessed, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1007** >=50% of total number of a patient's outpatient ra encounters assessed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1008** <50% of total number of a patient's outpatient ra encounters assessed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1009*** Discharge/discontinuation of the episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1010*** Discharge/discontinuation of the episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1011*** Discharge/discontinuation of the episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1012*** Discharge/discontinuation of the episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1013*** Discharge/discontinuation of the episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1014*** Discharge/discontinuation of the episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PATIENT STATUS (M1016-M1018)

C **M1016** Female patients unable to bear children ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1018** Patients with an active diagnosis or history of cancer (except basal cell and squamous cell skin carcinoma), patients who are heavy tobacco smokers, lung cancer screening patients M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ADOLESCENT DEPRESSION, REMISSION AND MANAGEMENT (M1019-M1021)

C **M1019** Adolescent patients 12 to 17 years of age with major depression or dysthymia who reached remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5 Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1020** Adolescent patients 12 to 17 years of age with major depression or dysthymia who did not reach remission at twelve months as demonstrated by a twelve month (+/-60 days) phq-9 or phq-9m score of less than 5. either phq-9 or phq-9m score was not assessed or is greater than or equal to 5 Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1021** Patient had only urgent care visits during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HEAD IMAGING (M1027-M1029)

C **M1027** Imaging of the head (ct or mri) was obtained M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1028** Documentation of patients with primary headache diagnosis and imaging other than ct or mri obtained M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1029** Imaging of the head (ct or mri) was not obtained, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PHARMACOTHERAPY FOR OUD (M1032-M1036)

C **M1032** Adults currently taking pharmacotherapy for oud Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1034** Adults who have at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1035** Adults who are deliberately phased out of medication assisted treatment (mat) prior to 180 days of continuous treatment Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

*This code has the same descriptor as another code. At press time, CMS did not provide any further explanation.

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C **M1036** Adults who have not had at least 180 days of continuous pharmacotherapy with a medication prescribed for oud without a gap of more than seven days M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

LUMBAR SPINE ASSOCIATED CONDITIONS (M1037-M1041)

C **M1037** Patients with a diagnosis of lumbar spine region cancer at the time of the procedure M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1038** Patients with a diagnosis of lumbar spine region fracture at the time of the procedure M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1039** Patients with a diagnosis of lumbar spine region infection at the time of the procedure M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1040** Patients with a diagnosis of lumbar idiopathic or congenital scoliosis M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1041** Patient had cancer, acute fracture or infection related to the lumbar spine or patient had neuromuscular, idiopathic or congenital lumbar scoliosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

FUNCTIONAL STATUS MEASUREMENT (M1043-M1049)

C **M1043** Functional status was not measured by the oswestry disability index (odi version 2.1a) at one year (9 to 15 months) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1045** Functional status measured by the oxford knee score (oks) at one year (9 to 15 months) postoperatively was greater than or equal to 37 or knee injury and osteoarthritis outcome score joint replacement (koos, jr.) was greater than or equal to 71 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1046** Functional status measured by the oxford knee score (oks) at one year (9 to 15 months) postoperatively was less than 37 or the knee injury and osteoarthritis outcome score joint replacement (koos, jr.) was less than 7 postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1049** Functional status was not measured by the oswestry disability index (odi version 2.1a) at three months (6 - 20 weeks) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

LUMBAR SPINE CONDITIONS (M1051)

C **M1051** Patient had cancer, acute fracture or infection related to the lumbar spine or patient had neuromuscular, idiopathic or congenital lumbar scoliosis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

LIMB PAIN ASSESSMENT (M1052)

C **M1052** Leg pain was not measured by the visual analog scale (vas) or numeric pain scale at one year (9 to 15 months) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

URGENT CARE VISIT (M1054)

C **M1054** Patient had only urgent care visits during the performance period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ANTICOAGULATION MANAGEMENT (M1055-M1057)

C **M1055** Aspirin or another antiplatelet therapy used M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1056** Prescribed anticoagulant medication during the performance period, history of gi bleeding, history of intracranial bleeding, bleeding disorder and specific provider documented reasons: allergy to aspirin or anti-platelets, use of non-steroidal anti-inflammatory agents, drug-drug interaction, uncontrolled hypertension > 180/110 mmhg or gastroesophageal reflux disease M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1057** Aspirin or another antiplatelet therapy not used, reason not given M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PERFORMANCE ASSESSMENT (M1058-M1060)

C **M1058** Patient was a permanent nursing home resident at any time during the performance period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1059** Patient was in hospice or receiving palliative care at any time during the performance period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1060** Patient died prior to the end of the performance period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOSPICE SERVICES (M1067)

C **M1067** Hospice services for patient provided any time during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MOBILITY STATUS (M1068)

C **M1068** Adults who are not ambulatory Ⓐ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

FALL RISK ASSESSMENT (M1069-M1070)

C **M1069** Patient screened for future fall risk M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1070** Patient not screened for future fall risk, reason not given M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

EPISODE OF CARE (M1106-M1143)

C **M1106** The start of an episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1107** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1108** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1109** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1110** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1111** The start of an episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1112** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1113** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1114** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1115** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1116** The start of an episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1117** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1118** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1119** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1120** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1121** The start of an episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1122** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1123** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1124** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1125** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1126** The start of an episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1127** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1128** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1129** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1130** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1131** Documentation stating patient has a diagnosis of a degenerative neurological condition such as als, ms, or parkinson's diagnosed at any time before or during the episode of care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1132** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1133** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1134** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1135** The start of an episode of care documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1141** Functional status was not measured by the oxford knee score (oks) or the knee injury and osteoarthritis outcome score joint replacement (koos, jr.) at one year (9 to 15 months) postoperatively M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1142** Emergent cases M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1143** Initiated episode of rehabilitation therapy, medical, or chiropractic care for neck impairment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

OTHER SERVICES (M1146-M1425)

C **M1146** Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1147** Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1148** Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1149** Patient unable to complete the neck fs prom at initial evaluation and/or discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility, and an adequate proxy is not available M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1150** Current or prior left ventricular ejection fraction (lvef) less than or equal to 40% or documentation of moderately or severely depressed left ventricular systolic function M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1151** Patients with a history of heart transplant or with a left ventricular assist device (lvad) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1152** Patients with a history of heart transplant or with a left ventricular assist device (lvad) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1153** Patient with diagnosis of osteoporosis on date of encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1159** Hospice services provided to patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1160** Patient had anaphylaxis due to the meningococcal vaccine any time on or before the patient's 13th birthday Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1161** Patient had anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1162** Patient had encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the patient's 13th birthday Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1163** Patient had anaphylaxis due to the hpv vaccine any time on or before the patient's 13th birthday Ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1164** Patients with dementia any time during the patient's history through the end of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1165** Patients who use hospice services any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1166** Pathology report for tissue specimens produced from wide local excisions or re-excisions M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1167** In hospice or using hospice services during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1168** Patient received an influenza vaccine on or between july of the year prior to the measurement period and june 30 of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1169** Documentation of medical reason(s) for not administering influenza vaccine (e.g., prior anaphylaxis due to the influenza vaccine) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1170** Patient did not receive an influenza vaccine on or between july of the year prior to the measurement period and june 30 of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1171** Patient received at least one td vaccine or one tdap vaccine between nine years prior to the encounter and the end of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1172** Documentation of medical reason(s) for not administering td or tdap vaccine (e.g., prior anaphylaxis due to the td or tdap vaccine or history of encephalopathy within seven days after a previous dose of a td-containing vaccine) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1173** Patient did not receive at least one td vaccine or one tdap vaccine between nine years prior to the encounter and the end of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1174** Patient received at least two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1175** Documentation of medical reason(s) for not administering zoster vaccine (e.g., prior anaphylaxis due to the zoster vaccine) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1176** Patient did not receive two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patient's 50th birthday before or during the measurement period A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1177** Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1178** Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g., prior anaphylaxis due to the pneumococcal vaccine) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1179** Patient did not receive any pneumococcal conjugate or polysaccharide vaccine, on or after their 19th birthday and before or during measurement period A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1180** Patients on immune checkpoint inhibitor therapy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1181** Grade 2 or above diarrhea and/or grade 2 or above colitis M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1182** Patients not eligible due to pre-existing inflammatory bowel disease (ibd) (e.g., ulcerative colitis, crohn's disease) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1183** Documentation of immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1184** Documentation of medical reason(s) for not prescribing or administering corticosteroid or immunosuppressant treatment (e.g., allergy, intolerance, infectious etiology, pancreatic insufficiency, hyperthyroidism, prior bowel surgical interventions, celiac disease, receiving other medication, awaiting diagnostic workup results for alternative etiologies, other medical reasons/contraindication) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1185** Documentation of immune checkpoint inhibitor therapy not held and/or corticosteroids or immunosuppressants prescribed or administered was not performed, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1186** Patients who have an order for or are receiving hospice or palliative care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1187** Patients with a diagnosis of end stage renal disease (esrd) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1188** Patients with a diagnosis of chronic kidney disease (ckd) stage 5 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1189** Documentation of a kidney health evaluation defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr) performed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1190** Documentation of a kidney health evaluation was not performed or defined by an estimated glomerular filtration rate (egfr) and urine albumin-creatinine ratio (uacr) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1191** Hospice services provided to patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1192** Patients with an existing diagnosis of squamous cell carcinoma of the esophagus M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1193** Surgical pathology reports that contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1194** Documentation of medical reason(s) surgical pathology reports did not contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both tests were not included (e.g., patient will not be treated with checkpoint inhibitor therapy, no residual carcinoma is present in the sample [tissue exhausted or status post neoadjuvant treatment], insufficient tumor for testing) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1195** Surgical pathology reports that do not contain impression or conclusion of or recommendation for testing of mmr by immunohistochemistry, msi by dna-based testing status, or both, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1196** Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1197** Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1198** Itch severity assessment score was not reduced by at least 3 points from initial (index) score to the follow-up visit score or assessment was not completed during the follow-up encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1199** Patients receiving rrt M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1200** Ace inhibitor (ace-i) or arb therapy prescribed during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1201** Documentation of medical reason(s) for not prescribing ace inhibitor (ace-i) or arb therapy during the measurement period (e.g., pregnancy, history of angioedema to ace-i, other allergy to ace-i and arb, hyperkalemia or history of hyperkalemia while on ace-i or arb therapy, acute kidney injury due to ace-i or arb therapy), other medical reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1202** Documentation of patient reason(s) for not prescribing ace inhibitor or arb therapy during the measurement period, (e.g., patient declined, other patient reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1203** Ace inhibitor or arb therapy not prescribed during the measurement period, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1204** Initial (index visit) numeric rating scale (nrs), visual rating scale (vrs), or itchyquant assessment score of greater than or equal to 4 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1205** Itch severity assessment score is reduced by 3 or more points from the initial (index) assessment score to the follow-up visit score M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1206** Itch severity assessment score was not reduced by at least 3 points from initial (index) score to the follow-up visit score or assessment was not completed during the follow-up encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1207** Patient is screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1208** Patient is not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1209** At least two orders for high-risk medications from the same drug class, (table 4), without appropriate diagnoses M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q2

C **M1210** At least two orders for high-risk medications from the same drug class, (table 4), not ordered M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1211** Most recent glycemic status assessment (hba1c or gmi) level > 9.0% M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1212** Glycemic status assessment (hba1c or gmi) level is missing, or was not performed during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1213** No history of spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) and present spirometry is >= 70% M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1214** Spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and reviewed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1215** Documentation of medical reason(s) for not documenting and reviewing spirometry results (e.g., patients with dementia or tracheostomy) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1216** No spirometry results with confirmed airflow obstruction (fev1/fvc < 70%) documented and/or no spirometry performed with results documented during the encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1217** Documentation of system reason(s) for not documenting and reviewing spirometry results (e.g., spirometry equipment not available at the time of the encounter) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1218** Patient has copd symptoms (e.g., dyspnea, cough/sputum, wheezing) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1220** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; with evidence of retinopathy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1221** Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist or artificial intelligence (ai) interpretation documented and reviewed; without evidence of retinopathy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1222** Glaucoma plan of care not documented, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1223** Glaucoma plan of care documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1224** Intraocular pressure (iop) reduced by a value less than 20% from the pre-intervention level M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1225** Intraocular pressure (iop) reduced by a value of greater than or equal to 20% from the pre-intervention level M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1226** Iop measurement not documented, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1227** Evidence-based therapy was prescribed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1228** Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, has hcv treatment initiated within 3 months of the reactive hcv antibody test M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1229** Patient, who has a reactive hcv antibody test, and has a follow up hcv viral test that detected hcv viremia, is referred within month of the reactive hcv antibody test to a clinician who treats hcv infection M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1230** Patient has a reactive hcv antibody test and does not have a follow up hcv viral test, or patient has a reactive hcv antibody test and has a follow up hcv viral test that detects hcv viremia and is not referred to a clinician who treats hcv infection within month and does not have hcv treatment initiated within 3 months of the reactive hcv antibody test, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1231** Patient receives hcv antibody test with nonreactive result M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1232** Patient receives hcv antibody test with reactive result M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1233** Patient does not receive hcv antibody test or patient does receive hcv antibody test but results not documented, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1234** Patient has a reactive hcv antibody test, and has a follow up hcv viral test that does not detect hcv viremia M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1235** Documentation or patient report of hcv antibody test or hcv rna test which occurred prior to the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1236** Baseline mrs > 2 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1237** Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (e.g., patient declined or other patient reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1238** Documentation that administration of second recombinant zoster vaccine could not occur during the performance period due to the recommended 2-6 month interval between doses (i.e, first dose received after october 31) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1239** Patient did not respond to the question of patient felt heard and understood by this provider and team M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1240** Patient did not respond to the question of patient felt this provider and team put my best interests first when making recommendations about my care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1241** Patient did not respond to the question of patient felt this provider and team saw me as a person, not just someone with a medical problem M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1242** Patient did not respond to the question of patient felt this provider and team understood what is important to me in my life M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1243** Patient provided a response other than "completely true" for the question of patient felt heard and understood by this provider and team M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1244** Patient provided a response other than "completely true" for the question of patient felt this provider and team put my best interests first when making recommendations about my care M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1245** Patient provided a response other than "completely true" for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1246** Patient provided a response other than "completely true" for the question of patient felt this provider and team understood what is important to me in my life M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1247** Patient responded "completely true" for the question of patient felt this provider and team put my best interests first when making recommendations about my care M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1248** Patient responded "completely true" for the question of patient felt this provider and team saw me as a person, not just someone with a medical problem M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1249** Patient responded "completely true" for the question of patient felt this provider and team understood what is important to me in my life M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1250** Patient responded as "completely true" for the question of patient felt heard and understood by this provider and team M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1251** Patients for whom a proxy completed the entire hu survey on their behalf for any reason (no patient involvement) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1252** Patients who did not complete at least one of the four patient experience hu survey items and return the hu survey within 60 days of the ambulatory palliative care visit M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1253** Patients who respond on the patient experience hu survey that they did not receive care by the listed ambulatory palliative care provider in the last 60 days (disavowal) M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1254** Patients who were deceased when the hu survey reached them M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1255** Patients who have another reason for visiting the clinic [not prenatal or postpartum care] and have a positive pregnancy test but have not established the clinic as an ob provider (e.g., plan to terminate the pregnancy or seek prenatal services elsewhere) ♀ M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1256** Prior history of known cvd M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1257** Cvd risk assessment not performed or incompiete (e.g., cvd risk assessment was not documented), reason not otherwise specified M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1258** Cvd risk assessment performed, have a documented calculated risk score M MIPS

BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1259** Patient status documented within the first year of initiating dialysis M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1260** Patient status not documented within the first year of initiating dialysis M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1261** Patients that were on the kidney or kidney-pancreas waitlist prior to initiation of dialysis M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1262** Patients who had a transplant prior to initiation of dialysis M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1263** Patients in hospice on their initiation of dialysis date or during the month of evaluation M

BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1265** Cms medical evidence form 2728 for dialysis patients: initial form completed M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1266** Patients admitted to a skilled nursing facility (snf) M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1267** Patients not observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1268** Patients observed in active status on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1269** Receiving esrd mcp dialysis services by the provider on the last day of the reporting month M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1270** Patients not on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1271** Patients with dementia at any time prior to or during the month M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1272** Patients observed on any kidney or kidney-pancreas transplant waitlist as of the last day of each month during the measurement period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1273** Patients who were admitted to a skilled nursing facility (snf) within one year of dialysis initiation according to the cms-2728 form M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1274** Patients who were admitted to a skilled nursing facility (snf) during the month of evaluation were excluded from that month M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1275** Patients determined to be in hospice were excluded from month of evaluation and the remainder of reporting period M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1276** Bmi documented outside normal parameters, no follow-up plan documented, no reason given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1277** Colorectal cancer screening results documented and reviewed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1278** Elevated or hypertensive blood pressure reading documented, and the indicated follow-up is documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1279** Elevated or hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1280** Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1281** Blood pressure reading not documented, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1282** Patient screened for tobacco use and identified as a tobacco non-user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1283** Patient screened for tobacco use and identified as a tobacco user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1284** Patients age 66 or older in institutional special needs plans (snp) or residing in long term care with pos code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period A M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1285** Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1286** Bmi is documented as being outside of normal parameters, follow-up plan is not completed for documented medical reason M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1287** Bmi is documented below normal parameters and a follow-up plan is documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1288** Documented reason for not screening or recommending a follow-up for high blood pressure M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1289** Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1290** Patient not eligible due to active diagnosis of hypertension M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1291** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1292** Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and an advanced illness diagnosis during the measurement period or the year prior to the measurement period ⓐ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1293** Bmi is documented above normal parameters and a follow-up plan is documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1294** Normal blood pressure reading documented, follow-up not required M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1295** Patients with a diagnosis or past history of total colectomy or colorectal cancer M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1296** Bmi is documented within normal parameters and no follow-up plan is required M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1297** Bmi not documented due to medical reason or patient refusal of height or weight measurement M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1298** Documentation of patient pregnancy anytime during the measurement period prior to and including the current encounter ♀ M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1299** Influenza immunization administered or previously received M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1300** Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1301** Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1302** Screening, diagnostic, film digital or digital breast tomosynthesis (3d) mammography results documented and reviewed M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1303** Hospice services provided to patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1304** Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1305** Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1306** Patient had anaphylaxis due to the pneumococcal vaccine any time during or before the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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C **M1307** Documentation stating the patient has received or is currently receiving palliative or hospice care M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1308** Influenza immunization was not administered, reason not given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1309** Palliative care services provided to patient any time during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1310** Patient screened for tobacco use and received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling, pharmacotherapy, or both), if identified as a tobacco user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1311** Anaphylaxis due to the vaccine on or before the date of the encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1312** Patient not screened for tobacco use M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1313** Tobacco screening not performed or tobacco cessation intervention not provided during the measurement period or in the six months prior to the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1314** Bmi not documented and no reason is given M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1315** Colorectal cancer screening results were not documented and reviewed; reason not otherwise specified M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1316** Current tobacco non-user M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1317** Patients who are counseled on connection with a csp and explicitly opt out M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1318** Patients who did not have documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening or documentation that there was no contact with a csp M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1319** Patients who had documented contact with a csp for at least one of their screened positive hrsns within 60 days after screening M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1320** Patients who screened positive for at least of the 5 hrsns M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1321** Patients who were not seen within 7 weeks following the date of injection for follow up or who did not have a documented iop or no plan of care documented if the iop was >25 mm hg M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1322** Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop =<25 mm hg for injected eye M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1323** Patients seen within 7 weeks following the date of injection and are screened for elevated intraocular pressure (iop) with tonometry with documented iop >25 mm hg and a plan of care was documented M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1324** Patients who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1325** Patients who were not seen for reasons documented by clinician for patient or medical reasons (e.g., inadequate time for follow-up, patients who received a prior intravitreal or periocular steroid injection within the last six (6) months and had a subsequent iop evaluation with iop <25mm hg within seven (7) weeks of treatment) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **M1326** Patients with a diagnosis of hypotony M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1327** Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 8 weeks M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1328** Patients with a diagnosis of acute vitreous hemorrhage M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1329** Patients with a post-operative encounter of the eye with the acute pvd within 2 weeks before the initial encounter or 8 weeks after initial acute pvd encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1330** Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1331** Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks from initial exam M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1332** Patients who were not appropriately evaluated during the initial exam and/or who were not re-evaluated within 2 weeks M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1333** Acute vitreous hemorrhage M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1334** Patients with a post-operative encounter of the eye with the acute pvd within 2 weeks before the initial encounter or 2 weeks after initial acute pvd encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1335** Documentation of patient reason(s) for not having a follow up exam (e.g., inadequate time for follow up) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1336** Patients who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1337** Acute pvd M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1338** Patients who had follow-up assessment 30 to 180 days after the index assessment who did not demonstrate positive improvement or maintenance of functioning scores during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1339** Patients who had follow-up assessment 30 to 180 days after the index assessment who demonstrated positive improvement or maintenance of functioning scores during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1340** Index assessment completed using the 12-item whodas 2.0 or sds during the denominator identification period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1341** Patients who did not have a follow-up assessment or did not have an assessment within 30 to 180 days after the index assessment during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1342** Patients who died during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1343** Patients who are at pam level 4 at baseline or patients who are flagged with extreme straight line response sets on the pam or with excessive missing responses M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1344** Patients who did not have a baseline pam score and/or a second score within 4 to 12 months of baseline pam score M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1345** Patients who had a baseline pam score and a second score within 4 to 12 month of baseline pam score M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1346** Patients who did not have a net increase in pam score of at least 6 points within a 4 to 12 month period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1347** Patients who achieved a net increase in pam score of at least 3 points in a 4 to 12 month period (passing) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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▲ C **M1348** Patients who achieved a net increase in pam score of at least 6-points in a 4 to 12 month period (excellent) M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

▲ C **M1349** Patients who did not have a net increase in pam score of at least 3 points within a 4 to 12 month period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1350** Patients who had a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1351** Patients who had a suicide safety plan initiated, reviewed, or updated and reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1352** Suicidal ideation and/or behavior symptoms based on the c-ssrs or equivalent assessment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1353** Patients who did not have a completed suicide safety plan initiated, reviewed or updated in collaboration with their clinician (concurrent or within 24 hours) of the index clinical encounter M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1354** Patients who did not have a suicide safety plan initiated, reviewed, or updated or reviewed and updated in collaboration with the patient and their clinician concurrent or within 24 hours of clinical encounter and within 120 days after initiation M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1355** Suicide risk based on their clinician's evaluation or a clinician-rated tool M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1356** Patients who died during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1357** Patients who had a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1358** Patients who did not have a reduction in suicidal ideation and/or behavior upon follow-up assessment within 120 days of index assessment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1359** Index assessment during the denominator period when the suicidal ideation and/or behavior symptoms or increased suicide risk by clinician determination occurs and a non-zero c-ssrs score is obtained M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1360** Suicidal ideation and/or behavior symptoms based on the c-ssrs M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1361** Suicide risk based on their clinician's evaluation or a clinician-rated tool M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1362** Patients who died during the measurement period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1363** Patients who did not have a follow-up assessment within 120 days of the index assessment M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1364** Calculated 10-year ascvd risk score of >= 20 percent during the performance period M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1365** Patient encounter during the performance period with hospice and palliative care specialty code 17 M MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1366** Focusing on women's health mips value pathway ♀ M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1367** Quality care for the treatment of ear, nose, and throat disorders mips value pathway M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1368** Prevention and treatment of infectious disorders including hepatitis c and hiv mips value pathway M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **M1369** Quality care in mental health and substance use disorders mips value pathway M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **M1370** Rehabilitative support for musculoskeletal care mips value pathway M
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1371** Most recent glycemic status assessment (hba1c or gmi) level < 7.0%
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1372** Most recent glycemic status assessment (hba1c or gmi) level >= 7.0% and < 8.0%
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1373** Most recent glycemic status assessment (hba1c or gmi) level >= 8.0% and <= 9.0%
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1374** An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1375** An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1376** An additional encounter with an ra diagnosis during the performance period or prior performance period that is at least 90 days before or after an encounter with an ra diagnosis during the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1377** Recommended follow-up interval for repeat colonoscopy of 10 years documented in colonoscopy report and communicated with patient A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1378** Documentation of medical reason(s) for not recommending a 10 year follow-up interval (e.g., inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, or life expectancy < 10 years, other medical reasons) A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1379** A 10 year follow-up interval for colonoscopy not recommended, reason not otherwise specified A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1380** Filled at least two prescriptions during the performance period for any combination of the qualifying oral antipsychotic medications listed under "denominator note" or the long-acting injectable antipsychotic medications listed under "denominator note"
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1381** Patients with secondary stroke (e.g., a subsequent stroke that may occur with vasospasm in the setting of subarachnoid hemorrhage) within 5 days of the initial procedure
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1382** Patient encounter during the performance period with place of service code 11
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1383** Acute pvd A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1384** Patients who died during the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1385** Documentation of patient reasons for patients who were not seen for the second pam survey (e.g., less than four months between baseline pam assessment and follow-up
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1386** Patients with an excisional surgery for melanoma or melanoma in situ in the past 5 years with an initial ajcc staging of 0, I, or II at the start of the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1387** Patients who died during the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1388** Patients with documentation of an exam performed for recurrence of melanoma
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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- C **M1389** Documentation of patient reasons for no examination i.e., refusal of examination or lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail - at least one method must be documented)
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1390** Patients who do not have a documented exam performed for recurrence of melanoma or no documentation within the performance period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1391** All patients who were diagnosed with recurrent melanoma during the current performance period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1392** Documentation of patient reasons for no examination, i.e., refusal of examination or lost to follow-up (documentation must include information that the clinician was unable to reach the patient by phone, mail or secure electronic mail - at least one method must be documented)
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1393** Patients who were not diagnosed with recurrent melanoma during the current performance period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1394** Stages i-iii breast cancer
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1395** Patients receiving an initial chemotherapy regimen with a defined duration with the eligible clinician or group
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1396** Patients on a therapeutic clinical trial
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1397** Patients with recurrence/disease progression
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1398** Patients with baseline and follow-up promis surveys documented in the medical record
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1399** Patients who leave the practice during the follow-up period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1400** Patients who died during the follow-up period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1401** Stages i-iii breast cancer
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1402** Patients receiving an initial chemotherapy regimen with a defined duration with the eligible clinician or group
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1403** Patients with baseline and follow-up promis surveys documented in the medical record
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1404** Patients on a therapeutic clinical trial
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1405** Patients with recurrence/disease progression
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1406** Patients who leave the practice during the follow-up period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1407** Patients who died during the follow-up period
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1408** Patients who have germline brca testing completed before diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1409** Patients who received germline testing for brca and brca2 or genetic counseling completed within 6 months of diagnosis
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1410** Patients who did not have germline testing for brca and brca2 or genetic counseling completed within 6 months of diagnosis
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B
- C **M1411** Currently on first-line immune checkpoint inhibitors without chemotherapy
  BETOS: Z2 Undefined codes
  Service not separately priced by Part B

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● C **M1412** Patients with metastatic nsclc with epidermal growth factor receptor (egfr) mutations, alk genomic tumor aberrations, or other targetable genomic abnormalities with approved first-line targeted therapy, such as nsclc with ros rearrangement, braf v600e mutation, ntrk 1/2/3 gene fusion, met ex14 skipping mutation, and ret rearrangement
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1413** Patients who had a positive pd-l biomarker expression test result prior to the initiation of first-line immune checkpoint inhibitor therapy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1414** Documentation of medical reason(s) for not performing the pd-l biomarker expression test prior to initiation of first-line immune checkpoint inhibitor therapy (e.g., patient is in an urgent or emergent situation where delay of treatment would jeopardize the patient's health status; other medical reasons/contraindication)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1415** Patients who did not have a positive pd-l biomarker expression test result prior to the initiation of first-line immune checkpoint inhibitor therapy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1416** Patient received hospice services any time during the performance period
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1417** Patients who are up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1418** Patients who are not up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination because of a medical contraindication documented by clinician
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1419** Patients who are not up to date on their covid-19 vaccinations as defined by cdc recommendations on current vaccination
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1420** Complete ophthalmologic care mips value pathway
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1421** Dermatological care mips value pathway
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1422** Gastroenterology care mips value pathway
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1423** Optimal care for patients with urologic conditions mips value pathway
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1424** Pulmonology care mips value pathway
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● C **M1425** Surgical care mips value pathway
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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PATHOLOGY AND LABORATORY SERVICES (P2028-P9615)

LABORATORY TESTS OF BLOOD AND HAIR (P2028-P2038)

D P2028 Cephalin flocculation, blood A
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Other carrier priced

D P2029 Congo red, blood A
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Other carrier priced

M P2031 Hair analysis (excluding arsenic) E1
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Service not separately priced by Part B

D P2033 Thymol turbidity, blood A
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Other carrier priced

D P2038 Mucoprotein, blood (seromucoid) (medical necessity procedure) A
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Price subject to national limitation amount

PAP SMEARS (P3000, P3001)

D P3000 Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision ♀ A
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Price subject to national limitation amount

D P3001 Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician ♀ B
BETOS: T1G Lab tests - other
(Medicare fee schedule)
Price established using national RVUs

URINE BACTERIAL CULTURE AND SENSITIVITY STUDIES (P7001)

I P7001 Culture, bacterial, urine; quantitative, sensitivity study E1
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Service not separately priced by Part B

BLOOD AND BLOOD PRODUCTS, WITH ASSOCIATED PROCEDURES (P9010-P9100)

D P9010 Blood (whole), for transfusion, per unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D P9011 Blood, split unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

D P9012 Cryoprecipitate, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D P9016 Red blood cells, leukocytes reduced, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2004, Q4

D P9017 Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D P9019 Platelets, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D P9020 Platelet rich plasma, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D P9021 Red blood cells, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2004, Q4

D P9022 Red blood cells, washed, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D P9023 Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

C P9025 Plasma, cryoprecipitate reduced, pathogen reduced, each unit R
BETOS: T1H Lab tests - other
(Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2021, Q4

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C **P9026** Cryoprecipitated fibrinogen complex, pathogen reduced, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2021, Q4

● C **P9027** Red blood cells, leukocytes reduced, oxygen/ carbon dioxide reduced, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge

D **P9031** Platelets, leukocytes reduced, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D **P9032** Platelets, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

D **P9033** Platelets, leukocytes reduced, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

D **P9034** Platelets, pheresis, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D **P9035** Platelets, pheresis, leukocytes reduced, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D **P9036** Platelets, pheresis, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

D **P9037** Platelets, pheresis, leukocytes reduced, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

D **P9038** Red blood cells, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

D **P9039** Red blood cells, deglycerolized, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D **P9040** Red blood cells, leukocytes reduced, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3; 2005, Q2

C **P9041** Infusion, albumin (human), 5%, 50 ml K2 ASC K
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Drugs: ALBUMIN (HUMAN), ALBUMINAR-5, ALBUMINEX 5%, ALBURX, ALBUTEIN 5%, ALBUTEIN®, ALBUTEIN® 5% ALBUMIN 500 ML, BUMINATE, PLASBUMIN-5
Coding Clinic: 2004, Q3

D **P9043** Infusion, plasma protein fraction (human), 5%, 50 ml R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

D **P9044** Plasma, cryoprecipitate reduced, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Coding Clinic: 2004, Q3

C **P9045** Infusion, albumin (human), 5%, 250 ml K2 ASC K
BETOS: Y2 Other - Non-Medicare fee schedule
Reasonable charge
Drugs: ALBUKED 5, ALBUMIN (HUMAN), ALBUMINAR-5, ALBUMINEX 5%, ALBURX, ALBUTEIN® 5% ALBUMIN 500 ML, ALBUTEIN® 5%, BUMINATE, PLASBUMIN-5
Coding Clinic: 2002, Q1; 2004, Q3

C **P9046** Infusion, albumin (human), 25%, 20 ml K2 ASC K
BETOS: Y2 Other - Non-Medicare fee schedule
Reasonable charge
Drugs: ALBUKED 25, ALBUMIN (HUMAN), ALBUMINAR-25, ALBUMINEX 25%, ALBURX, ALBUTEIN, ALBUTEIN 25%, ALBUTEIN®, ALBUTEIN® 25% ALBUMIN 100 ML, BUMINATE, FLEXBUMIN, KEDBUMIN, PLASBUMIN-25
Coding Clinic: 2002, Q1; 2004, Q3

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C **P9047** Infusion, albumin (human), 25%, 50 ml K2 ASC K
BETOS: Y2 Other - Non-Medicare fee schedule
Reasonable charge
Drugs: ALBUKED 25, ALBUMIN (HUMAN), ALBUMINAR-25, ALBUMINEX 25%, ALBURX, ALBUTEIN, ALBUTEIN® 25%, ALBUTEIN® 25% ALBUMIN 100 ML, BUMINATE, FLEXBUMIN, HUMAN ALBUMIN GRIFOLS, KEDBUMIN, PLASBUMIN-25
Coding Clinic: 2002, Q1; 2004, Q3

C **P9048** Infusion, plasma protein fraction (human), 5%, 250 ml R
BETOS: Y2 Other - Non-Medicare fee schedule
Reasonable charge
Coding Clinic: 2002, Q1; 2004, Q3

C **P9050** Granulocytes, pheresis, each unit K5 ASC E2
BETOS: Z2 Undefined codes
Reasonable charge
Coding Clinic: 2002, Q1; 2004, Q3

D **P9051** Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3

D **P9052** Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3

D **P9053** Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3; 2005, Q2

D **P9054** Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3

D **P9055** Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3

D **P9056** Whole blood, leukocytes reduced, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3; 2005, Q2

D **P9057** Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3; 2005, Q2

D **P9058** Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3; 2005, Q2

D **P9059** Fresh frozen plasma between 8-24 hours of collection, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3

D **P9060** Fresh frozen plasma, donor retested, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2004, Q3

D **P9070** Plasma, pooled multiple donor, pathogen reduced, frozen, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2016, Q1

D **P9071** Plasma (single donor), pathogen reduced, frozen, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2016, Q1

D **P9073** Platelets, pheresis, pathogen-reduced, each unit R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge
Statute: 1833T
Coding Clinic: 2018, Q1

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **P9099** Blood component or product not otherwise classified R
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Reasonable charge

D **P9100** Pathogen(s) test for platelets S
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Other carrier priced
Coding Clinic: 2018, Q1

SPECIMEN COLLECTION, TRAVEL ALLOWANCE (P9603, P9604)

D **P9603** Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled A
BETOS: Y2 Other - Non-Medicare fee schedule
Price established by carriers
Pub: 100-4, Chapter-16, 60.2

D **P9604** Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge. A
BETOS: Y2 Other - Non-Medicare fee schedule
Price established by carriers
Pub: 100-4, Chapter-16, 60.2

SPECIMEN COLLECTION, CATHETERIZATION (P9612, P9615)

D **P9612** Catheterization for collection of specimen, single patient, all places of service A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Other carrier priced
Coding Clinic: 2007, Q3; 2009, Q2

D **P9615** Catheterization for collection of specimen (s) (multiple patients) N
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Other carrier priced

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TEMPORARY CODES (Q0035-Q9998)

MISCELLANEOUS DRUGS AND TESTS (Q0035-Q0144)

D **Q0035** Cardiokymography N1 ASC Q1
BETOS: T2D Other tests - other
Price established using national RVUs

D **Q0081** Infusion therapy, using other than chemotherapeutic drugs, per visit B
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Service not separately priced by Part B
Coding Clinic: 2002, Q1; 2002, Q2; 2002, Q2; 2002, Q4; 2004, Q1; 2004, Q2; 2004, Q4; 2005, Q1; 2006, Q4

C **Q0083** Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit B
BETOS: O1D Chemotherapy
Service not separately priced by Part B
Coding Clinic: 2002, Q1; 2002, Q1; 2004, Q1; 2004, Q4; 2005, Q1; 2006, Q4

D **Q0084** Chemotherapy administration by infusion technique only, per visit B
BETOS: O1D Chemotherapy
Service not separately priced by Part B
Coding Clinic: 2002, Q1; 2002, Q1; 2004, Q1; 2004, Q2; 2004, Q4; 2005, Q1; 2006, Q4

C **Q0085** Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit B
BETOS: O1D Chemotherapy
Service not separately priced by Part B
Coding Clinic: 2002, Q1; 2002, Q1; 2004, Q1; 2004, Q4; 2006, Q4

D **Q0091** Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory ♀ S
BETOS: P6C Minor procedures - other (Medicare fee schedule)
Price established using national RVUs
Coding Clinic: 2002, Q4; 2008, Q4; 2024, Q2

D **Q0092** Set-up portable X-ray equipment N1 ASC N
BETOS: I1F Standard imaging - other
Price established using national RVUs

C **Q0111** Wet mounts, including preparations of vaginal, cervical or skin specimens A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

C **Q0112** All potassium hydroxide (KOH) preparations A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

C **Q0113** Pinworm examinations A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

C **Q0114** Fern test ♀ Ⓐ A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

C **Q0115** Post-coital direct, qualitative examinations of vaginal or cervical mucous ♀ A
BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price subject to national limitation amount

C **Q0138** Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use) K2 ASC K
BETOS: O1E Other drugs
Drugs: FERAHEME, FERUMOXYTOL

C **Q0139** Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis) K2 ASC K
BETOS: O1E Other drugs
Drugs: FERAHEME, FERUMOXYTOL

M **Q0144** Azithromycin dihydrate, oral, capsules/ powder, 1 gram E1
BETOS: O1E Other drugs
Service not separately priced by Part B

CHEMOTHERAPY ANTI-EMETIC MEDICATIONS (Q0155-Q0181), SEE ALSO CHEMOTHERAPY MEDICATIONS (Q5101)

● D **Q0155** Dronabinol (syndros), 0.1 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 Ⓐ
BETOS: O1D Chemotherapy
Statute: 4557

C **Q0161** Chlorpromazine hydrochloride, 5 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 N1 ASC N
BETOS: O1D Chemotherapy
Coding Clinic: 2002, Q2; 2014, Q1

D **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 N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557
Drugs: ONDANSETRON, ONDANSETRON HCL, ONDANSETRON ODT

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **Q0163** Diphenhydramine hydrochloride, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557
Coding Clinic: 2002, Q1; 2008, Q1; 2009, Q2; 2012, Q2; 2019, Q4; 2020, Q1; 2024, Q1

D **Q0164** Prochlorperazine maleate, 5 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 N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0166** Granisetron hydrochloride, 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 24 hour dosage regimen N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0167** Dronabinol, 2.5 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 N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557
Drugs: DRONABINOL, MARINOL

D **Q0169** Promethazine hydrochloride, 12.5 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 N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0173** Trimethobenzamide hydrochloride, 250 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 K5 ASC E2
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0174** Thiethylperazine maleate, 10 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 K5 ASC E2
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0175** Perphenazine, 4 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 N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0177** Hydroxyzine pamoate, 25 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 N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0180** Dolasetron mesylate, 100 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 24 hour dosage regimen N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557

D **Q0181** Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen N1 ASC N
BETOS: O1D Chemotherapy
Statute: 4557
Coding Clinic: 2006, Q1; 2008, Q1; 2009, Q2; 2012, Q2; 2019, Q4; 2020, Q1; 2024, Q1

COVID-19 INFUSION THERAPY (Q0220-Q0249)

C **Q0220** Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 300 mg L1 ◎ ASC L
BETOS: O1G Immunizations/Vaccinations

C **Q0221** Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not

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recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 600 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2022, Q2

C **Q0222** Injection, bebtelovimab, 175 mg L1 A ASC K
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2022, Q2

• C **Q0224** Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known sars-cov-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to covid-19 vaccination, 4500 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Drugs: PEMGARDA
Coding Clinic: 2024, Q3

C **Q0240** Injection, casirivimab and imdevimab, 600 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3; 2021, Q4

C **Q0243** Injection, casirivimab and imdevimab, 2400 mg L1 ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2020, Q4; 2021, Q1

C **Q0244** Injection, casirivimab and imdevimab, 1200 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q4

C **Q0245** Injection, bamlanivimab and etesevimab, 2100 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q1

C **Q0247** Injection, sotrovimab, 500 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2021, Q3

C **Q0249** Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg L1 A ASC L
BETOS: O1G Immunizations/Vaccinations
Drugs: ACTEMRA IV
Coding Clinic: 2021, Q4

VENTRICULAR ASSIST DEVICES (Q0477-Q0509)

D **Q0477** Power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

D **Q0478** Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type DME A
BETOS: D1F Prosthetic/Orthotic devices

D **Q0479** Power module for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

D **Q0480** Driver for use with pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0481** Microprocessor control unit for use with electric ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0482** Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0483** Monitor/display module for use with electric ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0484** Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0485** Monitor control cable for use with electric ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0486** Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0487** Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

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D **Q0488** Power pack base for use with electric ventricular assist device, replacement only A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0489** Power pack base for use with electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0490** Emergency power source for use with electric ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0491** Emergency power source for use with electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0492** Emergency power supply cable for use with electric ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0493** Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0494** Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0495** Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0496** Battery, other than lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0497** Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0498** Holster for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0499** Belt/vest/bag for use to carry external peripheral components of any type ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0500** Filters for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0501** Shower cover for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0502** Mobility cart for pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0503** Battery for pneumatic ventricular assist device, replacement only, each DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0504** Power adapter for pneumatic ventricular assist device, replacement only, vehicle type DME A
BETOS: D1F Prosthetic/Orthotic devices
Coding Clinic: 2005, Q3

D **Q0506** Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only DME A
BETOS: D1F Prosthetic/Orthotic devices

D **Q0507** Miscellaneous supply or accessory for use with an external ventricular assist device A
BETOS: D1F Prosthetic/Orthotic devices

D **Q0508** Miscellaneous supply or accessory for use with an implanted ventricular assist device A
BETOS: D1F Prosthetic/Orthotic devices

D **Q0509** Miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under Medicare Part A A
BETOS: D1F Prosthetic/Orthotic devices

PHARMACY SUPPLY AND DISPENSING FEES (Q0510-Q0514)

D **Q0510** Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant B
BETOS: O1E Other drugs

D **Q0511** Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30-day period B
BETOS: O1E Other drugs

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D **Q0512** Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period B
BETOS: O1E Other drugs

D **Q0513** Pharmacy dispensing fee for inhalation drug(s); per 30 days B
BETOS: O1E Other drugs

D **Q0514** Pharmacy dispensing fee for inhalation drug(s); per 90 days B
BETOS: O1E Other drugs

MISCELLANEOUS DRUG AND NEW TECHNOLOGY CODES (Q0515-Q2028)

D **Q0515** Injection, sermorelin acetate, 1 microgram K5 ASC E2
BETOS: O1E Other drugs

● D **Q0521** Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription
BETOS: O1E Other drugs
Statute: 1861(ddd)

D **Q1004** New technology intraocular lens category 4 as defined in Federal Register notice E1
BETOS: D1F Prosthetic/Orthotic devices
Other carrier priced

D **Q1005** New technology intraocular lens category 5 as defined in Federal Register notice E1
BETOS: D1F Prosthetic/Orthotic devices
Other carrier priced

D **Q2004** Irrigation solution for treatment of bladder calculi, for example renacidin, per 500 ml K2 ASC K
BETOS: O1E Other drugs
Statute: 1861S2B

D **Q2009** Injection, fosphenytoin, 50 mg phenytoin equivalent K2 ASC K
BETOS: O1E Other drugs
Statute: 1861S2B
Drugs: CEREBYX, FOSPHENYTOIN SODIUM

D **Q2017** Injection, teniposide, 50 mg K5 ASC E2
BETOS: O1D Chemotherapy
Statute: 1861S2B

D **Q2026** Injection, Radiesse, 0.1 ml K2 ASC K
BETOS: O1E Other drugs
Coding Clinic: 2010, Q3
Pub: 100-4, Chapter-32, 260.2.1; 100-4, Chapter-32, 260.2.2

D **Q2028** Injection, sculptra, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

INFLUENZA VIRUS VACCINES (Q2034-Q2039)

D **Q2034** Influenza virus vaccine, split virus, for intramuscular use (Agriflu) L1 ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2012, Q3

D **Q2035** Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria) L1 Ⓐ ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2010, Q4; 2011, Q1

D **Q2036** Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval) L1 Ⓐ ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2010, Q4; 2011, Q1

D **Q2037** Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin) L1 Ⓐ ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2010, Q4; 2011, Q1

D **Q2038** Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone) L1 Ⓐ ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2010, Q4; 2011, Q1

D **Q2039** Influenza virus vaccine, not otherwise specified L1 ASC L
BETOS: O1G Immunizations/Vaccinations
Coding Clinic: 2010, Q4; 2011, Q1; 2017, Q4

OTHER DRUGS AND SERVICE FEES (Q2041-Q3031)

C **Q2041** Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose K
BETOS: O1E Other drugs
Drugs: YESCARTA
Coding Clinic: 2012, Q1; 2018, Q1; 2018, Q2; 2019, Q2

C **Q2042** Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose K
BETOS: O1E Other drugs
Drugs: KYMRIAH
Coding Clinic: 2012, Q1; 2019, Q1; 2019, Q2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **Q2043** Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion K2 ♂ ASC K
BETOS: P1G Major procedure - other
Drugs: PROVENGE
Coding Clinic: 2012, Q1; 2012, Q2
Pub: 100-4, Chapter-32, 280.5; 100-4, Chapter-32, 280.4; 100-4, Chapter-32, 280.2

C **Q2049** Injection, doxorubicin hydrochloride, liposomal, imported Lipodox, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Coding Clinic: 2012, Q3

D **Q2050** Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: DOXIL, DOXORUBICIN HCL, LIPOSOMAL
Coding Clinic: 2013, Q3; 2013, Q4

D **Q2052** Services, supplies and accessories used in the home for the administration of intravenous immune globulin (ivig) A
BETOS: O1E Other drugs
Other carrier priced
Coding Clinic: 2014, Q2; 2024, Q1

C **Q2053** Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose Ⓐ K
BETOS: O1E Other drugs
Drugs: TECARTUS
Coding Clinic: 2021, Q1

C **Q2054** Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose K
BETOS: O1E Other drugs
Drugs: BREYANZI
Coding Clinic: 2021, Q4

▲ C **Q2055** Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose K
BETOS: O1D Chemotherapy
Drugs: ABECMA
Coding Clinic: 2022, Q1; 2024, Q3

C **Q2056** Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose Ⓐ G
BETOS: O1D Chemotherapy
Drugs: CARVYKTI
Coding Clinic: 2022, Q4

D **Q3001** Radioelements for brachytherapy, any type, each B
BETOS: P7A Oncology - radiation therapy
Other carrier priced

C **Q3014** Telehealth originating site facility fee A
BETOS: Y2 Other - Non-Medicare fee schedule
Coding Clinic: 2019, Q3

D **Q3027** Injection, interferon beta-1a, 1 mcg for intramuscular use K2 ASC K
BETOS: O1E Other drugs
Drugs: AVONEX, AVONEX PEN
Coding Clinic: 2014, Q1

I **Q3028** Injection, interferon beta-1a, 1 mcg for subcutaneous use E1
BETOS: O1E Other drugs
Service not separately priced by Part B

D **Q3031** Collagen skin test N1 ASC N
BETOS: D1A Medical/surgical supplies
Price established using national RVUs

CAST AND SPLINT SUPPLIES (Q4001-Q4051)

C **Q4001** Casting supplies, body cast adult, with or without head, plaster DME Ⓐ B
BETOS: D1A Medical/surgical supplies
Coding Clinic: 2002, Q2

C **Q4002** Cast supplies, body cast adult, with or without head, fiberglass DME Ⓐ B
BETOS: D1A Medical/surgical supplies

C **Q4003** Cast supplies, shoulder cast, adult (11 years +), plaster DME Ⓐ B
BETOS: D1A Medical/surgical supplies

C **Q4004** Cast supplies, shoulder cast, adult 11 years +), fiberglass DME Ⓐ B
BETOS: D1A Medical/surgical supplies

C **Q4005** Cast supplies, long arm cast, adult (11 years +), plaster DME Ⓐ B
BETOS: D1A Medical/surgical supplies



Short arm cast

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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Q4006 Cast supplies, long arm cast, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4007 Cast supplies, long arm cast, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4008 Cast supplies, long arm cast, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4009 Cast supplies, short arm cast, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4010 Cast supplies, short arm cast, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4011 Cast supplies, short arm cast, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4012 Cast supplies, short arm cast, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4013 Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4014 Cast supplies, gauntlet cast (includes lower forearm and hand), adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4015 Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4016 Cast supplies, gauntlet cast (includes lower forearm and hand), pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4017 Cast supplies, long arm splint, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4018 Cast supplies, long arm splint, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4019 Cast supplies, long arm splint, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4020 Cast supplies, long arm splint, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4021 Cast supplies, short arm splint, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4022 Cast supplies, short arm splint, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4023 Cast supplies, short arm splint, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4024 Cast supplies, short arm splint, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4025 Cast supplies, hip spica (one or both legs), adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4026 Cast supplies, hip spica (one or both legs), adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4027 Cast supplies, hip spica (one or both legs), pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4028 Cast supplies, hip spica (one or both legs), pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4029 Cast supplies, long leg cast, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4030 Cast supplies, long leg cast, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4031 Cast supplies, long leg cast, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4032 Cast supplies, long leg cast, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4033 Cast supplies, long leg cylinder cast, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4034 Cast supplies, long leg cylinder cast, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4035 Cast supplies, long leg cylinder cast, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

Q4036 Cast supplies, long leg cylinder cast, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

Q4037 Cast supplies, short leg cast, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

♂ Male only ♀ Female only A Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **Q4038** Cast supplies, short leg cast, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

C **Q4039** Cast supplies, short leg cast, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

C **Q4040** Cast supplies, short leg cast, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

C **Q4041** Cast supplies, long leg splint, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

C **Q4042** Cast supplies, long leg splint, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

C **Q4043** Cast supplies, long leg splint, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

C **Q4044** Cast supplies, long leg splint, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

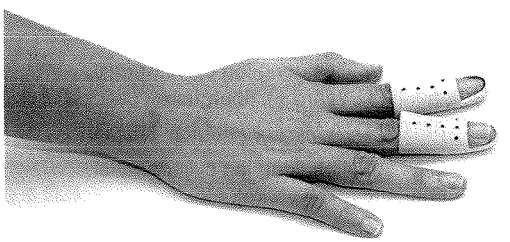
C **Q4045** Cast supplies, short leg splint, adult (11 years +), plaster DME A B
BETOS: D1A Medical/surgical supplies

C **Q4046** Cast supplies, short leg splint, adult (11 years +), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

C **Q4047** Cast supplies, short leg splint, pediatric (0-10 years), plaster DME A B
BETOS: D1A Medical/surgical supplies

C **Q4048** Cast supplies, short leg splint, pediatric (0-10 years), fiberglass DME A B
BETOS: D1A Medical/surgical supplies

C **Q4049** Finger splint, static DME B
BETOS: D1A Medical/surgical supplies
Coding Clinic: 2007, Q2



Finger splint

C **Q4050** Cast supplies, for unlisted types and materials of casts B
BETOS: D1A Medical/surgical supplies
Other carrier priced

C **Q4051** Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies) B
BETOS: D1A Medical/surgical supplies
Other carrier priced
Coding Clinic: 2002, Q2

MISCELLANEOUS DRUGS (Q4074-Q4082)

C **Q4074** Iloprost, inhalation solution, Food and Drug Administration (FDA)-approved final product, non-compounded, administered through DME, unit dose form, up to 20 micrograms Y
BETOS: D1G Drugs Administered through DME
Drugs: VENTAVIS

D **Q4081** Injection, epoetin alfa, 100 units (for ESRD on dialysis) N
BETOS: O1E Other drugs
Other carrier priced
Drugs: EPOGEN, PROCRIT

C **Q4082** Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP) B
BETOS: D1E Other DME

SKIN SUBSTITUTES AND BIOLOGICALS (Q4100-Q4353)

C **Q4100** Skin substitute, not otherwise specified N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4; 2009, Q1; 2010, Q1; 2012, Q2; 2018, Q2; 2022, Q2

C **Q4101** Apligraf, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: APLIGRAF
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2

C **Q4102** Oasis wound matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: OASIS WOUND MATRIX
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2; 2012, Q3

C **Q4103** Oasis burn matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ANIMAL-DERIVED, EXTRACELLULAR MATRIX WOUND CARE PRODUCT
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2

C **Q4104** Integra bilayer matrix wound dressing (BMWD), per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: INTEGRA BILAYER WOUND MATRIX, INTEGRA MESHED BILAYER WOUND MATRIX
Coding Clinic: 2008, Q4; 2010, Q1; 2010, Q1; 2011, Q1; 2012, Q2; 2014, Q3

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Q4105 Integra dermal regeneration template (DRT) or integra omnigraft dermal regeneration matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: INTEGRA DERMAL REGENERATION TEMPLATE, INTEGRA MESHED DERMAL REGENERATION TEMPLATE, INTEGRA OMNIGRAFT DERMAL REGENERATION MATRIX
Coding Clinic: 2008, Q4; 2010, Q1; 2010, Q1; 2011, Q1; 2012, Q2

Q4106 Dermagraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2

Q4107 GRAFTJACKET, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2; 2021, Q1

Q4108 Integra matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: INTEGRA WOUND MATRIX, INTEGRA WOUND MATRIX THIN
Coding Clinic: 2008, Q4; 2010, Q1; 2010, Q1; 2011, Q1; 2012, Q2

Q4110 PriMatrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: PRIMATRIX, PRIMATRIX AG
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2

Q4111 GammaGraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: GAMMAGRAFT
Coding Clinic: 2008, Q4; 2009, Q1; 2010, Q1; 2011, Q1; 2012, Q2

Q4112 Cymetra, injectable, 1cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2

Q4113 GRAFTJACKET XPRESS, injectable, 1cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2008, Q4; 2010, Q1; 2011, Q1; 2012, Q2

Q4114 Integra flowable wound matrix, injectable, 1cc N1 ASC N
BETOS: O1E Other drugs
Drugs: INTEGRA FLOWABLE WOUND MATRIX
Coding Clinic: 2008, Q4; 2010, Q1; 2010, Q1; 2012, Q2

Q4115 AlloSkin, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ALLOSKIN, ALLOSKIN CRYO
Coding Clinic: 2009, Q3; 2010, Q1; 2011, Q1; 2012, Q2

Q4116 AlloDerm, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2009, Q3; 2010, Q1; 2011, Q1; 2012, Q2

Q4117 HYALOMATRIX, per square centimeter N1 ASC N
BETOS: O1E Other drugs

Q4118 MatriStem micromatrix, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: ACELL MICROMATRIX (FINE) 100MG, ACELL MICROMATRIX 1000MG, ACELL MICROMATRIX 100MG, ACELL MICROMATRIX 200MG, ACELL MICROMATRIX 20MG, ACELL MICROMATRIX 30MG, ACELL MICROMATRIX 500MG, ACELL MICROMATRIX 60MG
Coding Clinic: 2011, Q1; 2012, Q2; 2013, Q4

Q4121 TheraSkin, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: THERASKIN
Coding Clinic: 2011, Q1; 2012, Q2

Q4122 Dermacell, dermacell awm or dermacell awm porous, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2012, Q1; 2012, Q2

Q4123 AlloSkin RT, per square centimeter N1 ASC N
BETOS: O1E Other drugs

Q4124 OASIS ultra tri-layer wound matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: OASIS ULTRA TRI-LAYER MATRIX
Coding Clinic: 2012, Q2

Q4125 Arthroflex, per square centimeter N1 ASC N
BETOS: O1E Other drugs

Q4126 MemoDerm, DermaSpan, TranZgraft or InteguPly, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: DERMASPAN, DERMASPAN ACD

Q4127 Talymed, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: TALYMED

Q4128 Flex hd, or allopatch hd, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ACELLULAR DERMAL ALLOGRAFT, ALLOPATCH, ALLOPATCH HD, FLEX PLIABLE, FLEX PLIABLE PERFORATED, FLEX STRUCTURAL, FLEXHD, FLEXHD PLIABLE, FLEXHD PLIABLE (SHAPED), FLEXHD PLIABLE HD, FLEXHD PLIABLE MAX, FLEXHD PLIABLE PERFORATED, FLEXHD PLIABLE SHAPED, FLEXHD PLIABLE SHAPED - LARGE, FLEXHD PLIABLE SHAPED - MEDIUM, FLEXHD

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PLIABLE SHAPED - SMALL, FLEXHD PLIABLE SHAPED PERFORATED, MATRIX HD, MATRIX HD FENESTRATED, WC ALLOPATCH
Coding Clinic: 2022, Q4

C **Q4130** Strattice™, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2012, Q2

C **Q4132** Grafix CORE and GrafixPL CORE, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: GRAFIX CORE

C **Q4133** Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CRYOPRESERVED UMBILICAL TISSUE, GRAFIX PRIME, GRAFIX XC, GRAFIXPL PRIME, STRAVIX, STRAVIX PL

C **Q4134** Hmatrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs

C **Q4135** Mediskin, per square centimeter N1 ASC N
BETOS: O1E Other drugs

C **Q4136** E-Z Derm, per square centimeter N1 ASC N
BETOS: O1E Other drugs

C **Q4137** Amnioexcel, amnioexcel plus or biodexcel, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOEXCEL, AMNIOEXCEL PLUS

C **Q4138** BioDFence dryflex, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4139** AmnioMatrix or biodmatrix, injectable, 1 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4140** Biodfence, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4141** AlloSkin AC, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4142** XCM BIOLOGIC tissue matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4143** Repriza, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ACELLULAR DERMAL MATRIX, REPRIZA
Coding Clinic: 2014, Q1

C **Q4145** EpiFix, injectable, 1 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4146** Tensix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4147** Architect, Architect PX, or Architect FX, extracellular matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ARCHITECT
Coding Clinic: 2014, Q1

C **Q4148** NEOX CORD 1K, NEOX CORD RT, or CLARIX CORD 1K, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CLARIX CORD 1K, NEOX CORD 1K, NEOX CORD RT
Coding Clinic: 2014, Q1

C **Q4149** Excellagen, 0.1 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q1

C **Q4150** Allowrap DS or Dry, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ALLOWRAP DRY, ALLOWRAP DS
Coding Clinic: 2014, Q4

C **Q4151** AmnioBand or Guardian, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOBAND MEMBRANE, AMNIOBAND VIABLE, WC AMNIOBAND
Coding Clinic: 2014, Q4

C **Q4152** DermaPure, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: DERMAPURE
Coding Clinic: 2014, Q4

C **Q4153** Dermavest and plurivest, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: DERMAVEST, PLURIVEST
Coding Clinic: 2014, Q4; 2016, Q1

C **Q4154** Biovance, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: BIOVANCE
Coding Clinic: 2014, Q4

C **Q4155** NeoxFlo or clarixFlo, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: CLARIX FLO, NEOX FLO
Coding Clinic: 2014, Q4

C **Q4156** NEOX 100 or CLARIX 100, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CLARIX 100, NEOX 100
Coding Clinic: 2014, Q4

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C **Q4157** Revitalon, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2014, Q4

C **Q4158** Kerecis Omega3, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: MARIGEN, MARIGEN EXPANSE, MARIGEN FENESTRATED, MARIGEN MICRO
Coding Clinic: 2014, Q4

C **Q4159** Affinity, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AFFINITY
Coding Clinic: 2014, Q4

C **Q4160** NuShield, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: NUSHIELD
Coding Clinic: 2014, Q4

C **Q4161** Bio-ConneKt wound matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: BIO-CONNEKT, BIO-CONNEKT WOUND MATRIX, ORTHONOVIS CONNECT
Coding Clinic: 2016, Q1

C **Q4162** WoundEx Flow, BioSkin Flow, 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2016, Q1

C **Q4163** WoundEx, BioSkin, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: WOUNDEX MEMBRANE, WOUNDEX® MEMBRANE
Coding Clinic: 2016, Q1

C **Q4164** Helicoll, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: HELICOLL
Coding Clinic: 2016, Q1

C **Q4165** Keramatrix or kerasorb, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2016, Q1

C **Q4166** Cytal, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CYTAL BURN MATRIX, CYTAL WOUND MATRIX
Coding Clinic: 2017, Q1

C **Q4167** Truskin, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2017, Q1

C **Q4168** Amnioband, 1 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2017, Q1

C **Q4169** Artacent wound, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2017, Q1

C **Q4170** Cygnus, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CYGNUS CRYO MAX, CYGNUS MAX, CYGNUS MAX XL, CYGNUS SOLO
Coding Clinic: 2017, Q1

C **Q4171** Interfyl, 1 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: INTERFYL
Coding Clinic: 2017, Q1

C **Q4173** Palingen or palingen xplus, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: PALINGEN HYDROMEMBRANE, PALINGEN MEMBRANE, PALINGEN XPLUS HYDROMEMBRANE, PALINGEN XPLUS MEMBRANE
Coding Clinic: 2017, Q1

C **Q4174** Palingen or promatrx, 0.36 mg per 0.25 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2017, Q1

C **Q4175** Miroderm, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: MIRODERM, MIRODERM FENESTRATED, MIRODERM FENESTRATED PLUS
Coding Clinic: 2017, Q1

C **Q4176** Neopatch or therion, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2018, Q1; 2020, Q2

C **Q4177** Floweramnioflo, 0.1 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2018, Q1

C **Q4178** Floweramniopatch, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: FLOWERPATCH
Coding Clinic: 2018, Q1

C **Q4179** Flowerderm, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2018, Q1

C **Q4180** Revita, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: REVITA
Coding Clinic: 2018, Q1

C **Q4181** Amnio wound, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2018, Q1

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **Q4182** Transcyte, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2018, Q1

C **Q4183** Surgigraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4184** Cellesta or cellesta duo, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CELLESTA
Coding Clinic: 2019, Q1

C **Q4185** Cellesta flowable amnion (25 mg per cc); per 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4186** Epifix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: EPIFIX, EPIFIX AMNIOTIC MEMBRANE ALLOGRAFT
Coding Clinic: 2019, Q1

C **Q4187** Epicord, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: EPICORD
Coding Clinic: 2019, Q1

C **Q4188** Amnioarmor, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOARMOR, AMNIOARMOR DUAL LAYER AMNION PATCH
Coding Clinic: 2019, Q1

C **Q4189** Artacent ac, 1 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4190** Artacent ac, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ARTACENT AC
Coding Clinic: 2019, Q1

C **Q4191** Restorigin, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: RESTORIGIN, RESTORIGIN AMNION PATCH
Coding Clinic: 2019, Q1

C **Q4192** Restorigin, 1 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4193** Coll-e-derm, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: COLL-E-DERM, COLL-E-DERM™
Coding Clinic: 2019, Q1

C **Q4194** Novachor, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: NOVACHOR
Coding Clinic: 2019, Q1

C **Q4195** Puraply, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4196** Puraply am, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: PURAPLY AM
Coding Clinic: 2019, Q1

C **Q4197** Puraply xt, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: PURAPLY AM XT
Coding Clinic: 2019, Q1

C **Q4198** Genesis amniotic membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4199** Cygnus matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CYGNUS MATRIX
Coding Clinic: 2022, Q1

C **Q4200** Skin te, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4201** Matrion, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: MATRION
Coding Clinic: 2019, Q1

C **Q4202** Keroxx (2.5g/cc), 1cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4203** Derma-gide, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

C **Q4204** Xwrap, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: XWRAP
Coding Clinic: 2019, Q1

C **Q4205** Membrane graft or membrane wrap, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: MEMBRANE WRAP
Coding Clinic: 2019, Q4

C **Q4206** Fluid flow or fluid GF, 1 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4208** Novafix, per square cenitmeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4209** Surgraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

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C **Q4211** Amnion bio or Axobiomembrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4212** Allogen, per cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4213** Ascent, 0.5 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4214** Cellesta cord, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4215** Axolotl ambient or axolotl cryo, 0.1 mg N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4216** Artacent cord, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4217** Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: WOUNDFIX, WOUNDFIX®
Coding Clinic: 2019, Q4

C **Q4218** Surgicord, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4219** Surgigraft-dual, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4220** BellaCell HD or Surederm, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4221** Amniowrap2, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMINOWRAP, AMINOWRAP2
Coding Clinic: 2019, Q4

C **Q4222** Progenamatrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: PROGENAMATRIX, PROGENAMATRIX 3 CM X 3 CM
Coding Clinic: 2019, Q4

C **Q4224** Human health factor 10 amniotic patch (hhf10-p), per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2022, Q2

C **Q4225** Amniobind or dermabind tl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOBIND, DERMABIND TL
Coding Clinic: 2022, Q2; 2024, Q1

C **Q4226** MyOwn skin, includes harvesting and preparation procedures, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2019, Q4

C **Q4227** Amniocore, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOCORE, AMNIOCORE SURGICAL
Coding Clinic: 2020, Q2

C **Q4229** Cogenex amniotic membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: COGENEX
Coding Clinic: 2020, Q2

C **Q4230** Cogenex flowable amnion, per 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4231** Corplex p, per cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4232** Corplex, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CORPLEX
Coding Clinic: 2020, Q2

C **Q4233** Surfactor or nudyn, per 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4234** Xcellerate, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: XCELLERATE
Coding Clinic: 2020, Q2

C **Q4235** Amniorepair or altiply, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOREPAIR
Coding Clinic: 2020, Q2

C **Q4236** Carepatch, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CAREPATCH AMNIOTIC MEMBRANE
Coding Clinic: 2020, Q2; 2021, Q4; 2021, Q4

C **Q4237** Cryo-cord, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4238** Derm-maxx, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: DERM-MAXX
Coding Clinic: 2020, Q2

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C **Q4239** Amnio-maxx or amnio-maxx lite, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMINO-MAXX, AMNIO-MAXX
Coding Clinic: 2020, Q2

C **Q4240** Corecyte, for topical use only, per 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4241** Polycyte, for topical use only, per 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4242** Amniocyte plus, per 0.5 cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4245** Amniotext, per cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4246** Coretext or protext, per cc N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4247** Amniotext patch, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q2

C **Q4248** Dermacyte amniotic membrane allograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: DERMACYTE, DERMACYTE AMNIOTIC WOUND CARE MATRIX
Coding Clinic: 2020, Q2

C **Q4249** Amniply, for topical use only, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q4

C **Q4250** Amnioamp-mp, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q4

C **Q4251** Vim, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2021, Q4

C **Q4252** Vendaje, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: VENDAJE
Coding Clinic: 2021, Q4

C **Q4253** Zenith amniotic membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ZENITH
Coding Clinic: 2021, Q4

C **Q4254** Novafix dl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q4

C **Q4255** Reguard, for topical use only, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2020, Q4

C **Q4256** Mlg-complete, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: MLG-COMPLETE, MLG-COMPLETE WOUND CARE
Coding Clinic: 2022, Q2

C **Q4257** Relese, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: RELESE
Coding Clinic: 2022, Q2

C **Q4258** Enverse, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ENVERSE
Coding Clinic: 2022, Q2

C **Q4259** Celera dual layer or celera dual membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CELERA, CELERA DUAL LAYER, CELERA DUAL MEMBRANE
Coding Clinic: 2022, Q3

C **Q4260** Signature apatch, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2022, Q3

C **Q4261** Tag, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2022, Q3

C **Q4262** Dual layer impax membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: IMPAX DUAL LAYER MEMBRANE
Coding Clinic: 2023, Q1

C **Q4263** Surgraft tl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: SURGRAFT TL MEMBRANE
Coding Clinic: 2023, Q1

C **Q4264** Cocoon membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q1

C **Q4265** Neostim tl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: NEOSTIM TL MEMBRANE
Coding Clinic: 2023, Q2

C **Q4266** Neostim membrane, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: NEOSTIM MEMBRANE
Coding Clinic: 2023, Q2

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C **Q4267** Neostim dl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: NEOSTIM DL, NEOSTIM DL MEMBRANE
Coding Clinic: 2023, Q2

C **Q4268** Surgraft ft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: SURGRAFT FT FULL THICKNESS GRAFT
Coding Clinic: 2023, Q2

C **Q4269** Surgraft xt, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q2

C **Q4270** Complete sl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q2

C **Q4271** Complete ft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: COMPLETE FT
Coding Clinic: 2023, Q2

C **Q4272** Esano a, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **Q4273** Esano aaa, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **Q4274** Esano ac, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **Q4275** Esano aca, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **Q4276** Orion, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ORION
Coding Clinic: 2023, Q3

C **Q4278** Epieffect, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: EPIEFFECT
Coding Clinic: 2023, Q3

C **Q4279** Vendaje ac, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: VENDAJE AC
Coding Clinic: 2024, Q1

C **Q4280** Xcell amnio matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: XCELL AMNIO MATRIX, XCELL AMNIO MATRIX 2CM X 2CM
Coding Clinic: 2023, Q3

C **Q4281** Barrera sl or barrera dl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: BARRERA DL
Coding Clinic: 2023, Q3

C **Q4282** Cygnus dual, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: CYGNUS DUAL, CYGNUS DUAL AMNIOTIC PATCH
Coding Clinic: 2023, Q3

C **Q4283** Biovance tri-layer or biovance 3l, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: BIOVANCE 3L
Coding Clinic: 2023, Q3

C **Q4284** Dermabind sl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q3

C **Q4285** Nudyn dl or nudyn dl mesh, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q4

C **Q4286** Nudyn sl or nudyn slw, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2023, Q4

C **Q4287** Dermabind dl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1

C **Q4288** Dermabind ch, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1

C **Q4289** Revoshield + amniotic barrier, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1

C **Q4290** Membrane wrap-hydro, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: MEMBRANE WRAP - HYDRO
Coding Clinic: 2024, Q1

C **Q4291** Lamellas xt, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1

C **Q4292** Lamellas, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1

C **Q4293** Acesso dl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ACESSO DL
Coding Clinic: 2024, Q1

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C **Q4294** Amnio quad-core, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIO QUAD-CORE
Coding Clinic: 2024, Q1

C **Q4295** Amnio tri-core amniotic, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIO TRI-CORE
Coding Clinic: 2024, Q1

C **Q4296** Rebound matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: REBOUND
Coding Clinic: 2024, Q1

C **Q4297** Emerge matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: EMERGE
Coding Clinic: 2024, Q1

C **Q4298** Amnicore pro, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q1

C ~~**Q4299**~~ Amnicore pro+, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AMNIOCORE PRO+
Coding Clinic: 2024, Q1

C **Q4300** Acesso tl, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ACESSO TL
Coding Clinic: 2024, Q1

C **Q4301** Activate matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: ACTIVATE MATRIX
Coding Clinic: 2024, Q1

C **Q4302** Complete aca, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: COMPLETE ACA
Coding Clinic: 2024, Q1

C **Q4303** Complete aa, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: COMPLETE AA
Coding Clinic: 2024, Q1

C **Q4304** Grafix plus, per square centimeter N
BETOS: O1E Other drugs
Drugs: GRAFIX PL, GRAFIX PLUS
Coding Clinic: 2024, Q1

● C **Q4305** American amnion ac tri-layer, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **Q4306** American amnion ac, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **Q4307** American amnion, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **Q4308** Sanopellis, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **Q4309** Via matrix, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **Q4310** Procenta, per 100 mg N1 ASC N
BETOS: O1E Other drugs
Drugs: PROCENTA
Coding Clinic: 2024, Q2

● C **Q4311** Acesso, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4312** Acesso ac, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4313** Dermabind fm, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4314** Reeva ft, per square cenitmeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4315** Regenelink amniotic membrane allograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4316** Amchoplast, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4317** Vitograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4318** E-graft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4319** Sanograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4320** Pellograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4321** Renograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

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● C **Q4322** Caregraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4323** Alloply, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4324** Amniotx, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4325** Acapatch, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4326** Woundplus, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4327** Duoamnion, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4328** Most, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4329** Singlay, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4330** Total, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4331** Axolotl graft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4332** Axolotl dualgraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Drugs: AXOLOTL DUALGRAFT
Coding Clinic: 2024, Q3

● C **Q4333** Ardeograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q4334** Amnioplast 1, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4335** Amnioplast 2, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4336** Artacent c, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4337** Artacent trident, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4338** Artacent velos, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4339** Artacent vericlen, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4340** Simpligraft, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4341** Simplimax, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4342** Theramend, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4343** Dermacyte ac matrix amniotic membrane allograft, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4344** Tri-membrane wrap, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4345** Matrix hd allograft dermis, per square centimeter N1 ASC N
BETOS: O1E Other drugs

● C **Q4346** Shelter dm matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4347** Rampart dl matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4348** Sentry sl matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4349** Mantle dl matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4350** Palisade dm matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4351** Enclose tl matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4352** Overlay sl matrix, per square centimeter
BETOS: O1E Other drugs

● C **Q4353** Xceed tl matrix, per square centimeter
BETOS: O1E Other drugs

HOSPICE AND HOME HEALTH CARE (Q5001-Q5010)

D **Q5001** Hospice or home health care provided in patient's home/residence B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5002** Hospice or home health care provided in assisted living facility B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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D **Q5003** Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF) B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5004** Hospice care provided in skilled nursing facility (SNF) B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5005** Hospice care provided in inpatient hospital B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5006** Hospice care provided in inpatient hospice facility B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5007** Hospice care provided in long term care facility B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5008** Hospice care provided in inpatient psychiatric facility B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5009** Hospice or home health care provided in place not otherwise specified (NOS) B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

D **Q5010** Hospice home care provided in a hospice facility B
BETOS: Y2 Other - Non-Medicare fee schedule
Service not separately priced by Part B

CHEMOTHERAPY MEDICATIONS (Q5101), SEE ALSO CHEMOTHERAPY ANTI-EMETIC MEDICATIONS (Q0155-Q0181)

D **Q5101** Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: ZARXIO
Coding Clinic: 2016, Q2; 2018, Q1; 2018, Q2

ANTI-INFLAMMATORY MEDICATION AND CHEMOTHERAPY MEDICATION (Q5103-Q5106)

D **Q5103** Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: INFLECTRA
Coding Clinic: 2018, Q1; 2018, Q2; 2018, Q2

D **Q5104** Injection, infliximab-abda, biosimilar, (renflexis), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: RENFLEXIS
Coding Clinic: 2018, Q1; 2018, Q2; 2018, Q2; 2018, Q2

D **Q5105** Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for esrd on dialysis), 100 units K2 ASC K
BETOS: O1E Other drugs
Other carrier priced
Drugs: RETACRIT
Coding Clinic: 2018, Q2

D **Q5106** Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units K2 ASC K
BETOS: O1E Other drugs
Drugs: RETACRIT
Coding Clinic: 2018, Q2

ANTI-INFLAMMATORY MEDICATION (Q5107-Q5111)

D **Q5107** Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: MVASI
Coding Clinic: 2019, Q1; 2019, Q4

C **Q5108** Injection, pegfilgrastim-jmdb (fulphila), biosimilar, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: FULPHILA
Coding Clinic: 2018, Q3; 2018, Q4; 2019, Q1; 2023, Q2

D **Q5109** Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg K5 ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2019, Q1

D **Q5110** Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram K2 ASC K
BETOS: O1E Other drugs
Drugs: NIVESTYM
Coding Clinic: 2018, Q3; 2019, Q1

C **Q5111** Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: UDENYCA
Coding Clinic: 2019, Q1; 2023, Q2

CANCER AND VISION ASSOCIATED DRUGS (Q5112-Q5146)

C **Q5112** Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ONTRUZANT
Coding Clinic: 2019, Q3

C **Q5113** Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: HERZUMA
Coding Clinic: 2019, Q3

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C **Q5114** Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: OGIVRI
Coding Clinic: 2019, Q3

D **Q5115** Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg K2 ASC K
BETOS: O1D Chemotherapy
Drugs: TRUXIMA
Coding Clinic: 2019, Q3

C **Q5116** Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: TRAZIMERA
Coding Clinic: 2019, Q4

C **Q5117** Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: KANJINTI, KANJINTI (KIT)
Coding Clinic: 2019, Q4

C **Q5118** Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ZIRABEV
Coding Clinic: 2019, Q4

C **Q5119** Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: RUXIENCE
Coding Clinic: 2020, Q2

C **Q5120** Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: ZIEXTENZO
Coding Clinic: 2020, Q2; 2023, Q2

C **Q5121** Injection, infliximab-axxq, biosimilar, (avsola), 10 mg K2 Ⓐ ASC K
BETOS: O1E Other drugs
Drugs: AVSOLA
Coding Clinic: 2020, Q2

C **Q5122** Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: NYVEPRIA
Coding Clinic: 2021, Q1; 2023, Q2

C **Q5123** Injection, rituximab-arrx, biosimilar, (riabni), 10 mg K2 Ⓐ ASC K
BETOS: O1D Chemotherapy
Drugs: RIABNI
Coding Clinic: 2021, Q3

C **Q5124** Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: BYOOVIZ
Coding Clinic: 2022, Q2

C **Q5125** Injection, filgrastim-ayow, biosimilar, (releuko), 1 microgram K2 ASC G
BETOS: O1E Other drugs
Drugs: RELEUKO
Coding Clinic: 2022, Q4

C **Q5126** Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg K2 ASC G
BETOS: O1D Chemotherapy
Drugs: ALYMSYS
Coding Clinic: 2023, Q1

C **Q5127** Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: STIMUFEND
Coding Clinic: 2023, Q2

C **Q5128** Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: CIMERLI
Coding Clinic: 2023, Q2

C **Q5129** Injection, bevacizumab-adcd (vegzelma), biosimilar, 10 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: VEGZELMA
Coding Clinic: 2023, Q2

C **Q5130** Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg K2 ASC G
BETOS: O1E Other drugs
Drugs: FYLNETRA
Coding Clinic: 2023, Q2

● C **Q5133** Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: TOFIDENCE
Coding Clinic: 2024, Q2

● C **Q5134** Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg Ⓐ E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q2

● C **Q5135** Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg K2 Ⓐ ASC G
BETOS: O1E Other drugs
Drugs: TYENNE

● C **Q5136** Injection, denosumab-bbdz (jubbonti/ wyost), biosimilar, 1 mg E2
BETOS: O1D Chemotherapy

● C **Q5137** Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg N1 Ⓐ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

● C **Q5138** Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg N1 Ⓐ ASC E2
BETOS: O1E Other drugs
Coding Clinic: 2024, Q3

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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● C **Q5139** Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg
BETOS: O1E Other drugs

● C **Q5140** Injection, adalimumab-fkjp, biosimilar, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **Q5141** Injection, adalimumab-aaty, biosimilar, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **Q5142** Injection, adalimumab-ryvk biosimilar, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **Q5143** Injection, adalimumab-adbm, biosimilar, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **Q5144** Injection, adalimumab-aacf (idacio), biosimilar, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **Q5145** Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg Ⓐ
BETOS: O1E Other drugs

● C **Q5146** Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg
BETOS: O1E Other drugs

ASSESSMENT AND COUNSELING CHAPLAIN SERVICES (Q9001-Q9004)

C **Q9001** Assessment by chaplain services B
BETOS: Z2 Undefined codes
Value not established
Coding Clinic: 2022, Q4; 2024, Q1

C **Q9002** Counseling, individual, by chaplain services B
BETOS: Z2 Undefined codes
Value not established
Coding Clinic: 2022, Q4; 2024, Q1

C **Q9003** Counseling, group, by chaplain services B
BETOS: Z2 Undefined codes
Value not established
Coding Clinic: 2022, Q4; 2024, Q1

C **Q9004** Department of veterans affairs whole health partner services E1
BETOS: Z2 Undefined codes
Value not established

CONTRAST AGENTS/DIAGNOSTIC IMAGING (Q9950-Q9983), SEE ALSO IMAGING STUDIES (S8030-S8092)

C **Q9950** Injection, sulfur hexafluoride lipid microspheres, per ml N1 ASC N
BETOS: I1F Standard imaging - other
Other carrier priced
Drugs: LUMASON, LUMASON NOVAPLUS
Coding Clinic: 2006, Q1; 2008, Q1; 2016, Q1; 2016, Q4

D **Q9951** Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2006, Q1; 2012, Q3

D **Q9953** Injection, iron-based magnetic resonance contrast agent, per ml N1 ASC N
BETOS: I1F Standard imaging - other
Other carrier priced
Coding Clinic: 2006, Q1; 2012, Q3

D **Q9954** Oral magnetic resonance contrast agent, per 100 ml N1 ASC N
BETOS: I1F Standard imaging - other
Other carrier priced
Coding Clinic: 2006, Q1; 2012, Q3
Pub: 100-4, Chapter-13, 40

C **Q9955** Injection, perflexane lipid microspheres, per ml N1 ASC N
BETOS: I1F Standard imaging - other
Other carrier priced
Coding Clinic: 2012, Q3

C **Q9956** Injection, octafluoropropane microspheres, per ml N1 ASC N
BETOS: I1F Standard imaging - other
Other carrier priced
Drugs: OPTISON
Coding Clinic: 2012, Q3

C **Q9957** Injection, perflutren lipid microspheres, per ml N1 ASC N
BETOS: I1F Standard imaging - other
Other carrier priced
Drugs: DEFINITY, DEFINITY RT
Coding Clinic: 2012, Q3

D **Q9958** High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: CYSTO-CONRAY II, CYSTOGRAFIN, CYSTOGRAFIN-DILUTE
Coding Clinic: 2005, Q3; 2007, Q1; 2011, Q4; 2012, Q3
Pub: 100-4, Chapter-13, 40

D **Q9959** High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q3; 2007, Q1; 2012, Q3

D **Q9960** High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q3; 2007, Q1; 2012, Q3

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D **Q9961** High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q3; 2007, Q1; 2012, Q3

D **Q9962** High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q3; 2007, Q1; 2012, Q3

D **Q9963** High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: GASTROGRAFIN, MD GASTROVIEW
Coding Clinic: 2005, Q3; 2007, Q1; 2012, Q3

D **Q9964** High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Coding Clinic: 2005, Q3; 2007, Q1; 2011, Q4; 2012, Q3
Pub: 100-4, Chapter-13, 40

D **Q9965** Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: OMNIPAQUE 140, OMNIPAQUE 180
Coding Clinic: 2008, Q1; 2011, Q4; 2012, Q3

D **Q9966** Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: IODIXANOL, IOMERON, IOPAMIDOL, ISOVUE-200, ISOVUE-250, ISOVUE-M-200, ISOVUE-M-201, OMNIPAQUE 240, OPTIRAY 240, ULTRAVIST 240, VISIPAQUE 270
Coding Clinic: 2008, Q1; 2012, Q3

D **Q9967** Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Drugs: IODIXANOL, IOMERON, IOVERSOL INJECTION 636 MG/ML, IOVERSOL INJECTION 678 MG/ML, IOVERSOL INJECTION 741 MG/ML, ISOVUE-300, ISOVUE-370, ISOVUE-M-300, OMNIPAQUE 300, OMNIPAQUE 300 (NOVAPLUS), OMNIPAQUE 350, OMNIPAQUE 350 (NOVAPLUS), OPTIRAY 300, OPTIRAY 320, OPTIRAY 350, OXILAN 350, ULTRAVIST 300, ULTRAVIST 370, VISIPAQUE 320
Coding Clinic: 2008, Q1; 2011, Q4; 2012, Q3

C **Q9968** Injection, non-radioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg K2 ASC K
BETOS: I1E Standard imaging - nuclear medicine
Drugs: ISOSULFAN BLUE, PROVAYBLUE

D **Q9969** Tc-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose K
BETOS: Y1 Other - Medicare fee schedule

D **Q9982** Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Service not separately priced by Part B
Coding Clinic: 2016, Q2; 2016, Q2

D **Q9983** Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries N1 ASC N
BETOS: I1E Standard imaging - nuclear medicine
Service not separately priced by Part B
Coding Clinic: 2016, Q2; 2016, Q2

OTHER DRUGS (Q9991-Q9998)

C **Q9991** Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SUBLOCADE
Coding Clinic: 2018, Q2

C **Q9992** Injection, buprenorphine extended-release (sublocade), greater than 100 mg K2 ASC K
BETOS: O1E Other drugs
Drugs: SUBLOCADE
Coding Clinic: 2018, Q2

● C **Q9996** Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg A
BETOS: O1E Other drugs

● C **Q9997** Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg A
BETOS: O1E Other drugs

● C **Q9998** Injection, ustekinumab-aekn (selarsdi), 1 mg A
BETOS: O1E Other drugs

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NOTES

DIAGNOSTIC RADIOLOGY SERVICES (R0070-R0076)

TRANSPORTATION, PORTABLE RADIOLOGY EQUIPMENT (R0070-R0076)

D **R0070** Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen B

BETOS: I1F Standard imaging - other

Price established by carriers

D **R0075** Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen B

BETOS: I1F Standard imaging - other

Price established by carriers

D **R0076** Transportation of portable EKG to facility or location, per patient B

BETOS: I1F Standard imaging - other

Price established by carriers

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NOTES

TEMPORARY NATIONAL CODES (NON-MEDICARE) (S0012-S9999)

NON-MEDICARE DRUG CODES (S0012-S0197)

S0012 Butorphanol tartrate, nasal spray, 25 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0013 Esketamine, nasal spray, 1 mg Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0014 Tacrine hydrochloride, 10 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0017 Injection, aminocaproic acid, 5 grams
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0021 Injection, cefoperazone sodium, 1 gram
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0023 Injection, cimetidine hydrochloride, 300 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0028 Injection, famotidine, 20 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0032 Injection, nafcillin sodium, 2 grams
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0034 Injection, ofloxacin, 400 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0039 Injection, sulfamethoxazole and trimethoprim, 10 ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0040 Injection, ticarcillin disodium and clavulanate potassium, 3.1 grams
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0074 Injection, cefotetan disodium, 500 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0078 Injection, fosphenytoin sodium, 750 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0080 Injection, pentamidine isethionate, 300 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0081 Injection, piperacillin sodium, 500 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0088 Imatinib, 100 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0090 Sildenafil citrate, 25 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0091 Granisetron hydrochloride, 1 mg (for circumstances falling under the Medicare statute, use Q0166)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0092 Injection, hydromorphone hydrochloride, 250 mg (loading dose for infusion pump)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0093 Injection, morphine sulfate, 500 mg (loading dose for infusion pump)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0104 Zidovudine, oral, 100 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0106 Bupropion HCL sustained release tablet, 150 mg, per bottle of 60 tablets
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0108 Mercaptopurine, oral, 50 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0109 Methadone, oral, 5 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0117 Tretinoin, topical, 5 grams
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0119 Ondansetron, oral, 4 mg (for circumstances falling under the Medicare statute, use HCPCS Q code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0122 Injection, menotropins, 75 IU
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0126 Injection, follitropin alfa, 75 IU
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0128 Injection, follitropin beta, 75 IU
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0132 Injection, ganirelix acetate, 250 mcg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S0136 Clozapine, 25 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0137 Didanosine (ddi), 25 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0138 Finasteride, 5 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0139 Minoxidil, 10 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0140 Saquinavir, 200 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0142 Colistimethate sodium, inhalation solution administered through DME, concentrated form, per mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0145 Injection, pegylated interferon alfa-2a, 180 mcg per ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0148 Injection, pegylated interferon alfa-2b, 10 mcg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0155 Sterile dilutant for epoprostenol, 50ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0156 Exemestane, 25 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0157 Becaplermin gel 0.01%, 0.5 gm
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0160 Dextroamphetamine sulfate, 5 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0169 Calcitrol, 0.25 microgram
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0170 Anastrozole, oral, 1 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0172 Chlorambucil, oral, 2 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0174 Dolasetron mesylate, oral 50 mg (for circumstances falling under the Medicare statute, use Q0180)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0175 Flutamide, oral, 125 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0176 Hydroxyurea, oral, 500 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0177 Levamisole hydrochloride, oral, 50 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0178 Lomustine, oral, 10 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0179 Megestrol acetate, oral, 20 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0182 Procarbazine hydrochloride, oral, 50 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0183 Prochlorperazine maleate, oral, 5 mg (for circumstances falling under the Medicare statute, use Q0164)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0187 Tamoxifen citrate, oral, 10 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0189 Testosterone pellet, 75 mg
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0190 Mifepristone, oral, 200 mg ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0191 Misoprostol, oral, 200 mcg ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0194 Dialysis/stress vitamin supplement, oral, 100 capsules
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0197 Prenatal vitamins, 30-day supply ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS PROVIDER SERVICES (S0199-S0400), SEE ALSO MISCELLANEOUS PROVIDER SERVICES AND SUPPLIES (S0630-S3722)

S0199 Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S0201 Partial hospitalization services, less than 24 hours, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0207 Paramedic intercept, non-hospital-based ALS service (non-voluntary), non-transport
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0208 Paramedic intercept, hospital-based ALS service (non-voluntary), non-transport
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0209 Wheelchair van, mileage, per mile
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0215 Non-emergency transportation; mileage, per mile
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0220 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 30 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0221 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 60 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0250 Comprehensive geriatric assessment and treatment planning performed by assessment team
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0255 Hospice referral visit (advising patient and family of care options) performed by nurse, social worker, or other designated staff
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0257 Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0260 History and physical (outpatient or office) related to surgical procedure (list separately in addition to code for appropriate evaluation and management service)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0265 Genetic counseling, under physician supervision, each 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0270 Physician management of patient home care, standard monthly case rate (per 30 days)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0271 Physician management of patient home care, hospice monthly case rate (per 30 days) MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0272 Physician management of patient home care, episodic care monthly case rate (per 30 days)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0273 Physician visit at member's home, outside of a capitation arrangement
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0274 Nurse practitioner visit at member's home, outside of a capitation arrangement
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0280 Medical home program, comprehensive care coordination and planning, initial plan
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0281 Medical home program, comprehensive care coordination and planning, maintenance of plan
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0285 Colonoscopy consultation performed prior to a screening colonoscopy procedure
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q2

S0302 Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service) Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0310 Hospitalist services (list separately in addition to code for appropriate evaluation and management service)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0311 Comprehensive management and care coordination for advanced illness, per calendar month MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q2

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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S0315 Disease management program; initial assessment and initiation of the program
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0316 Disease management program, follow-up/ reassessment
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0317 Disease management program; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0320 Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0340 Lifestyle modification program for management of coronary artery disease, including all supportive services; first quarter / stage
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0341 Lifestyle modification program for management of coronary artery disease, including all supportive services; second or third quarter / stage
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0342 Lifestyle modification program for management of coronary artery disease, including all supportive services; fourth quarter / stage
BETOS: Z2 Undefined codes
Service not separately priced by Part B

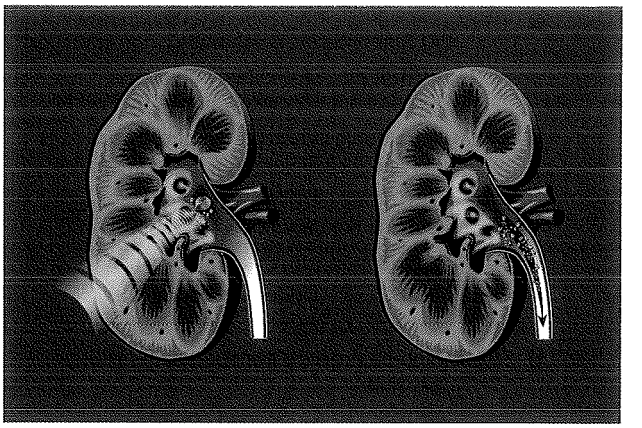
S0353 Treatment planning and care coordination management for cancer, initial treatment
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0354 Treatment planning and care coordination management for cancer, established patient with a change of regimen
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0390 Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0395 Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0400 Global fee for extracorporeal shock wave lithotripsy treatment of kidney stone(s)
BETOS: Z2 Undefined codes
Service not separately priced by Part B



Extracorporeal shock wave lithotripsy

VISION SUPPLIES (S0500-S0596)

S0500 Disposable contact lens, per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0504 Single vision prescription lens (safety, athletic, or sunglass), per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0506 Bifocal vision prescription lens (safety, athletic, or sunglass), per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0508 Trifocal vision prescription lens (safety, athletic, or sunglass), per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0510 Non-prescription lens (safety, athletic, or sunglass), per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0512 Daily wear specialty contact lens, per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0514 Color contact lens, per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0515 Scleral lens, liquid bandage device, per lens
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0516 Safety eyeglass frames
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S0518 Sunglasses frames
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0580 Polycarbonate lens (list this code in addition to the basic code for the lens)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0581 Nonstandard lens (list this code in addition to the basic code for the lens)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0590 Integral lens service, miscellaneous services reported separately
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0592 Comprehensive contact lens evaluation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0595 Dispensing new spectacle lenses for patient supplied frame
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0596 Phakic intraocular lens for correction of refractive error
BETOS: Z2 Undefined codes
Service not separately priced by Part B

SCREENINGS AND EXAMINATIONS (S0601-S0622)

S0601 Screening proctoscopy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0610 Annual gynecological examination, new patient ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0612 Annual gynecological examination, established patient ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0613 Annual gynecological examination; clinical breast examination without pelvic evaluation ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0618 Audiometry for hearing aid evaluation to determine the level and degree of hearing loss
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0620 Routine ophthalmological examination including refraction; new patient
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0621 Routine ophthalmological examination including refraction; established patient
BETOS: Z2 Undefined codes
Service not separately priced by Part B

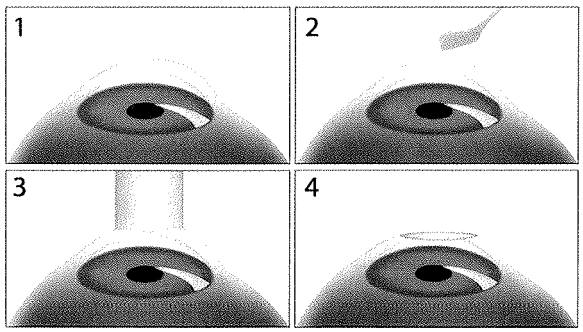
S0622 Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS PROVIDER SERVICES AND SUPPLIES (S0630-S3722), SEE ALSO MISCELLANEOUS PROVIDER SERVICES (S0199-S0400)

S0630 Removal of sutures; by a physician other than the physician who originally closed the wound
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0800 Laser in situ keratomileusis (LASIK)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S0810 Photorefractive keratectomy (PRK)
BETOS: Z2 Undefined codes
Service not separately priced by Part B



Phototherapeutic keratectomy

S0812 Phototherapeutic keratectomy (PTK)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1001 Deluxe item, patient aware (list in addition to code for basic item)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1002 Customized item (list in addition to code for basic item)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1015 IV tubing extension set
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S1016 Non-PVC (polyvinyl chloride) intravenous administration set, for use with drugs that are not stable in PVC e.g. paclitaxel
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1030 Continuous noninvasive glucose monitoring device, purchase (for physician interpretation of data, use CPT® code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1031 Continuous noninvasive glucose monitoring device, rental, including sensor, sensor replacement, and download to monitor (for physician interpretation of data, use CPT® code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1034 Artificial pancreas device system (e.g., low glucose suspend (LGS) feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1035 Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1036 Transmitter; external, for use with artificial pancreas device system
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1037 Receiver (monitor); external, for use with artificial pancreas device system
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1040 Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s) Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S1091 Stent, non-coronary, temporary, with delivery system (propel)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2053 Transplantation of small intestine and liver allografts
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2054 Transplantation of multivisceral organs
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2055 Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2060 Lobar lung transplantation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2061 Donor lobectomy (lung) for transplantation, living donor
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2065 Simultaneous pancreas kidney transplantation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2066 Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2067 Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2068 Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
BETOS: Z2 Undefined codes
Service not separately priced by Part B

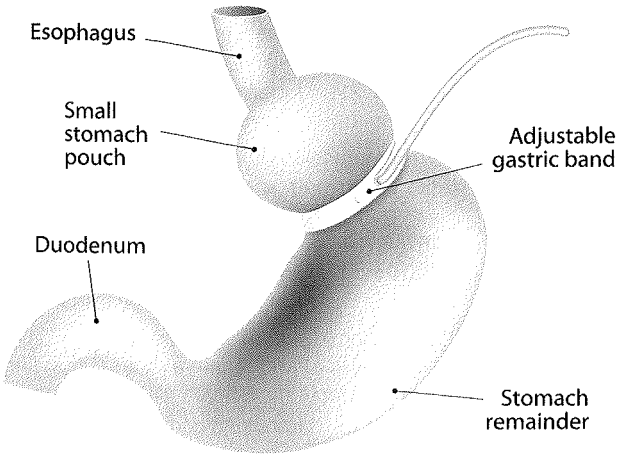
S2070 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with endoscopic laser treatment of ureteral calculi (includes ureteral catheterization)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2079 Laparoscopic esophagomyotomy (Heller type)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2080 Laser-assisted uvulopalatoplasty (LAUP)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S2083 Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline
BETOS: Z2 Undefined codes
Service not separately priced by Part B



Gastric Band

S2095 Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2102 Islet cell tissue transplant from pancreas; allogeneic
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2103 Adrenal tissue transplant to brain
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2107 Adoptive immunotherapy i.e. development of specific anti-tumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2112 Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2115 Osteotomy, periacetabular, with internal fixation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2117 Arthroereisis, subtalar
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2118 Metal-on-metal total hip resurfacing, including acetabular and femoral components
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2120 Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2140 Cord blood harvesting for transplantation, allogeneic ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2142 Cord blood-derived stem-cell transplantation, allogeneic ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2150 Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation, and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services; and the number of days of pre-and post-transplant care in the global definition
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2152 Solid organ(s), complete or segmental, single organ or combination of organs; deceased or living donor (s), procurement, transplantation, and related complications; including: drugs; supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic, emergency, and rehabilitative services, and the number of days of pre- and post-transplant care in the global definition
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2202 Echosclerotherapy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2205 Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), single coronary arterial graft MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2206 Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using arterial graft(s), two coronary arterial grafts MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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S2207 Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using venous graft only, single coronary venous graft MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2208 Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using single arterial and venous graft(s), single venous graft MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2209 Minimally invasive direct coronary artery bypass surgery involving mini-thoracotomy or mini-sternotomy surgery, performed under direct vision; using two arterial grafts and single venous graft MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2225 Myringotomy, laser-assisted
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2230 Implantation of magnetic component of semi-implantable hearing device on ossicles in middle ear
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2235 Implantation of auditory brain stem implant
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2260 Induced abortion, 17 to 24 weeks ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2265 Induced abortion, 25 to 28 weeks ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2266 Induced abortion, 29 to 31 weeks ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2267 Induced abortion, 32 weeks or greater ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2300 Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2325 Hip core decompression
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2017, Q3

S2340 Chemodenervation of abductor muscle(s) of vocal cord
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2341 Chemodenervation of adductor muscle(s) of vocal cord
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2342 Nasal endoscopy for post-operative debridement following functional endoscopic sinus surgery, nasal and/or sinus cavity(s), unilateral or bilateral
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2348 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2350 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2351 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy, lumbar, each additional interspace (list separately in addition to code for primary procedure)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2400 Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2401 Repair, urinary tract obstruction in the fetus, procedure performed in utero ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2402 Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2403 Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2404 Repair, myelomeningocele in the fetus, procedure performed in utero ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2405 Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S2409 Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2411 Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S2900 Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2010, Q1

S3000 Diabetic indicator; retinal eye exam, dilated, bilateral
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3005 Performance measurement, evaluation of patient self assessment, depression
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3600 STAT laboratory request (situations other than S3601)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3601 Emergency STAT laboratory charge for patient who is homebound or residing in a nursing facility
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3620 Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-D; phenylalanine (PKU); and thyroxine, total)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3630 Eosinophil count, blood, direct
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3645 HIV-1 antibody testing of oral mucosal transudate
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3650 Saliva test, hormone level; during menopause ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3652 Saliva test, hormone level; to assess preterm labor risk ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3655 Antisperm antibodies test (immunobead) ♂
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3708 Gastrointestinal fat absorption study
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3722 Dose optimization by area under the curve (AUC) analysis, for infusional 5-fluorouracil
BETOS: Z2 Undefined codes
Service not separately priced by Part B

GENETIC TESTING (S3800-S3870)

S3800 Genetic testing for amyotrophic lateral sclerosis (ALS)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3840 DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3841 Genetic testing for retinoblastoma
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3842 Genetic testing for Von Hippel-Lindau disease
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3844 DNA analysis of the connexin 26 gene (GJB2) for susceptibility to congenital, profound deafness
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3845 Genetic testing for alpha-thalassemia
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3846 Genetic testing for hemoglobin E beta-thalassemia
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3849 Genetic testing for niemann-pick disease
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3850 Genetic testing for sickle cell anemia
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3852 DNA analysis for APOE epsilon 4 allele for susceptibility to alzheimer's disease
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3853 Genetic testing for myotonic muscular dystrophy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S3854 Gene expression profiling panel for use in the management of breast cancer treatment
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2016, Q2

S3861 Genetic testing, sodium channel, voltage-gated, type V, alpha subunit (SCN5A) and variants for suspected brugada syndrome
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3865 Comprehensive gene sequence analysis for hypertrophic cardiomyopathy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3866 Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mutation in the family
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3870 Comparative genomic hybridization (CGH) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS TESTS (S3900-S3904)

S3900 Surface electromyography (EMG)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3902 Ballistocardiogram
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S3904 Masters two step
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ASSORTED OBSTETRICAL AND FERTILITY SERVICES (S4005-S4989)

S4005 Interim labor facility global (labor occurring but not resulting in delivery) ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4011 In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4013 Complete cycle, gamete intrafallopian transfer (GIFT), case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4014 Complete cycle, zygote intrafallopian transfer (ZIFT), case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4015 Complete in vitro fertilization cycle, not otherwise specified, case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4016 Frozen in vitro fertilization cycle, case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4017 Incomplete cycle, treatment cancelled prior to stimulation, case rate ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4018 Frozen embryo transfer procedure cancelled before transfer, case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4020 In vitro fertilization procedure cancelled before aspiration, case rate ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4021 In vitro fertilization procedure cancelled after aspiration, case rate ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4022 Assisted oocyte fertilization, case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4023 Donor egg cycle, incomplete, case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4025 Donor services for in vitro fertilization (sperm or embryo), case rate
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4026 Procurement of donor sperm from sperm bank ♂
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4027 Storage of previously frozen embryos ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4028 Microsurgical epididymal sperm aspiration (MESA) ♂
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4030 Sperm procurement and cryopreservation services; initial visit ♂
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● New code ▲ Revised code C Carrier judgment D Special coverage instructions apply
I Not payable by Medicare M Non-covered by Medicare S Non-covered by Medicare statute AHA Coding Clinic®

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S4031 Sperm procurement and cryopreservation services; subsequent visit ♂
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4035 Stimulated intrauterine insemination (IUI), case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4037 Cryopreserved embryo transfer, case rate ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

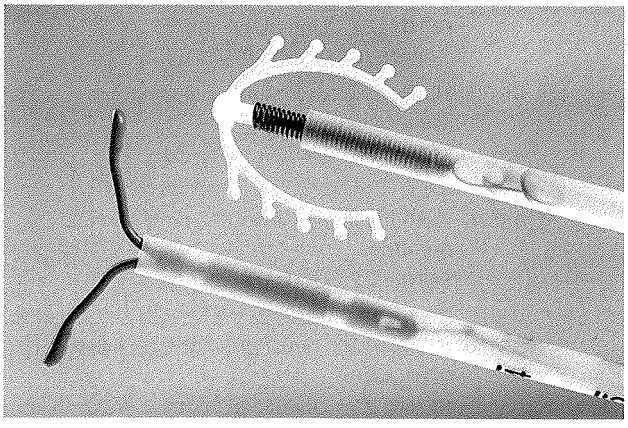
S4040 Monitoring and storage of cryopreserved embryos, per 30 days ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4042 Management of ovulation induction (interpretation of diagnostic tests and studies, non-face-to-face medical management of the patient), per cycle ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4981 Insertion of levonorgestrel-releasing intrauterine system ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● **S4988** Penile contracture device, manual, greater than 3 lbs traction force ♂
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q2

S4989 Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B



Intrauterine device

MISCELLANEOUS MEDICATIONS AND THERAPEUTIC SUBSTANCES (S4990-S5014)

S4990 Nicotine patches, legend
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4991 Nicotine patches, non-legend
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4993 Contraceptive pills for birth control ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S4995 Smoking cessation gum
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5000 Prescription drug, generic
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5001 Prescription drug, brand name
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5010 5% dextrose and 0.45% normal saline, 1000 ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5012 5% dextrose with potassium chloride, 1000 ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5013 5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1000 ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5014 5% dextrose/0.45% normal saline with potassium chloride and magnesium sulfate, 1500 ml
BETOS: Z2 Undefined codes
Service not separately priced by Part B

VARIOUS HOME CARE SERVICES (S5035-S5199)

S5035 Home infusion therapy, routine service of infusion device (e.g., pump maintenance)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5036 Home infusion therapy, repair of infusion device (e.g., pump repair)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5100 Day care services, adult; per 15 minutes Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S5101 Day care services, adult; per half day
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5102 Day care services, adult; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5105 Day care services, center-based; services not included in program fee, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5108 Home care training to home care client, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5109 Home care training to home care client, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5110 Home care training, family; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5111 Home care training, family; per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5115 Home care training, non-family; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5116 Home care training, non-family; per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5120 Chore services; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5121 Chore services; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5125 Attendant care services; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5126 Attendant care services; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5130 Homemaker service, NOS; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5131 Homemaker service, NOS; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5135 Companion care, adult (e.g., IADL/ADL); per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5136 Companion care, adult (e.g., IADL/ADL); per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5140 Foster care, adult; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5141 Foster care, adult; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5145 Foster care, therapeutic, child; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5146 Foster care, therapeutic, child; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5150 Unskilled respite care, not hospice; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5151 Unskilled respite care, not hospice; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5160 Emergency response system; installation and testing
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5161 Emergency response system; service fee, per month (excludes installation and testing)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5162 Emergency response system; purchase only
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5165 Home modifications; per service
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5170 Home delivered meals, including preparation; per meal
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5175 Laundry service, external, professional; per order
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5180 Home health respiratory therapy, initial evaluation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5181 Home health respiratory therapy, NOS, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S5185 Medication reminder service, non-face-to-face; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5190 Wellness assessment, performed by non-physician
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5199 Personal care item, NOS, each
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOME INFUSION THERAPY (S5497-S5523), SEE ALSO HOME INFUSION THERAPY (S9325-S9379); HOME THERAPY SERVICES (S9490-S9810)

S5497 Home infusion therapy, catheter care / maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5498 Home infusion therapy, catheter care / maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5501 Home infusion therapy, catheter care / maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5502 Home infusion therapy, catheter care / maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5517 Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5518 Home infusion therapy, all supplies necessary for catheter repair
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5520 Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5521 Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5522 Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only (no supplies or catheter included)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5523 Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

INSULIN AND DELIVERY DEVICES (S5550-S5571)

S5550 Insulin, rapid onset, 5 units
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5551 Insulin, most rapid onset (Lispro or Aspart); 5 units
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5552 Insulin, intermediate acting (NPH or LENTE); 5 units
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5553 Insulin, long acting; 5 units
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5560 Insulin delivery device, reusable pen; 1.5 ml size
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5561 Insulin delivery device, reusable pen; 3 ml size
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5565 Insulin cartridge for use in insulin delivery device other than pump; 150 units
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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S5566 Insulin cartridge for use in insulin delivery device other than pump; 300 units
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5570 Insulin delivery device, disposable pen (including insulin); 1.5 ml size
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S5571 Insulin delivery device, disposable pen (including insulin); 3 ml size
BETOS: Z2 Undefined codes
Service not separately priced by Part B

IMAGING STUDIES (S8030-S8092), SEE ALSO CONTRAST AGENTS/DIAGNOSTIC IMAGING (Q9950-Q9983)

S8030 Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8035 Magnetic source imaging
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8037 Magnetic resonance cholangiopancreatography (MRCP)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8040 Topographic brain mapping
BETOS: Z2 Undefined codes
Service not separately priced by Part B

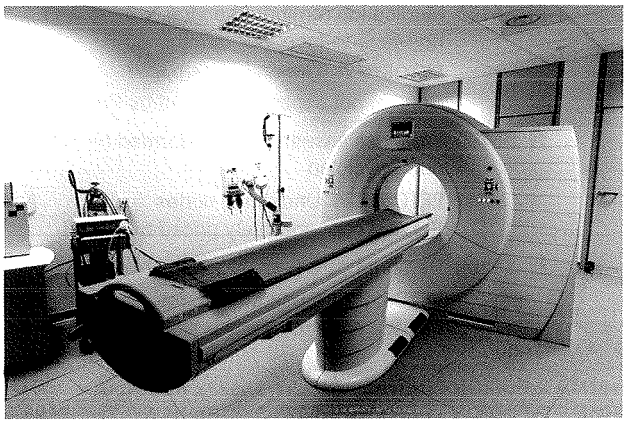
S8042 Magnetic resonance imaging (MRI), low-field
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8055 Ultrasound guidance for multifetal pregnancy reduction(s), technical component (only to be used when the physician doing the reduction procedure does not perform the ultrasound, guidance is included in the CPT® code for multifetal pregnancy reduction - 59866) ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8080 Scintimammography (radioimmunoscintigraphy of the breast), unilateral, including supply of radiopharmaceutical
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8085 Fluorine-18 fluorodeoxyglucose (F-18 FDG) imaging using dual-head coincidence detection system (non-dedicated PET scan)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8092 Electron beam computed tomography (also known as ultrafast CT, cine CT)
BETOS: Z2 Undefined codes
Service not separately priced by Part B



CT Scanner

ASSISTED BREATHING SUPPLIES (S8096-S8210), SEE ALSO BREATHING AIDS (A7000-A7049); INTERMITTENT POSITIVE PRESSURE BREATHING DEVICES (E0500); OTHER BREATHING AIDS (E0605, E0606)

S8096 Portable peak flow meter
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8097 Asthma kit (including but not limited to portable peak expiratory flow meter, instructional video, brochure, and/or spacer)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8100 Holding chamber or spacer for use with an inhaler or nebulizer; without mask
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8101 Holding chamber or spacer for use with an inhaler or nebulizer; with mask
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8110 Peak expiratory flow rate (physician services)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8120 Oxygen contents, gaseous, 1 unit equals 1 cubic foot
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8121 Oxygen contents, liquid, 1 unit equals 1 pound
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8130 Interferential current stimulator, 2 channel
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8131 Interferential current stimulator, 4 channel
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S8185 Flutter device
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8186 Swivel adapter
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8189 Tracheostomy supply, not otherwise classified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8210 Mucus trap
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS SUPPLIES AND SERVICES (S8265-S9152), SEE ALSO MISCELLANEOUS SUPPLIES AND SERVICES (S9381-S9485)

S8265 Haberman feeder for cleft lip/palate
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8270 Enuresis alarm, using auditory buzzer and/or vibration device
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8301 Infection control supplies, not otherwise specified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8415 Supplies for home delivery of infant
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8420 Gradient pressure aid (sleeve and glove combination), custom made
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8421 Gradient pressure aid (sleeve and glove combination), ready made
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8422 Gradient pressure aid (sleeve), custom made, medium weight
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8423 Gradient pressure aid (sleeve), custom made, heavy weight
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8424 Gradient pressure aid (sleeve), ready made
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8425 Gradient pressure aid (glove), custom made, medium weight
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8426 Gradient pressure aid (glove), custom made, heavy weight
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8427 Gradient pressure aid (glove), ready made
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8428 Gradient pressure aid (gauntlet), ready made
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8429 Gradient pressure exterior wrap
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8430 Padding for compression bandage, roll
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8431 Compression bandage, roll
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8450 Splint, prefabricated, digit (specify digit by use of modifier)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8451 Splint, prefabricated, wrist or ankle
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8452 Splint, prefabricated, elbow
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8460 Camisole, post-mastectomy ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8490 Insulin syringes (100 syringes, any size)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8930 Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8940 Equestrian/hippotherapy, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8948 Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8950 Complex lymphedema therapy, each 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S8990 Physical or manipulative therapy performed for maintenance rather than restoration
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S8999 Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9001 Home uterine monitor with or without associated nursing services ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B

● **S9002** Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device ♀
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2024, Q2

S9007 Ultrafiltration monitor
BETOS: Z2 Undefined codes
Service not separately priced by Part B

~~**S9024** Paranasal sinus ultrasound~~
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9025 Omnicardiogram/cardiointegram
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9034 Extracorporeal shockwave lithotripsy for gall stones (if performed with ercp, use 43265)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

~~**S9055** Procuren or other growth factor preparation~~ to promote wound healing
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9056 Coma stimulation per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9061 Home administration of aerosolized drug therapy (e.g., pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9083 Global fee urgent care centers
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9088 Services provided in an urgent care center (list in addition to code for service)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9090 Vertebral axial decompression, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9097 Home visit for wound care
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9098 Home visit, phototherapy services (e.g., Bili-lite), including equipment rental, nursing services, blood draw, supplies, and other services, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9110 Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9117 Back school, per visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9122 Home health aide or certified nurse assistant, providing care in the home; per hour
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9123 Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT® codes 99500-99602 can be used) MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

~~**S9124** Nursing care, in the home; by licensed~~ practical nurse, per hour MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9125 Respite care, in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9126 Hospice care, in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9127 Social work visit, in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9128 Speech therapy, in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9129 Occupational therapy, in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9131 Physical therapy; in the home, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S9140 Diabetic management program, follow-up visit to non-MD provider
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9141 Diabetic management program, follow-up visit to MD provider
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9145 Insulin pump initiation, instruction in initial use of pump (pump not included)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9150 Evaluation by ocularist
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9152 Speech therapy, re-evaluation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOME MANAGEMENT OF PREGNANCY (S9208-S9214)

S9208 Home management of preterm labor, including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9209 Home management of preterm premature rupture of membranes (PPROM), including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9211 Home management of gestational hypertension, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code) ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9212 Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code) ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9213 Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately); per diem (do not use this code with any home infusion per diem code) ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9214 Home management of gestational diabetes, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code) ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOME INFUSION THERAPY (S9325-S9379), SEE ALSO HOME INFUSION THERAPY (S5497-S5523); HOME THERAPY SERVICES (S9490-S9810)

S9325 Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with S9326, S9327 or S9328)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9326 Home infusion therapy, continuous (twenty-four hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9327 Home infusion therapy, intermittent (less than twenty-four hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9328 Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S9329 Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with S9330 or S9331)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9330 Home infusion therapy, continuous (twenty-four hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9331 Home infusion therapy, intermittent (less than twenty-four hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9335 Home therapy, hemodialysis; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing services coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9336 Home infusion therapy, continuous anticoagulant infusion therapy (e.g., Heparin), administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9338 Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9339 Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9340 Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9341 Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9342 Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9343 Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9345 Home infusion therapy, anti-hemophilic agent infusion therapy (e.g., factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9346 Home infusion therapy, alpha-1-proteinase inhibitor (e.g., Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9347 Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S9348 Home infusion therapy, sympathomimetic/ inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9349 Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9351 Home infusion therapy, continuous or intermittent anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9353 Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9355 Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9357 Home infusion therapy, enzyme replacement intravenous therapy; (e.g., Imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9359 Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e.g., Infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9361 Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9363 Home infusion therapy, anti-spasmotic therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9364 Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes S9365-S9368 using daily volume scales)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9365 Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9366 Home infusion therapy, total parenteral nutrition (TPN); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9367 Home infusion therapy, total parenteral nutrition (TPN); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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I S9368 Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9370 Home therapy, intermittent anti-emetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9372 Home therapy; intermittent anticoagulant injection therapy (e.g., Heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code for flushing of infusion devices with Heparin to maintain patency)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9373 Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use with hydration therapy codes S9374-S9377 using daily volume scales)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9374 Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9375 Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9376 Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9377 Home infusion therapy, hydration therapy; more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9379 Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS SUPPLIES AND SERVICES (S9381-S9485), SEE ALSO MISCELLANEOUS SUPPLIES AND SERVICES (S8265-S9152)

I S9381 Delivery or service to high risk areas requiring escort or extra protection, per visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9401 Anticoagulation clinic, inclusive of all services except laboratory tests, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9430 Pharmacy compounding and dispensing services
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9432 Medical foods for non-inborn errors of metabolism
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9433 Medical food nutritionally complete, administered orally, providing 100% of nutritional intake
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2008, Q4

I S9434 Modified solid food supplements for inborn errors of metabolism
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S9435 Medical foods for inborn errors of metabolism
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9436 Childbirth preparation/lamaze classes, non-physician provider, per session ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9437 Childbirth refresher classes, non-physician provider, per session ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9438 Cesarean birth classes, non-physician provider, per session ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9439 VBAC (vaginal birth after cesarean) classes, non-physician provider, per session ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9441 Asthma education, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9442 Birthing classes, non-physician provider, per session ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9443 Lactation classes, non-physician provider, per session ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9444 Parenting classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9445 Patient education, not otherwise classified, non-physician provider, individual, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9446 Patient education, not otherwise classified, non-physician provider, group, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9447 Infant safety (including CPR) classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9449 Weight management classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9451 Exercise classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9452 Nutrition classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9453 Smoking cessation classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9454 Stress management classes, non-physician provider, per session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9455 Diabetic management program, group session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9460 Diabetic management program, nurse visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9465 Diabetic management program, dietitian visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9470 Nutritional counseling, dietitian visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9472 Cardiac rehabilitation program, non-physician provider, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9473 Pulmonary rehabilitation program, non-physician provider, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9474 Enterostomal therapy by a registered nurse certified in enterostomal therapy, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9475 Ambulatory setting substance abuse treatment or detoxification services, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9476 Vestibular rehabilitation program, non-physician provider, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9480 Intensive outpatient psychiatric services, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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S9482 Family stabilization services, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9484 Crisis intervention mental health services, per hour MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9485 Crisis intervention mental health services, per diem MPFS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOME THERAPY SERVICES (S9490-S9810), SEE ALSO HOME INFUSION THERAPY (S9325-S9379); HOME INFUSION THERAPY (S5497-S5523)

S9490 Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9494 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with home infusion codes for hourly dosing schedules S9497-S9504)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9497 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9500 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9501 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9502 Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9503 Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9504 Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9529 Routine venipuncture for collection of specimen(s), single home bound, nursing home, or skilled nursing facility patient
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9537 Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, G-CSF, GM-CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9538 Home transfusion of blood product(s); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (blood products, drugs, and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9542 Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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S9558 Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9559 Home injectable therapy, interferon, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9560 Home injectable therapy; hormonal therapy (e.g.; leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9562 Home injectable therapy, palivizumab or other monoclonal antibody for rsv, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q2

S9563 Home injectable therapy, immunotherapy, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q2

S9590 Home therapy, irrigation therapy (e.g., sterile irrigation of an organ or anatomical cavity); including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9810 Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

VARIOUS SERVICES, FEES, AND COSTS (S9900-S9999)

S9900 Services by a Journal-listed Christian science practitioner for the purpose of healing, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9901 Services by a journal-listed christian science nurse, per hour
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9960 Ambulance service, conventional air service, nonemergency transport, one way (fixed wing)
BETOS: O1A Ambulance
Service not separately priced by Part B

S9961 Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
BETOS: O1A Ambulance
Service not separately priced by Part B

S9970 Health club membership, annual
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9975 Transplant related lodging, meals and transportation, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9976 Lodging, per diem, not otherwise classified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9977 Meals, per diem, not otherwise specified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9981 Medical records copying fee, administrative
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9982 Medical records copying fee, per page
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9986 Not medically necessary service (patient is aware that service not medically necessary)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9988 Services provided as part of a Phase I clinical trial
BETOS: Z2 Undefined codes
Service not separately priced by Part B

S9989 Services provided outside of the United States of America (list in addition to code(s) for service(s))
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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I S9990 Services provided as part of a Phase II clinical trial
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9991 Services provided as part of a Phase III clinical trial
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9992 Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9994 Lodging costs (e.g., hotel charges) for clinical trial participant and one caregiver/companion
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9996 Meals for clinical trial participant and one caregiver/companion
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I S9999 Sales tax
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2009, Q2

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NATIONAL CODES ESTABLISHED FOR STATE MEDICAID AGENCIES (T1000-T5999)

NURSING SERVICES (T1000-T1005), SEE ALSO ADDITIONAL NURSING SERVICES (T1030-T1031)

T1000 Private duty / independent nursing service(s) - licensed, up to 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2009, Q2

T1001 Nursing assessment / evaluation MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1002 RN services, up to 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1003 LPN/LVN services, up to 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1004 Services of a qualified nursing aide, up to 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1005 Respite care services, up to 15 minutes MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ALCOHOL AND SUBSTANCE ABUSE SERVICES (T1006-T1012)

T1006 Alcohol and/or substance abuse services, family/couple counseling
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1007 Alcohol and/or substance abuse services, treatment plan development and/or modification
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1009 Child sitting services for children of the individual receiving alcohol and/or substance abuse services Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1010 Meals for individuals receiving alcohol and/or substance abuse services (when meals not included in the program)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1012 Alcohol and/or substance abuse services, skills development
BETOS: Z2 Undefined codes
Service not separately priced by Part B

OTHER SERVICES (T1013-T1018)

T1013 Sign language or oral interpretive services, per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1014 Telehealth transmission, per minute, professional services bill separately
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1015 Clinic visit/encounter, all-inclusive MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2002, Q1

T1016 Case management, each 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1017 Targeted case management, each 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1018 School-based individualized education program (IEP) services, bundled
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOME HEALTH SERVICES (T1019-T1022)

T1019 Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1020 Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1021 Home health aide or certified nurse assistant, per visit MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1022 Contracted home health agency services, all services provided under contract, per day MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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SCREENINGS, ASSESSMENTS, AND TREATMENTS, INDIVIDUAL AND FAMILY (T1023-T1029)

T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1024 Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1025 Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per diem Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1026 Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per hour Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1027 Family training and counseling for child development, per 15 minutes Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1028 Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1029 Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling
BETOS: Z2 Undefined codes
Service not separately priced by Part B

ADDITIONAL NURSING SERVICES (T1030-T1031), SEE ALSO NURSING SERVICES (T1000-T1005)

T1030 Nursing care, in the home, by registered nurse, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1031 Nursing care, in the home, by licensed practical nurse, per diem MIPS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

DOULA BIRTH WORKER SERVICES (T1032-T1033)

T1032 Services performed by a doula birth worker, per 15 minutes ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2022, Q4

T1033 Services performed by a doula birth worker, per diem ♀ Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2022, Q4

BEHAVIORAL HEALTH SERVICES (T1040-T1041)

T1040 Medicaid certified community behavioral health clinic services, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1041 Medicaid certified community behavioral health clinic services, per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

MISCELLANEOUS SERVICES AND SUPPLIES (T1502-T1999)

T1502 Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1503 Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1505 Electronic medication compliance management device, includes all components and accessories, not otherwise classified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T1999 Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks"
BETOS: Z2 Undefined codes
Service not separately priced by Part B

TRANSPORTATION SERVICES (T2001-T2007)

T2001 Non-emergency transportation; patient attendant/escort
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2002 Non-emergency transportation; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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T2003 Non-emergency transportation; encounter/trip
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2004 Non-emergency transport; commercial carrier, multi-pass
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2005 Non-emergency transportation; stretcher van
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2007 Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PREADMISSION SCREENING (T2010, T2011)

T2010 Preadmission screening and resident review (PASRR) level I identification screening, per screen
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2011 Preadmission screening and resident review (PASRR) level II evaluation, per evaluation
BETOS: Z2 Undefined codes
Service not separately priced by Part B

WAIVER SERVICES (T2012-T2041)

T2012 Habilitation, educational; waiver, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2013 Habilitation, educational, waiver; per hour
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2014 Habilitation, prevocational, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2015 Habilitation, prevocational, waiver; per hour
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2016 Habilitation, residential, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2017 Habilitation, residential, waiver; 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2018 Habilitation, supported employment, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2019 Habilitation, supported employment, waiver; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2020 Day habilitation, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2021 Day habilitation, waiver; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2022 Case management, per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2023 Targeted case management; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2024 Service assessment/plan of care development, waiver
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2025 Waiver services; not otherwise specified (NOS)
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2026 Specialized childcare, waiver; per diem Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2027 Specialized childcare, waiver; per 15 minutes Ⓐ
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2028 Specialized supply, not otherwise specified, waiver
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2029 Specialized medical equipment, not otherwise specified, waiver
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2030 Assisted living, waiver; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2031 Assisted living; waiver, per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2032 Residential care, not otherwise specified (NOS), waiver; per month
BETOS: Z2 Undefined codes
Service not separately priced by Part B

T2033 Residential care, not otherwise specified (NOS), waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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I **T2034** Crisis intervention, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2035** Utility services to support medical equipment and assistive technology/devices, waiver
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2036** Therapeutic camping, overnight, waiver; each session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2037** Therapeutic camping, day, waiver; each session
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2038** Community transition, waiver; per service
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2039** Vehicle modifications, waiver; per service
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2040** Financial management, self-directed, waiver; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2041** Supports brokerage, self-directed, waiver; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

HOSPICE CARE (T2042-T2046)

I **T2042** Hospice routine home care; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2043** Hospice continuous home care; per hour
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2044** Hospice inpatient respite care; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2045** Hospice general inpatient care; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2046** Hospice long term care, room and board only; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

PREVOCATIONAL HABILITATION WAIVER SERVICES (T2047)

I **T2047** Habilitation, prevocational, waiver; per 15 minutes
BETOS: Z2 Undefined codes
Service not separately priced by Part B

LONG-TERM RESIDENTIAL CARE (T2048)

I **T2048** Behavioral health; long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem MDS
BETOS: Z2 Undefined codes
Service not separately priced by Part B

NON-EMERGENCY TRANSPORTATION FEES (T2049)

I **T2049** Non-emergency transportation; stretcher van, mileage; per mile
BETOS: Z2 Undefined codes
Service not separately priced by Part B

FINANCIAL MANAGEMENT AND SUPPORTS BROKERAGE SERVICES, PER DIEM (T2050-T2051)

I **T2050** Financial management, self-directed, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T2051** Supports brokerage, self-directed, waiver; per diem
BETOS: Z2 Undefined codes
Service not separately priced by Part B

SERVICES RELATED TO BREAST MILK (T2101)

I **T2101** Human breast milk processing, storage and distribution only ♀ A
BETOS: Z2 Undefined codes
Service not separately priced by Part B

INCONTINENCE SUPPLIES (T4521-T4545)

M **T4521** Adult sized disposable incontinence product, brief/diaper, small, each A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4522** Adult sized disposable incontinence product, brief/diaper, medium, each A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4523** Adult sized disposable incontinence product, brief/diaper, large, each A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4524** Adult sized disposable incontinence product, brief/diaper, extra large, each A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4525** Adult sized disposable incontinence product, protective underwear/pull-on, small size, each A
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

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M **T4526** Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4527** Adult sized disposable incontinence product, protective underwear/pull-on, large size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4528** Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4529** Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4530** Pediatric sized disposable incontinence product, brief/diaper, large size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4531** Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4532** Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4533** Youth sized disposable incontinence product, brief/diaper, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4534** Youth sized disposable incontinence product, protective underwear/pull-on, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4535** Disposable liner/shield/guard/pad/ undergarment, for incontinence, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4536** Incontinence product, protective underwear/pull-on, reusable, any size, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4537** Incontinence product, protective underpad, reusable, bed size, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4538** Diaper service, reusable diaper, each diaper
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4539** Incontinence product, diaper/brief, reusable, any size, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4540** Incontinence product, protective underpad, reusable, chair size, each
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

I **T4541** Incontinence product, disposable underpad, large, each
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T4542** Incontinence product, disposable underpad, small size, each
BETOS: Z2 Undefined codes
Service not separately priced by Part B

M **T4543** Adult sized disposable incontinence product, protective brief/diaper, above extra large, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4544** Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each Ⓐ
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

M **T4545** Incontinence product, disposable, penile wrap, each ♂
BETOS: D1A Medical/surgical supplies
Service not separately priced by Part B

OTHER AND UNSPECIFIED SUPPLIES (T5001-T5999)

I **T5001** Positioning seat for persons with special orthopedic needs
BETOS: Z2 Undefined codes
Service not separately priced by Part B

I **T5999** Supply, not otherwise specified
BETOS: Z2 Undefined codes
Service not separately priced by Part B

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NOTES

CORONAVIRUS DIAGNOSTIC PANEL (U0001-U0002)

C **U0001** Cdc 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel A

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price established by carriers
Coding Clinic: 2020, Q2

C **U0002** 2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-cdc A

BETOS: T1H Lab tests - other (Non-Medicare fee schedule)
Price established by carriers
Coding Clinic: 2020, Q2

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NOTES

VISION SERVICES (V2020-V2799)

SPECTACLE FRAMES (V2020, V2025)

D V2020 Frames, purchases DME A
BETOS: D1F Prosthetic/Orthotic devices

M V2025 Deluxe frame E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

LENSES, SINGLE VISION (V2100-V2199)

C V2100 Sphere, single vision, plano to plus or minus 4.00, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2101 Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2102 Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2103 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2104 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2105 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2106 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2107 Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, .12 to 2.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2108 Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2109 Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2110 Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2111 Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2112 Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2113 Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2114 Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2115 Lenticular, (myodisc), per lens, single vision DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2118 Aniseikonic lens, single vision DME A
BETOS: D1F Prosthetic/Orthotic devices

D V2121 Lenticular lens, per lens, single DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2199 Not otherwise classified, single vision lens A
BETOS: D1F Prosthetic/Orthotic devices

LENSES, BIFOCAL (V2200-V2299)

C V2200 Sphere, bifocal, plano to plus or minus 4.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2201 Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2202 Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2203 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2204 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2205 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C V2206 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **V2207** Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2208** Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2209** Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2210** Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2211** Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2212** Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2213** Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2214** Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2215** Lenticular (myodisc), per lens, bifocal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2218** Aniseikonic, per lens, bifocal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2219** Bifocal seg width over 28 mm DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2220** Bifocal add over 3.25d DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2221** Lenticular lens, per lens, bifocal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2299** Specialty bifocal (by report) A
BETOS: D1F Prosthetic/Orthotic devices

LENSES, TRIFOCAL (V2300-V2399)

C **V2300** Sphere, trifocal, plano to plus or minus 4.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2301** Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2302** Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2303** Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, .12-2.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2304** Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25-4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2305** Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2306** Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2307** Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2308** Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2309** Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2310** Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2311** Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2312** Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2313** Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2314** Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2315** Lenticular, (myodisc), per lens, trifocal DME A
BETOS: D1F Prosthetic/Orthotic devices

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C **V2318** Aniseikonic lens, trifocal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2319** Trifocal seg width over 28 mm DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2320** Trifocal add over 3.25d DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2321** Lenticular lens, per lens, trifocal DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2399** Specialty trifocal (by report) A
BETOS: D1F Prosthetic/Orthotic devices

LENSES, ASPHERICAL AND VARIABLE SPHERICITY (V2410-V2499)

C **V2410** Variable asphericity lens, single vision, full field, glass or plastic, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2430** Variable asphericity lens, bifocal, full field, glass or plastic, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2499** Variable sphericity lens, other type A
BETOS: D1F Prosthetic/Orthotic devices

ASSORTED CONTACT LENSES (V2500-V2599)

C **V2500** Contact lens, PMMA, spherical, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2501** Contact lens, PMMA, toric or prism ballast, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2502** Contact lens, PMMA, bifocal, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2503** Contact lens, PMMA, color vision deficiency, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2510** Contact lens, gas permeable, spherical, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2511** Contact lens, gas permeable, toric, prism ballast, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2512** Contact lens, gas permeable, bifocal, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2513** Contact lens, gas permeable, extended wear, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2520** Contact lens, hydrophilic, spherical, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2521** Contact lens, hydrophilic, toric, or prism ballast, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2522** Contact lens, hydrophilic, bifocal, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2523** Contact lens, hydrophilic, extended wear, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2524** Contact lens, hydrophilic, spherical, photochromic additive, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

M **V2525** Contact lens, hydrophilic, dual focus, per lens Ⓐ E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

M **V2526** Contact lens, hydrophilic, with blue-violet filter, per lens E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Coding Clinic: 2023, Q4

C **V2530** Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325) DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2531** Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325) DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2599** Contact lens, other type A
BETOS: D1F Prosthetic/Orthotic devices

LOW AND NEAR VISION AIDS (V2600-V2615)

C **V2600** Hand held low vision aids and other nonspectacle mounted aids A
BETOS: D1F Prosthetic/Orthotic devices

C **V2610** Single lens spectacle mounted low vision aids A
BETOS: D1F Prosthetic/Orthotic devices

C **V2615** Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system A
BETOS: D1F Prosthetic/Orthotic devices

EYE PROSTHETICS AND SERVICES (V2623-V2629)

D **V2623** Prosthetic eye, plastic, custom DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2624** Polishing/resurfacing of ocular prosthesis DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2625** Enlargement of ocular prosthesis DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2626** Reduction of ocular prosthesis DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2627** Scleral cover shell DME A
BETOS: D1F Prosthetic/Orthotic devices

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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C **V2628** Fabrication and fitting of ocular conformer DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2629** Prosthetic eye, other type A
BETOS: D1F Prosthetic/Orthotic devices

LENSES, INTRAOCULAR (V2630-V2632)

D **V2630** Anterior chamber intraocular lens N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **V2631** Iris supported intraocular lens N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices

D **V2632** Posterior chamber intraocular lens N1 DME ASC N
BETOS: D1F Prosthetic/Orthotic devices
Pub: 100-4, Chapter-32, 120.2

VISION SERVICES (V2700-V2799)

C **V2700** Balance lens, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

M **V2702** Deluxe lens feature E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **V2710** Slab off prism, glass or plastic, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2715** Prism, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2718** Press-on lens, Fresnell prism, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2730** Special base curve, glass or plastic, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2744** Tint, photochromatic, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2745** Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2750** Anti-reflective coating, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2755** U-V lens, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2756** Eye glass case E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B

C **V2760** Scratch resistant coating, per lens DME E1
BETOS: D1F Prosthetic/Orthotic devices

D **V2761** Mirror coating, any type, solid, gradient or equal, any lens material, per lens B
BETOS: D1F Prosthetic/Orthotic devices

D **V2762** Polarization, any lens material, per lens DME E1
BETOS: D1F Prosthetic/Orthotic devices

C **V2770** Occluder lens, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2780** Oversize lens, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2781** Progressive lens, per lens B
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

D **V2782** Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2783** Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

D **V2784** Lens, polycarbonate or equal, any index, per lens DME A
BETOS: D1F Prosthetic/Orthotic devices

C **V2785** Processing, preserving and transporting corneal tissue F4 ASC F
BETOS: D1F Prosthetic/Orthotic devices
Pub: 100-4, Chapter-4, 200.1

D **V2786** Specialty occupational multifocal lens, per lens DME E1
BETOS: D1F Prosthetic/Orthotic devices

S **V2787** Astigmatism correcting function of intraocular lens E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1862(a)(7)
Pub: 100-4, Chapter-14, 40.9; 100-4, Chapter-32, 120.1; 100-4, Chapter-32, 120.2

S **V2788** Presbyopia correcting function of intraocular lens E1
BETOS: Z2 Undefined codes
Service not separately priced by Part B
Statute: 1862(a)(7)
Pub: 100-4, Chapter-14, 40.9; 100-4, Chapter-32, 120.1; 100-4, Chapter-32, 120.2

C **V2790** Amniotic membrane for surgical reconstruction, per procedure N
BETOS: Z2 Undefined codes
Other carrier priced

C **V2797** Vision supply, accessory and/or service component of another HCPCS vision code E1
BETOS: D1F Prosthetic/Orthotic devices
Service not separately priced by Part B

C **V2799** Vision item or service, miscellaneous A
BETOS: D1F Prosthetic/Orthotic devices

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HEARING SERVICES (V5008-V5364)

HEARING ASSESSMENTS AND EVALUATIONS (V5008-V5020)

M **V5008** Hearing screening E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B

S **V5010** Assessment for hearing aid E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5011** Fitting/orientation/checking of hearing aid E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5014** Repair/modification of a hearing aid E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5020** Conformity evaluation E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

HEARING AID, MONAURAL (V5030-V5060)

S **V5030** Hearing aid, monaural, body worn, air conduction E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5040** Hearing aid, monaural, body worn, bone conduction E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5050** Hearing aid, monaural, in the ear E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5060** Hearing aid, monaural, behind the ear E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

MISCELLANEOUS HEARING SERVICES AND SUPPLIES (V5070-V5110)

S **V5070** Glasses, air conduction E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5080** Glasses, bone conduction E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5090** Dispensing fee, unspecified hearing aid E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5095** Semi-implantable middle ear hearing prosthesis E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5100** Hearing aid, bilateral, body worn E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5110** Dispensing fee, bilateral E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

HEARING AIDS (V5120-V5267)

S **V5120** Binaural, body E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5130** Binaural, in the ear E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5140** Binaural, behind the ear E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5150** Binaural, glasses E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5160** Dispensing fee, binaural E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5171** Hearing aid, contralateral routing device, monaural, in the ear (ite) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5172** Hearing aid, contralateral routing device, monaural, in the canal (itc) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5181** Hearing aid, contralateral routing device, monaural, behind the ear (bte) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

♂ Male only ♀ Female only Ⓐ Age A2 - Z3 = ASC Payment indicator A - Y = APC Status indicator
ASC = ASC Approved Procedure DME Paid under the DME fee schedule MIPS MIPS code

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S V5190 Hearing aid, contralateral routing, monaural, glasses E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5200 Dispensing fee, contralateral, monaural E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5211 Hearing aid, contralateral routing system, binaural, ite/ite E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5212 Hearing aid, contralateral routing system, binaural, ite/itc E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5213 Hearing aid, contralateral routing system, binaural, ite/bte E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5214 Hearing aid, contralateral routing system, binaural, itc/itc E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5215 Hearing aid, contralateral routing system, binaural, itc/bte E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5221 Hearing aid, contralateral routing system, binaural, bte/bte E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5230 Hearing aid, contralateral routing system, binaural, glasses E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5240 Dispensing fee, contralateral routing system, binaural E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S V5241 Dispensing fee, monaural hearing aid, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5242 Hearing aid, analog, monaural, CIC (completely in the ear canal) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5243 Hearing aid, analog, monaural, ITC (in the canal) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5244 Hearing aid, digitally programmable analog, monaural, CIC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5245 Hearing aid, digitally programmable, analog, monaural, ITC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5246 Hearing aid, digitally programmable analog, monaural, ITE (in the ear) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5247 Hearing aid, digitally programmable analog, monaural, BTE (behind the ear) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5248 Hearing aid, analog, binaural, CIC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5249 Hearing aid, analog, binaural, ITC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5250 Hearing aid, digitally programmable analog, binaural, CIC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S V5251 Hearing aid, digitally programmable analog, binaural, ITC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

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S **V5252** Hearing aid, digitally programmable, binaural, ITE E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5253** Hearing aid, digitally programmable, binaural, BTE E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5254** Hearing aid, digital, monaural, CIC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5255** Hearing aid, digital, monaural, ITC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5256** Hearing aid, digital, monaural, ITE E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5257** Hearing aid, digital, monaural, BTE E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5258** Hearing aid, digital, binaural, CIC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5259** Hearing aid, digital, binaural, ITC E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5260** Hearing aid, digital, binaural, ITE E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5261** Hearing aid, digital, binaural, BTE E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5262** Hearing aid, disposable, any type, monaural E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5263** Hearing aid, disposable, any type, binaural E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5264** Ear mold/insert, not disposable, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5265** Ear mold/insert, disposable, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5266** Battery for use in hearing device E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5267** Hearing aid or assistive listening device/ supplies/accessories, not otherwise specified E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

ASSISTIVE HEARING DEVICES (V5268-V5290)

S **V5268** Assistive listening device, telephone amplifier, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5269** Assistive listening device, alerting, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5270** Assistive listening device, television amplifier, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5271** Assistive listening device, television caption decoder E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

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S **V5272** Assistive listening device, TDD E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5273** Assistive listening device, for use with cochlear implant E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5274** Assistive listening device, not otherwise specified E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5275** Ear impression, each E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7
Coding Clinic: 2002, Q1

S **V5281** Assistive listening device, personal FM/DM system, monaural, (1 receiver, transmitter, microphone), any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5282** Assistive listening device, personal FM/DM system, binaural, (2 receivers, transmitter, microphone), any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5283** Assistive listening device, personal FM/DM neck, loop induction receiver E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5284** Assistive listening device, personal FM/DM, ear level receiver E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5285** Assistive listening device, personal FM/DM, direct audio input receiver E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5286** Assistive listening device, personal blue tooth FM/DM receiver E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5287** Assistive listening device, personal FM/DM receiver, not otherwise specified E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5288** Assistive listening device, personal FM/DM transmitter assistive listening device E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5289** Assistive listening device, personal FM/DM adapter/boot coupling device for receiver, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

S **V5290** Assistive listening device, transmitter microphone, any type E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862a7

OTHER AND MISCELLANEOUS HEARING SERVICES AND SUPPLIES (V5298, V5299)

S **V5298** Hearing aid, not otherwise classified E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

D **V5299** Hearing service, miscellaneous B
BETOS: O1F Hearing and speech services
Price established by carriers

SPEECH-RELATED SCREENINGS AND COMMUNICATION DEVICE REPAIR (V5336-V5364)

S **V5336** Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid) E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862A7

S **V5362** Speech screening E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862(a)(7)

S **V5363** Language screening E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862(a)(7)

S **V5364** Dysphagia screening E1
BETOS: O1F Hearing and speech services
Service not separately priced by Part B
Statute: 1862(a)(7)

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Appendix A
Table of Drugs and Biologicals

Generic and brand-name drugs found throughout the Table of Drugs and Biologicals are a representative sample of drugs and biologicals commonly associated with HCPCS Level II codes. Please check the CMS and FDA websites for the most up-to-date information on coverage, active brand names, and validity of drugs.

Caution: Never code directly from the Table of Drugs and Biologicals. Always cross-reference the code to the Tabular List before final code assignment. Questions regarding coding and billing guidance should be submitted to the insurer in whose jurisdiction a claim would be filed. For private sector health insurance systems, please contact the individual private insurance entity. For Medicaid systems, please contact the Medicaid agency in the state in which the claim is being filed. For Medicare, contact the Medicare contractor.

Abbreviations used in the Table of Drugs and Biologicals

IA - Intra-arterial administration
IV - Intravenous administration
IM - Intramuscular administration
IT - Intrathecal
SC - Subcutaneous administration
INH - Administration by inhaled solution
VAR - Various routes of administration
OTH - Other routes of administration
ORAL - Administered orally

Intravenous administration includes all methods, such as gravity infusion, injections, and timed pushes into blood vessels, usually veins. IM refers to injections into muscles; IT to injections into the spinal column; and SC to injections into tissues (not muscle) under the skin. VAR denotes various routes of administration and is used for drugs that are commonly administered into joints, cavities, tissues, or topical applications, in addition to other parenteral administrations. OTH indicates other administration methods, such as intraocular injections, suppositories, or catheter injections.

Drug	Amount	Route	Code
ABATACEPT	10 mg	IV	J0129
ABCIXIMAB	10 mg	IV	J0130
ABELCET®	10 mg	IV	J0287
ABILIFY ASIMTUFII®	1 mg	IV	J0402
ABILIFY MAINTENA®	1 mg	IM	J0401
ABOBOTULINUM TOXIN A	5 IU	IM	J0586
ABRAXANE®	1 mg	IV	J9264
ACETADOTE®	100 mg	IV	J0132
ACETAMINOPHEN (MADE BY B. BRAUN)	10 mg	IV	J0136
ACETAMINOPHEN (MADE BY FRESENIUS KABI)	10 mg	IV	J0134
ACETAMINOPHEN (MADE BY HIKMA)	10 mg	IV	J0137
ACETAMINOPHEN AND IBUPROFEN	10 mg/3mg	IV	J0138
ACETAMINOPHEN, NOS	10 mg	IV	J0131
ACETAZOLAMIDE SODIUM	up to 500 mg	IV, IM	J1120
ACETYLCYSTEINE	100 mg	IV	J0132
ACETYLCYSTEINE, UNIT DOSE, COMPOUNDED	1 g	INH	J7604
ACETYLCYSTEINE, UNIT DOSE, NON-COMPOUNDED	1 g	INH	J7608
ACTEMRA®	1 mg	IV	J3262
ACTHAR GEL®	up to 40 IU	IM, SC	J0801
ACTHREL®	1 mcg	IV, IM	J0795
ACTIMMUNE®	3 million IU	SC	J9216
ACTIVASE®	1 mg	IV	J2997
ACYCLOVIR	5 mg	IV	J0133
ADAKVEO®	5 mg	IV	J0791
ADALIMUMAB	1 mg	SC	J0139
ADAMTS13, RECOMBINANT-KRHN	10 IU	IV	J7171
ADASUVE®	1 mg	OTH	J2062
ADCETRIS®	1 mg	IV	J9042
ADENOSINE	1 mg	IV	J0153

Drug	Amount	Route	Code
ADO-TRASTUZUMAB EMTANSINE	1 mg	IV	J9354
ADRENALIN, EPINEPHRINE	0.1 mg	IM, SC	J0171
ADSTILADRIN®	per therapeutic dose	OTH	J9029
ADUCANUMAB-AVWA	2 mg	IV	J0172
ADUHELM®	2 mg	IV	J0172
ADVATE®	1 IU	IV	J7192
ADYNOVATE®	1 IU	IV	J7207
AFAMELANOTIDE IMPLANT	1 mg	OTH	J7352
AFLIBERCEPT	1 mg	OTH	J0178
AFLIBERCEPT HD	1 mg	OTH	J0177
AFSTYLA®	1 IU	IV	J7210
AGALSIDASE BETA	1 mg	IV	J0180
AGGRASTAT®	0.25 mg	IV, IM	J3246
AJOVY®	1 mg	SC	J3031
AKYNZEO®	0.25 mg	IV	J1454
AKYNZEO®	300 mg	ORAL	J8655
ALATROFLOXACIN MESYLATE	100 mg	IV	J0200
ALBUTEROL AND IPRATROPIUM BROMIDE, NON-COMPOUNDED	up to 2.5 mg/ up to 0.5 mg	INH	J7620
ALBUTEROL, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7610
ALBUTEROL, CONCENTRATED FORM, NON-COMPOUNDED	1 mg	INH	J7611
ALBUTEROL, UNIT DOSE, COMPOUNDED	1 mg	INH	J7609
ALBUTEROL, UNIT DOSE, NON-COMPOUNDED	1 mg	INH	J7613
ALDESLEUKIN	single use vial	IV	J9015
ALDURAZYME®	0.1 mg	IV	J1931
ALEFACEPT	0.5 mg	IV, IM	J0215
ALEMTUZUMAB	1 mg	IV	J0202
ALFENTANIL HYDROCHLORIDE	500 mcg	IV	J0216
ALGLUCERASE	10 IU	IV	J0205
ALGLUCOSIDASE ALFA	10 mg	IV	J0220

Drug	Amount	Route	Code
ALGLUCOSIDASE ALFA (LUMIZYME®)	10 mg	IV	J0221
ALIQOPA®	1 mg	IV	J9057
ALLOPURINOL SODIUM	1 mg	IV	J0206
ALPHA 1-PROTEINASE INHIBITOR, HUMAN	10 mg	IV	J0256
ALPHA 1-PROTEINASE INHIBITOR, HUMAN (GLASSIA®)	10 mg	IV	J0257
ALPHANATE®	1 IU	IV	J7186
ALPHANINE®	1 IU	IV	J7193
ALPROLIX®	1 IU	IV	J7201
ALPROSTADIL, INJECTION	1.25 mcg	OTH	J0270
ALPROSTADIL, URETHRAL SUPPOSITORY	each	OTH	J0275
ALTEPLASE RECOMBINANT	1 mg	IV	J2997
ALTUVIIIO™	1 IU	IV	J7214
ALYGLO™	500 mg	IV	J1552
AMBISOME®	10 mg	IV	J0289
AMELUZ®	10 mg	OTH	J7345
AMEVIVE®	0.5 mg	IV, IM	J0215
AMIFOSTINE	500 mg	IV	J0207
AMIKACIN SULFATE	100 mg	IV	J0278
AMINOLEVULINIC ACID HCL, 10% GEL, TOPICAL	10 mg	OTH	J7345
AMINOLEVULINIC ACID HCL, TOPICAL, 20%	unit dose (354 mg)	OTH	J7308
AMINOPHYLLINE	up to 250 mg	IV	J0280
AMIODARONE HCL	30 mg	IV	J0282
AMIODARONE HCL, (NEXTERONE®)	30 mg	IV	J0283
AMISULPRIDE	1 mg	IV	J0184
AMITRIPTYLINE HCL	up to 20 mg	IM	J1320
AMIVANTAMAB-VMJW	2 mg	IV	J9061
AMOBARBITAL	up to 125 mg	IV, IM	J0300
AMONDYS 45®	10 mg	IV	J1426
AMPHOTERICIN B	50 mg	IV	J0285
AMPHOTERICIN B CHOLESTERYL SULFATE COMPLEX	10 mg	IV	J0288
AMPHOTERICIN B LIPOSOME	10 mg	IV	J0289
AMPHOTERICIN B, LIPID COMPLEX	10 mg	IV	J0287
AMPICILLIN SODIUM	500 mg	IV, IM	J0290
AMPICILLIN SODIUM/SULBACTAM SODIUM	1.5 g	IV, IM	J0295
ANACAULASE-BCDB, 8.8% GEL	1 g	OTH	J7353
ANASCORP®	up to 120 mg	IV	J0716
ANAVIP®	120 mg	IV	J0841
ANDEXXA®	10 mg	IV	J7169
ANGIOMAX®	1 mg	IV	J0583
ANIDULAFUNGIN	1 mg	IV	J0348
ANIFROLUMAB-FNIA	1 mg	IV	J0491
ANISTREPLASE	30 IU	IV	J0350
ANJESO®	1 mg	IV	J1738
ANTIEMETIC DRUG, NOT OTHERWISE SPECIFIED	-	ORAL	J8597
ANTIEMETIC DRUG, RECTAL/ SUPPOSITORY, NOT OTHERWISE SPECIFIED	-	OTH	J8498
ANTIHEMOPHILIC FACTOR VIII/ VON WILLEBRAND FACTOR COMPLEX (HUMAN)	1 IU	IV	J7186
ANTI-INHIBITOR COAGULANT COMPLEX	1 IU	IV	J7198
ANTI-NEOPLASTIC DRUGS, NOT OTHERWISE CLASSIFIED	-	-	J9999
ANTITHROMBIN III (HUMAN)	1 IU	IV	J7197
ANTITHROMBIN RECOMBINANT	50 IU	IV	J7196
APOMORPHINE HYDROCHLORIDE	1 mg	SC	J0364
APREPITANT	1 mg	IV	J0185
APREPITANT	5 mg	ORAL	J8501
APROTININ	10,000 kiu	IV	J0365
ARALAST NP®	10 mg	IV	J0256
ARANESP® (FOR ESRD)	1 mcg	IV, SC	J0882
ARANESP® (NON-ESRD)	1 mcg	IV, SC	J0881
ARBUTAMINE HCL	1 mg	IV	J0395
ARCALYST®	1 mg	SC	J2793
ARFORMOTEROL	15 mcg	INH	J7605
ARGATROBAN (FOR ESRD)	1 mg	IV	J0884
ARGATROBAN (MADE BY ACCORD), (FOR ESRD)	1 mg	IV	J0892
ARGATROBAN (MADE BY ACCORD), (NON-ESRD)	1 mg	IV	J0891
ARGATROBAN (MADE BY AUROMEDICS), (FOR ESRD)	1 mg	IV	J0899
ARGATROBAN (MADE BY AUROMEDICS), (NON-ESRD)	1 mg	IV	J0898
ARGATROBAN (NON-ESRD USE)	1 mg	IV	J0883
ARIPIPRAZOLE	0.25 mg	IM	J0400
ARIPIPRAZOLE (ABILIFY ASIMTUFII®)	1 mg	IV	J0402
ARIPIPRAZOLE LAUROXIL	1 mg	IM	J1944
ARIPIPRAZOLE LAUROXIL (ARISTADA INITIO®)	1 mg	IM	J1943
ARIPIPRAZOLE, EXTENDED RELEASE (ABILIFY MAINTENA®)	1 mg	IM	J0401
ARISTADA INITIO®	1 mg	IM	J1943
ARISTADA®	1 mg	IM	J1944
ARISTOSPAN®	5 mg	IV	J3303
ARIXTRA®	0.5 mg	SC	J1652
ARRANON®	50 mg	IV	J9261
ARSENIC TRIOXIDE	1 mg	IV	J9017
ARTESUNATE	1 mg	IV	J0391
ARZERRA®	10 mg	IV	J9302
ASCENIV™	500 mg	IV	J1554
ASPARAGINASE	1,000 IU	IV, IM	J9019

Drug	Amount	Route	Code
ASPARAGINASE, NOS	10,000 IU	IV, IM	J9020
ASPARAGINASE, RECOMBINANT, (RYLAZE™)	0.1 mg	IM	J9021
ASPARLAS®	10 units	IV	J9118
ASTAGRAF XL®	0.1 mg	ORAL	J7508
ATEZOLIZUMAB	10 mg	IV	J9022
ATGAM®	250 mg	IV	J7504
ATIVAN®	2 mg	IV, IM	J2060
ATROPINE SULFATE	0.01 mg	IV	J0461
ATROPINE, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7635
ATROPINE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7636
ATRYN®	50 IU	IV	J7196
AUROTHIOGLUCOSE	up to 50 mg	IM	J2910
AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT	each	OTH	J7330
AVACINCAPTAD PEGOL	0.1 mg	OTH	J2782
AVALGLUCOSIDASE ALFA-NGPT	4 mg	IV	J0219
AVASTIN®	10 mg	IV	J9035
AVEED®	1 mg	IM	J3145
AVELUMAB	10 mg	IV	J9023
AVONEX®	30 mcg	IM	J1826
AVYCAZ®	0.5 g/0.125 g	IV	J0714
AZACITIDINE	1 mg	IV, SC	J9025
AZASAN®	50 mg	ORAL	J7500
AZATHIOPRINE, ORAL	50 mg	ORAL	J7500
AZATHIOPRINE, PARENTERAL	100 mg	IV	J7501
AZITHROMYCIN	500 mg	IV	J0456
AZTREONAM	100 mg	IV	J0457
BACLOFEN	10 mg	IT	J0475
BACLOFEN FOR INTRATHECAL TRIAL	50 mcg	IT	J0476
BACTOCILL®	up to 250 mg	IV, IM	J2700
BAL®	100 mg	IM	J0470
BASILIXIMAB	20 mg	IV	J0480
BAVENCIO®	10 mg	IV	J9023
BCG LIVE INTRAVESICAL INSTILLATION	1 mg	OTH	J9030
BECLOMETHASONE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7622
BELANTAMAB MAFODOTIN-BLMF	0.5 mg	IV	J9037
BELATACEPT	1 mg	IV	J0485
BELEODAQ®	10 mg	IV	J9032
BELIMUMAB	10 mg	IV	J0490
BELINOSTAT	10 mg	IV	J9032
BELRAPZO®	1 mg	IV	J9036
BENDAMUSTINE HCL	1 mg	IV	J9033
BENDAMUSTINE HCL, (BENDEKA®)	1 mg	IV	J9034
BENDAMUSTINE HYDROCHLORIDE (BELRAPZO®)	1 mg	IV	J9036
BENDAMUSTINE HYDROCHLORIDE (VIVIMUSTA®)	1 mg	IV	J9056
BENDEKA®	1 mg	IV	J9034
BENEFIX®	1 IU	IV	J7195
BENLYSTA®	10 mg	IV	J0490
BENRALIZUMAB	1 mg	SC	J0517
BENTYL®	up to 20 mg	IM	J0500
BENZTROPINE MESYLATE	1 mg	IV, IM	J0515
BEOVU®	1 mg	OTH	J0179
BEREMAGENE GEPERPAVEC-SVDT	5 x 10^9 pfu/ml vector genomes, per 0.1 ml	Topical	J3401
BERINERT®	10 IU	IV	J0597
BESPONSA®	0.1 mg	IV	J9229
BETAMETHASONE ACETATE AND BETAMETHASONE SODIUM PHOSPHATE	3 mg/3 mg	IM	J0702
BETAMETHASONE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7624
BETASERON®	0.25 mg	SC	J1830
BETHANECHOL CHLORIDE	up to 5 mg	SC	J0520
BETHKIS®	300 mg	INH	J7682
BETIBEGLOGENE AUTOTEMCEL, PER TREATMENT	per treatment	IV	J3393
BEVACIZUMAB	10 mg	IV	J9035
BEZLOTOXUMAB	10 mg	IV	J0565
BICILLIN C-R®	100,000 IU	IM	J0558
BICILLIN L-A®	100,000 IU	IM	J0561
BICNU®	100 mg	IV	J9050
BIMATOPROST, INTRACAMERAL IMPLANT	1 IU	OTH	J7351
BIORPHEN®	20 mcg	IV	J2372
BIPERIDEN LACTATE	5 mg	IV	J0190
BITOLTEROL MESYLATE, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7628
BITOLTEROL MESYLATE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7629
BIVALIRUDIN	1 mg	IV	J0583
BIVIGAM®	500 mg	IV	J1556
BLENREP®	0.5 mg	IV	J9037
BLEOMYCIN SULFATE	15 IU	IV, IM, SC	J9040
BLINATUMOMAB	1 mcg	IV	J9039
BLINCYTO®	1 mcg	IV	J9039
BONSITY®	10 mcg	SC	J3110
BORTEZOMIB	0.1 mg	IV, SC	J9041
BORTEZOMIB (MADE BY DR. REDDY'S)	0.1 mg	IV, SC	J9046
BORTEZOMIB (MADE BY FRESENIUS KABI)	0.1 mg	IV, SC	J9048
BORTEZOMIB (MADE BY HOSPIRA)	0.1 mg	IV, SC	J9049
BORTEZOMIB (MADE BY MAIA)	0.1 mg	IV	J9051

Drug	Amount	Route	Code
BOTOX COSMETIC®	1 IU	IM	J0585
BOTOX®	1 IU	IM	J0585
BRENTUXIMAB VEDOTIN	1 mg	IV	J9042
BREXANOLONE	1 mg	IV	J1632
BRINEURA®	1 mg	IV	J0567
BRIUMVI®	1 mg	IV	J2329
BRIXADI®	Less than or equal to 7 days of therapy	SC	J0577
BRIXADI®	Greater than 7 days and up to 28 days of therapy	SC	J0578
BROLUCIZUMAB-DBLL	1 mg	OTH	J0179
BROMPHENIRAMINE MALEATE	10 mg	IV, IM, SC	J0945
BUDESONIDE INHALATION SOLUTION, COMPOUNDED	0.5 mg	INH	J7627
BUDESONIDE INHALATION SOLUTION, COMPOUNDED	0.25 mg	INH	J7634
BUDESONIDE INHALATION SOLUTION, NON-COMPOUNDED	0.5 mg	INH	J7626
BUDESONIDE INHALATION SOLUTION, NON-COMPOUNDED	0.25 mg	INH	J7633
BUMETANIDE	0.5 mg	IV	J1939
BUPIVACAINE LIPOSOME	1 mg	INJ	J0666
BUPIVICAINE, NOT OTHERWISE SPECIFIED	0.5 mg	IV	J0665
BUPRENEX®	0.1 mg	IM	J0592
BUPRENORPHINE	1 mg	ORAL	J0571
BUPRENORPHINE EXTENDED-RELEASE (BRIXADI®)	Less than or equal to 7 days of therapy	SC	J0577
BUPRENORPHINE EXTENDED-RELEASE (BRIXADI®)	Greater than 7 days and up to 28 days of therapy	SC	J0578
BUPRENORPHINE HYDROCHLORIDE	0.1 mg	IM	J0592
BUPRENORPHINE/NALOXONE	<=3 mg	ORAL	J0572
BUPRENORPHINE/NALOXONE	>3 mg but <=6 mg	ORAL	J0573
BUPRENORPHINE/NALOXONE	>6 mg but <=10 mg	ORAL	J0574
BUPRENORPHINE/NALOXONE	>10 mg	ORAL	J0575
BUROSUMAB-TWZA	1 mg	SC	J0584
BUSULFAN	1 mg	IV	J0594
BUSULFAN	2 mg	ORAL	J8510
BUTORPHANOL TARTRATE	1 mg	IM	J0595
C-1 ESTERACE INHIBITOR, HUMAN, (BERINERT®)	10 IU	IV	J0597
C-1 ESTERACE INHIBITOR, HUMAN, (CINRYZE®)	10 IU	IV	J0598
C-1 ESTERACE INHIBITOR, RECOMBINANT, (RUCONEST®)	10 IU	IV	J0596
C-1 ESTERACE INHIBITOR, SUBCUTANEOUS, HUMAN, (HAEGARDA®)	10 IU	SC	J0599
CABAZITAXEL	1 mg	IV	J9043
CABAZITAXEL (MADE BY SANDOZ)	1 mg	IV	J9064
CABERGOLINE	0.25 mg	ORAL	J8515
CABNUVA®	2 mg/3 mg	IV	J0741
CABOTEGRAVIR	1 mg	IM	J0739
CABOTEGRAVIR AND RILPIVIRINE	2 mg/3 mg	IV	J0741
CAFFEINE CITRATE	5 mg	IV	J0706
CALASPARGASE-PEGOL-MKNL	10 units	IV	J9118
CALCITONIN-SALMON	up to 400 IU	IM, SC	J0630
CALCITRIOL	0.1 mcg	IM	J0636
CALCIUM ACETATE, (FOR ESRD ON DIALYSIS)	23 mg	ORAL	J0615
CALCIUM CHLORIDE; DEXTROSE; MAGNESIUM SULFATE; POTASSIUM CHLORIDE; SODIUM BICARBONATE; SODIUM CHLORIDE; SODIUM PHOSPHATE, DIBASIC, HEPTAHYDRATE	1 ml	IT	J9175
CALCIUM DISODIUM VERSENATE®	up to 1000 mg	IV, IM	J0600
CALCIUM GLUCONATE (MADE BY WG CRITICAL CARE)	10 mg	IV	J0613
CALCIUM GLUCONATE, NOS	10 mg	IV	J0612
CALCIUM GLYCEROPHOSPHATE AND CALCIUM LACTATE	10 ml	IM, SC	J0620
CAMCEVI®	1 mg	SC	J1952
CAMPTOSAR®	20 mg	IV	J9206
CANAKINUMAB	1 mg	SC	J0638
CANCIDAS®	5 mg	IV	J0637
CANTHARIDIN FOR TOPICAL ADMINISTRATION, 0.7%	3.2 mg	OTH	J7354
CAPECITABINE, ORAL	50 mg	ORAL	J8522
CAPSAICIN 8% PATCH	per sq cm	OTH	J7336
CARBIDOPA/LEVODOPA, ENTERAL SUSPENSION	100 ml	OTH	J7340
CARBOPLATIN	50 mg	IV	J9045
CARFILZOMIB	1 mg	IV	J9047
CARIMUNE® NF	500 mg	IV	J1566
CARMUSTINE	100 mg	IV	J9050
CARMUSTINE (MADE BY ACCORD)	100 mg	IV	J9052
CARNITOR®	1 g	IV	J1955
CASIMERSEN	10 mg	IV	J1426
CASPOFUNGIN ACETATE	5 mg	IV	J0637
CATHFLO ACTIVASE®	1 mg	IV	J2997
CAVERJECT®	1.25 mcg	OTH	J0270
CEFAZOLIN SODIUM	500 mg	IV, IM	J0690
CEFAZOLIN SODIUM (MADE BY BAXTER)	500 mg	IV	J0689
CEFAZOLIN SODIUM (MADE BY HIKMA)	500 mg	IV	J0688

Drug	Amount	Route	Code
CEFAZOLIN SODIUM (MADE BY WG CRITICAL CARE), NOT THERAPEUTICALLY EQUIVALENT TO J0690	500 mg	IV, IM	J0687
CEFEPIME HCL (MADE BY B. BRAUN)	500 mg	IV	J0703
CEFEPIME HCL (MADE BY BAXTER)	500 mg	IV	J0701
CEFEPIME HYDROCHLORIDE	500 mg	IV	J0692
CEFIDEROCOL	10 mg	IV	J0699
CEFOTAXIME SODIUM	1 g	IV, IM	J0698
CEFOXITIN SODIUM	1 g	IV, IM	J0694
CEFTAROLINE FOSAMIL	10 mg	IV	J0712
CEFTAZIDIME	500 mg	IV, IM	J0713
CEFTAZIDIME AND AVIBACTAM	0.5 g/0.125 g	IV	J0714
CEFTIZOXIME SODIUM	500 mg	IV, IM	J0715
CEFTOLOZANE AND TAZOBACTAM	50 mg/25 mg	IV	J0695
CEFTRIAXONE	250 mg	IV, IM	J0696
CEFUROXIME SODIUM, STERILE	750 mg	IV, IM	J0697
CELESTONE SOLUSPAN®	3 mg/3 mg	IM	J0702
CELLCEPT®	250 mg	ORAL	J7517
CEMIPLIMAB-RWLC	1 mg	IV	J9119
CENTRUROIDES IMMUNE F(AB)2	up to 120 mg	IV	J0716
CEPHALOTHIN SODIUM	up to 1 g	IV, IM	J1890
CEPHAPIRIN SODIUM	up to 1 g	IV, IM	J0710
CEPROTIN®	10 IU	IV	J2724
CEREZYME®	10 IU	IV	J1786
CERLIPONASE ALFA	1 mg	IV	J0567
CERTOLIZUMAB PEGOL	1 mg	SC	J0717
CESAMET®	1 mg	ORAL	J8650
CETIRIZINE	0.5 mg	IV	J1201
CETUXIMAB	10 mg	IV	J9055
CHEMOTHERAPEUTIC, NOT OTHERWISE SPECIFIED	-	ORAL	J8999
CHIRHOSTIM®	1mcg	IV	J2850
CHLORAMPHENICOL SODIUM SUCCINATE	up to 1 g	IV	J0720
CHLORDIAZEPOXIDE	up to 100 mg	IV, IM	J1990
CHLOROPROCAINE HCL	1 mg	VAR	J2401
CHLOROPROCAINE HCL (CLOROTEKAL®)	1 mg	VAR	J2402
CHLOROPROCAINE HCL OPHTHALMIC, 3% GEL	1 mg	OTH	J2403
CHLOROQUINE HCL	up to 250 mg	IM	J0390
CHLOROTHIAZIDE SODIUM	500 mg	IV	J1205
CHLORPROMAZINE HCL	up to 50 mg	IV, IM	J3230
CHORIONIC GONADOTROPIN	1,000 IU	IM	J0725
CIDOFOVIR	375 mg	IV	J0740
CILASTATIN SODIUM, IMIPENEM	250 mg	IV, IM	J0743
CIMZIA®	1 mg	SC	J0717
CINACALCET, ORAL, (FOR ESRD ON DIALYSIS)	1 mg	ORAL	J0604
CINQAIR®	1 mg	IV	J2786
CINRYZE®	10 IU	IV	J0598
CINVANTI®	1 mg	IV	J0185
CIPAGLUCOSIDASE ALFA-ATGA	5 mg	IV	J1203
CIPROFLOXACIN	200 mg	IV	J0744
CIPROFLOXACIN, OTIC SUSPENSION	6 mg	OTH	J7342
CISPLATIN, POWDER OR SOLUTION	10 mg	IV	J9060
CLADRIBINE	1 mg	IV	J9065
CLINDAMYCIN PHOSPHATE	300 mg	IV, IM	J0736
CLINDAMYCIN PHOSPHATE (MADE BY BAXTER)	300 mg	IV, IM	J0737
CLOFARABINE	1 mg	IV	J9027
CLOLAR®	1 mg	IV	J9027
CLONIDINE HYDROCHLORIDE	1 mg	OTH	J0735
CLOROTEKAL®	1 mg	VAR	J2402
COAGADEX®	1 IU	IV	J7175
COAGULATION FACTOR IX (RECOMBINANT), IXINITY®	1 IU	IV	J7213
COAGULATION FACTOR XA (RECOMBINANT), INACTIVATED-ZHZO (ANDEXXA®)	10 mg	IV	J7169
CODEINE PHOSPHATE	30 mg	IV, IM, SC	J0745
COLISTIMETHATE SODIUM	up to 150 mg	IV, IM	J0770
COLLAGENASE CLOSTRIDIUM HISTOLYTICUM	0.01 mg	OTH	J0775
COLUMVI®	2.5 mg	IV	J9286
COLY-MYCIN M®	up to 150 mg	IV, IM	J0770
COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED	-	VAR	J7999
CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH	each	OTH	J7304
COPANLISIB	1 mg	IV	J9057
COPAXONE®	20 mg	SC	J1595
COPPER CONTRACEPTIVE, INTRAUTERINE	each	OTH	J7300
CORIFACT®	1 IU	IV	J7180
CORTICORELIN OVINE TRIFLUTATE	1 mcg	IV, IM	J0795
CORTICOTROPIN (ACTHAR GEL®)	up to 40 IU	IM, SC	J0801
CORTICOTROPIN (MADE BY ANI)	up to 40 IU	IM, SC	J0802
CORTROSYN®	0.25 mg	IV	J0834
CORVERT®	1 mg	IV	J1742
COSELA®	1 mg	IV	J1448
COSMEGEN®	0.5 mg	IV	J9120
COSYNTROPIN	0.25 mg	IV	J0834
CRESEMBA®	1 mg	IV	J1833
CRIZANLIZUMAB-TMCA	5 mg	IV	J0791
CROFAB®	up to 1 g	IV	J0840

Drug	Amount	Route	Code
CROMOLYN SODIUM, COMPOUNDED	10 mg	INH	J7632
CROMOLYN SODIUM, NON-COMPOUNDED	10 mg	INH	J7631
CROTALIDAE IMMUNE F(AB')2 (EQUINE)	120 mg	IV	J0841
CROTALIDAE POLYVALENT IMMUNE FAB (OVINE)	up to 1 g	IV	J0840
CROVALIMAB-AKKZ	10 mg	IV, SC	J1307
CRYSVITA®	1 mg	SC	J0584
CUBICIN®	1 mg	IV	J0878
CUTAQUIG®	100 mg	SC	J1551
CUVITRU®	100 mg	SC	J1555
CYANOCOBALAMIN, VITAMIN B-12	up to 1,000 mcg	IM, SC	J3420
CYCLOPHOSPHAMIDE	25 mg	ORAL	J8530
CYCLOPHOSPHAMIDE (MADE BY AUROMEDICS)	5 mg	IV	J9071
CYCLOPHOSPHAMIDE (MADE BY AVYXA)	5 mg	IV	J9072
CYCLOPHOSPHAMIDE (MADE BY BAXTER)	5 mg	IV	J9076
CYCLOPHOSPHAMIDE (MADE BY INGENUS)	5 mg	IV	J9073
CYCLOPHOSPHAMIDE (MADE BY SANDOZ)	5 mg	IV	J9074
CYCLOPHOSPHAMIDE, NOT OTHERWISE SPECIFIED	5 mg	IV	J9075
CYCLOSPORINE	250 mg	IV	J7516
CYCLOSPORINE, ORAL	100 mg	ORAL	J7502
CYCLOSPORINE, ORAL	25 mg	ORAL	J7515
CYRAMZA®	5 mg	IV	J9308
CYTARABINE	100 mg	IV, SC	J9100
CYTARABINE LIPOSOME	10 mg	IT	J9098
CYTOGAM®	vial	IV	J0850
CYTOMEGALOVIRUS IMMUNE GLOBULIN INTRAVENOUS (HUMAN)	vial	IV	J0850
D.H.E. 45®	1 mg	IV, IM	J1110
D5W	1000 cc	IV	J7070
DACARBAZINE	100 mg	IV	J9130
DACLIZUMAB	25 mg	IV	J7513
DACOGEN®	1 mg	IV	J0894
DACTINOMYCIN	0.5 mg	IV	J9120
DALBAVANCIN	5 mg	IV	J0875
DALTEPARIN SODIUM	2500 IU	SC	J1645
DALVANCE®	5 mg	IV	J0875
DANYELZA®	1 mg	IV	J9348
DAPRODUSTAT (FOR ESRD)	1 mg	ORAL	J0889
DAPTOMYCIN	1 mg	IV	J0878
DAPTOMYCIN (MADE BY BAXTER)	1 mg	IV	J0874
DAPTOMYCIN (MADE BY HOSPIRA)	1 mg	IV	J0877
DAPTOMYCIN (MADE BY XELLIA)	1 mg	IV	J0873
DAPTOMYCIN (MADE BY XELLIA), UNREFRIGERATED, NOT THERAPEUTICALLY EQUIVALENT TO J0878 OR J0873	1 mg	IV	J0872
DARATUMUMAB	10 mg	IV	J9145
DARATUMUMAB AND HYALURONIDASE-FIHJ	10 mg	SC	J9144
DARBEPOETIN ALFA (FOR ESRD)	1 mcg	IV, SC	J0882
DARBEPOETIN ALFA (NON-ESRD)	1 mcg	IV, SC	J0881
DARZALEX FASPRO®	10 mg	SC	J9144
DARZALEX®	10 mg	IV	J9145
DAUNORUBICIN	10 mg	IV	J9150
DAUNORUBICIN AND CYTARABINE, LIPOSOMAL	1 mg/2.27 mg	IV	J9153
DAUNORUBICIN CITRATE, LIPOSOMAL FORMULATION	10 mg	IV	J9151
DAXIBOTULINUMTOXINA-LANM	1 unit	IM	J0589
DDAVP®	1 mcg	IV, SC	J2597
DECITABINE	1 mg	IV	J0894
DECITABINE (MADE BY SUN PHARMA)	1 mg	IV	J0893
DEFEROXAMINE MESYLATE	500 mg	IV, IM, SC	J0895
DEGARELIX	1 mg	SC	J9155
DELANDISTROGENE MOXEPARVOVEC-ROKL	per therapeutic dose	IV	J1413
DELESTROGEN®	up to 10 mg	IM	J1380
DEMEROL®	100 mg	IV, IM, SC	J2175
DENOSUMAB	1 mg	SC	J0897
DEOXYCHOLIC ACID	1 mg	SC	J0591
DEPO ESTRADIOL®	up to 5 mg	IM	J1000
DEPO-ESTRADIOL CYPIONATE	up to 5 mg	IM	J1000
DEPO-PROVERA®	1 mg	IM	J1050
DEPO-TESTOSTERONE®	1 mg	IM	J1071
DESFERAL®	500 mg	IV, IM, SC	J0895
DESMOPRESSIN ACETATE	1 mcg	IV, SC	J2597
DEXAMETHASONE	0.25 mg	ORAL	J8540
DEXAMETHASONE (HEMADY®)	0.25 mg	ORAL	J8541
DEXAMETHASONE 9 PERCENT, INTRAOCULAR	1mcg	OTH	J1095
DEXAMETHASONE ACETATE	1 mg	IM	J1094
DEXAMETHASONE SODIUM PHOSPHATE	1 mg	IV, IM	J1100
DEXAMETHASONE, CONCENTRATED FORM. COMPOUNDED	1 mg	INH	J7637
DEXAMETHASONE, INTRAVITREAL IMPLANT	0.1 mg	OTH	J7312
DEXAMETHASONE, LACRIMAL OPHTHALMIC INSERT	0.1 mg	OTH	J1096
DEXAMETHASONE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7638
DEXMEDETOMIDINE	1 mcg	ORAL	J1105

Drug	Amount	Route	Code
DEXRAZOXANE HYDROCHLORIDE	250 mg	IV	J1190
DEXTENZA®	0.1 mg	OTH	J1096
DEXTRAN 40	500 ml	IV	J7100
DEXTRAN 75	500 ml	IV	J7110
DEXTROSE 5% IN LACTATED RINGERS	up to 1000 cc	IV	J7121
DEXTROSE 5% NORMAL SALINE SOLUTION	500 ml = 1 unit	IV	J7042
DEXTROSE/WATER (5%)	500 ml = 1 unit	IV	J7060
DEXYCU®	1mcg	OTH	J1095
DIAZEPAM	up to 5 mg	IV, IM	J3360
DIAZOXIDE	up to 300 mg	IV	J1730
DICLOFENAC SODIUM	0.5 mg	IV	J1130
DICYCLOMINE HCL	up to 20 mg	IM	J0500
DIETHYLSTILBESTROL DIPHOSPHATE	250 mg	IV	J9165
DIFELIKEFALIN (FOR ESRD)	0.1 microgram	IV	J0879
DIGIFAB®	vial	IV	J1162
DIGOXIN	up to 0.5 mg	IV, IM	J1160
DIGOXIN IMMUNE FAB (OVINE)	vial	IV	J1162
DIHYDROERGOTAMINE MESYLATE	1 mg	IV, IM	J1110
DIMENHYDRINATE	up to 50 mg	IV, IM	J1240
DIMERCAPROL	100 mg	IM	J0470
DIMETHYL SULFOXIDE (DMSO), 50%	50 ml	OTH	J1212
DIPHENHYDRAMINE	up to 50 mg	IV, IM	J1200
DIPRIVAN®	10 mg	IV	J2704
DIPYRIDAMOLE	10 mg	IV	J1245
DIURIL®	500 mg	IV	J1205
DOBUTAMINE HCL	250 mg	IV	J1250
DOCETAXEL	1 mg	IV	J9171
DOCETAXEL (DOCIVYX™)	1 mg	IV	J9172
DOCIVYX™	1 mg	IV	J9172
DOLASETRON MESYLATE	10 mg	IV	J1260
DONANEMAB-AZBT	2 mg	IV	J0175
DOPAMINE HCL	40 mg	IV	J1265
DORIPENEM	10 mg	IV	J1267
DORNASE ALPHA, UNIT DOSE FORM, NON-COMPOUNDED	1 mg	INH	J7639
DOSTARLIMAB-GXLY	10 mg	IV	J9272
DOXERCALCIFEROL	1 mcg	IV	J1270
DOXORUBICIN HCL	10 mg	IV	J9000
DROPERIDOL	up to 5 mg	IV, IM	J1790
DROPERIDOL AND FENTANYL CITRATE	up to 2 ml ampule	IV, IM	J1810
DRUG ADMINISTERED THROUGH A METERED DOSE INHALER	per dose	INH	J3535
DUOPA®	100 ml	OTH	J7340
DURACLON®	1 mg	OTH	J0735
DURAMORPH®	10 mg	OTH	J2274
DUROLANE®	1 mg	OTH	J7318
DURVALUMAB	10 mg	IV	J9173
DURYSTA®	1 IU	OTH	J7351
DYPHYLLINE	up to 500 mg	IM	J1180
DYSPORT®	5 IU	IM	J0586
ECALLANTIDE	1 mg	SC	J1290
ECULIZUMAB	10 mg	IV	J1300
EDARAVONE	1 mg	IV	J1301
EDETATE CALCIUM DISODIUM	up to 1000 mg	IV, IM	J0600
EDETATE DISODIUM	150 mg	IV	J3520
EFBEMALENOGRASTIM ALFA-VUXW	0.5 mg	SC	J9361
EFGARTIGIMOD ALFA AND HYALURONIDASE-QVFC	2 mg	SC	J9334
EFGARTIGIMOD ALFA-FCAB	2 mg	IV	J9332
EFLAPEGRASTIM-XNST	0.1 mg	IV	J1449
ELAHERE®	1 mg	IV	J9063
ELAPRASE®	1 mg	IV	J1743
ELELYSO®	10 IU	IV	J3060
ELEVIDYS®	per therapeutic dose	IV	J1413
ELFABRIO®	1 mg	IV	J2508
ELITEK®	0.5 mg	IV	J2783
ELLENCE®	2 mg	IV	J9178
ELLIOTTS' B® SOLUTION	1 ml	IT	J9175
ELOCTATE®	1 IU	IV	J7205
ELOSULFASE ALFA	1 mg	IV	J1322
ELOTUZUMAB	1 mg	IV	J9176
ELOXATIN®	0.5 mg	IV	J9263
ELRANATAMAB-BCMM	1 mg	SC	J1323
ELZONRIS®	10 mcg	IV	J9269
EMAPALUMAB-LZSG	1 mg	IV	J9210
EMEND®	1 mg	IV	J1453
EMEND®	5 mg	ORAL	J8501
EMICIZUMAB-KXWH	0.5 mg	SC	J7170
EMPLICITI®	1 mg	IV	J9176
EMTRICITABINE 200MG AND TENOFOVIR ALAFENAMIDE 25MG	various	ORAL	J0751
EMTRICITABINE 200MG AND TENOFOVIR DISOPROXIL FUMARATE 300MG	various	ORAL	J0750
ENBREL®	25 mg	SC	J1438
ENFORTUMAB VEDOTIN-EJFV	0.25 mg	IV	J9177
ENFUVIRTIDE	1 mg	SC	J1324
ENHERTU®	1 mg	IV	J9358
ENOXAPARIN SODIUM	10 mg	SC	J1650
ENSIFENTRINE, INHALATION SUSPENSION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME	unit dose form, 3 mg	OTH	J7601
ENTYVIO®	1 mg	IV	J3380

Drug	Amount	Route	Code
ENVARSUS XR®	0.25mg	ORAL	J7503
EPCORITAMAB-BYSP	0.16 mg	SC	J9321
EPINEPHRINE (MADE BY BELCHER)	0.1 mg	IV	J0173
EPIRUBICIN HYDROCHLORIDE	2 mg	IV	J9178
EPKINLY™	0.16 mg	SC	J9321
EPOETIN ALFA (NON-ESRD)	1000 IU	IV, SC	J0885
EPOETIN BETA AND METHOXY POLYETHYLENE GLYCOL (FOR ESRD)	1 mcg	IV, SC	J0887
EPOETIN BETA AND METHOXY POLYETHYLENE GLYCOL (NON-ESRD USE)	1 mcg	IV, SC	J0888
EPOGEN/PROCRIT®	1000 IU	IV, SC	J0885
EPOPROSTENOL	0.5 mg	IV	J1325
EPTIFIBATIDE	5 mg	IV, IM	J1327
EPTINEZUMAB-JJMR	1 mg	IV	J3032
ERAVACYCLINE	1 mg	IV	J0122
ERAXIS®	1 mg	IV	J0348
ERBITUX®	10 mg	IV	J9055
ERGONOVINE MALEATE	up to 0.2 mg	IV, IM	J1330
ERIBULIN MESYLATE	0.1 mg	IV	J9179
ERTAPENEM SODIUM	500 mg	IV, IM	J1335
ERYTHROCIN®	500 mg	IV	J1364
ERYTHROMYCIN LACTOBIONATE	500 mg	IV	J1364
ESMOLOL HYDROCHLORIDE	10 mg	IV	J1805
ESMOLOL HYDROCHLORIDE (MADE BY WG CRITICAL CARE)	10 mg	IV	J1806
ESPEROCT®	1 IU	IV	J7204
ESTRADIOL VALERATE	up to 10 mg	IM	J1380
ESTROGENS, CONJUGATED	25 mg	IV, IM	J1410
ESTRONE	1 mg	IM	J1435
ETANERCEPT	25 mg	SC	J1438
ETELCALCETIDE	0.1 mg	IV	J0606
ETEPLIRSEN	10 mg	IV	J1428
ETHAMOLIN®	100 mg	IV	J1430
ETHANOLAMINE OLEATE	100 mg	IV	J1430
ETHINYL ESTRADIOL AND ETONOGESTREL; MONTHLY VAGINAL RING	each	OTH	J7295
ETHYOL®	500 mg	IV	J0207
ETIDRONATE DISODIUM	300 mg	IV	J1436
ETONOGESTREL IMPLANT	each	OTH	J7307
ETOPOSIDE	50 mg	ORAL	J8560
ETOPOSIDE	10 mg	IV	J9181
ETRANACOGENE DEZAPARVOVEC-DRLB	per therapeutic dose	IV	J1411
EUFLEXXA®	dose	OTH	J7323
EVENITY®	1 mg	SC	J3111
EVEROLIMUS, ORAL	0.25 mg	ORAL	J7527
EVINACUMAB-DGNB	5 mg	IV	J1305
EVKEEZA®	5 mg	IV	J1305

Drug	Amount	Route	Code
EVOMELA®	50 mg	IV	J9246
EXAGAMGLOGENE AUTOTEMCEL	per treatment	IV	J3392
EXONDYS 51®	10 mg	IV	J1428
EXTAVIA®	0.25 mg	SC	J1830
EYLEA®	1 mg	OTH	J0178
FABRAZYME®	1 mg	IV	J0180
FACTOR IX, (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT)	1 IU	IV	J7193
FACTOR IX, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), GLYCOPEGYLATED, REBINYN®	1 IU	IV	J7203
FACTOR IX, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), NOT OTHERWISE SPECIFIED	1 IU	IV	J7195
FACTOR IX, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), RIXUBIS®	1 IU	IV	J7200
FACTOR IX, ALBUMIN FUSION PROTEIN, (RECOMBINANT), IDELVION®	1 IU	IV	J7202
FACTOR IX, COMPLEX	1 IU	IV	J7194
FACTOR IX, FC FUSION PROTEIN, (RECOMBINANT), ALPROLIX®	1 IU	IV	J7201
FACTOR VIIA, (ANTIHEMOPHILIC FACTOR, RECOMBINANT) - JNCW SEVENFACT®	1 IU	IV	J7212
FACTOR VIIA, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), NOVOSEVEN RT®	1 mcg	IV	J7189
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, (PORCINE))	1 IU	IV	J7191
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, HUMAN)	1 IU	IV	J7190
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), AFSTYLA®	1 IU	IV	J7210
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), KOVALTRY®	1 IU	IV	J7211
FACTOR VIII, (ANTI-HEMOPHILIC FACTOR, RECOMBINANT), NOT OTHERWISE SPECIFIED	1 IU	IV	J7192
FACTOR VIII, (ANTI-HEMOPHILIC FACTOR, RECOMBINANT), NOVOEIGHT®	1 IU	IV	J7182
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), NUWIQ®	1 IU	IV	J7209
FACTOR VIII, (ANTI-HEMOPHILIC FACTOR, RECOMBINANT), OBIZUR®	1 IU	IV	J7188
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PEGYLATED	1 IU	IV	J7207
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PEGYLATED-AUCL, (JIVI®)	1 IU	IV	J7208

Drug	Amount	Route	Code
FACTOR VIII, (ANTIHEMOPHILIC FACTOR, RECOMBINANT), XYNTHA®	1 IU	IV	J7185
FACTOR VIII, (VON WILLEBRAND FACTOR COMPLEX, RECOMBINANT), ALTUVIIIO™	1 IU	IV	J7214
FACTOR VIII, ANITHEMOPHILIC FACTOR (RECOMBINANT), (ESPEROCT), GLYCOPEGYLATED-EXEI	1 IU	IV	J7204
FACTOR VIII, FC FUSION (RECOMBINANT)	1 IU	IV	J7205
FACTOR X, (HUMAN)	1 IU	IV	J7175
FACTOR XIII, ANTIHEMOPHILIC FACTOR (HUMAN)	1 IU	IV	J7180
FACTOR XIII, A-SUBUNIT (RECOMBINANT)	1 IU	IV	J7181
FAM-TRASTUZUMAB DERUXTECAN-NXKI	1 mg	IV	J9358
FARICIMAB-SVOA	0.1 mg	OTH	J2777
FASENRA®	1 mg	SC	J0517
FASLODEX®	25 mg	IM	J9395
FECAL MICROBIOTA, LIVE-JSLM	1 ml	OTH	J1440
FEIBA NF®	1 IU	IV	J7198
FENSOLVI®	0.25 mg	SC	J1951
FENTANYL CITRATE	0.1 mg	IV, IM	J3010
FERRIC CARBOXYMALTOSE	1 mg	IV	J1439
FERRIC CITRATE, 3 MG FERRIC IRON, (FOR ESRD ON DIALYSIS)	3 mg	ORAL	J0609
FERRIC DERISOMALTOSE	10 mg	IV	J1437
FERRIC OXYHYDROXIDE	12.5 mg	IV	J2916
FERRIC PYROPHOSPHATE CITRATE POWDER	0.1 mg of iron	IV	J1444
FERRIC PYROPHOSPHATE CITRATE SOLUTION (TRIFERIC AVNU®)	0.1 mg of iron	IV	J1445
FERRIC PYROPHOSPHATE CITRATE SOLUTION (TRIFERIC®)	0.1 mg of iron	IV	J1443
FETROJA®	10 mg	IV	J0699
FIASP®	per 5 units	INJ	J1812
FIASP® (ADMINISTERED THROUGH DME)	per 50 units	OTH	J1811
FIBRINOGEN CONCENTRATE (HUMAN) (FIBRYGA®)	1 mg	IV	J7177
FIBRINOGEN CONCENTRATE (HUMAN), NOS	1 mg	IV	J7178
FIBRYGA®	1 mg	IV	J7177
FIDANACOGENE ELAPARVOVEC-DZKT	per therapeutic dose	IV	J1414
FILGRASTIM (G-CSF), EXCLUDES BIOSIMILARS	1 mcg	IV, SC	J1442
FIRMAGON®	1 mg	SC	J9155
FLEBOGAMMA DIF®	500 mg	IV	J1572
FLOLAN®	0.5 mg	IV	J1325
FLOXURIDINE	500 mg	IA	J9200
FLUCONAZOLE	200 mg	IV	J1450
FLUDARABINE PHOSPHATE	50 mg	IV	J9185
FLUDARABINE PHOSPHATE, ORAL	10 mg	ORAL	J8562
FLUNISOLIDE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7641
FLUOCINOLONE ACETONIDE, (YUTIQ®)	0.01 mg	OTH	J7314
FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT (ILUVIEN®)	0.01 mg	OTH	J7313
FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT (RETISERT®)	0.01 mg	OTH	J7311
FLUOROURACIL	500 mg	IV	J9190
FLUPHENAZINE DECANOATE	up to 25 mg	IM	J2680
FLUPHENAZINE HCL	1.25 mg	IM	J2679
FOCINVEZ™	1 mg	IV	J1434
FOLOTYN®	1 mg	IV	J9307
FOMEPIZOLE	15 mg	IV	J1451
FOMIVIRSEN SODIUM, INTRAOCULAR	1.65 mg	OTH	J1452
FONDAPARINUX SODIUM	0.5 mg	SC	J1652
FORMOTEROL FUMARATE, UNIT DOSE, NON-COMPOUNDED	20 mcg	INH	J7606
FORMOTEROL, UNIT DOSE FORM, COMPOUNDED	12 mcg	INH	J7640
FORTAZ®	500 mg	IV, IM	J0713
FORTEO®	10 mcg	SC	J3110
FOSAPREPITANT	1 mg	IV	J1453
FOSAPREPITANT (FOCINVEZ™)	1 mg	IV	J1434
FOSAPREPITANT (MADE BY TEVA)	1 mg	IV	J1456
FOSCARNET SODIUM	1,000 mg	IV	J1455
FOSCAVIR®	1,000 mg	IV	J1455
FOSNETUPITANT AND PALONOSETRON	235 mg and 0.25 mg	IV	J1454
FRAGMIN®	2500 IU	SC	J1645
FREMANEZUMAB-VFRM	1 mg	SC	J3031
FULVESTRANT	25 mg	IM	J9395
FULVESTRANT (MADE BY FRESENIUS KABI)	25 mg	IM	J9394
FULVESTRANT (MADE BY TEVA)	25 mg	IM	J9393
FUROSCIX®	20 mg	INJ	J1941
FUROSEMIDE	up to 20 mg	IV, IM	J1940
FUROSEMIDE (FUROSCIX®)	20 mg	INJ	J1941
FUZEON®	1 mg	SC	J1324
GABLOFEN®	10 mg	IT	J0475
GABLOFEN®	50 mcg	IT	J0476
GALLIUM NITRATE	1 mg	IV	J1457
GALSULFASE	1 mg	IV	J1458
GAMASTAN S/D®	over 10 cc	IM	J1560

Drug	Amount	Route	Code
GAMIFANT®	1 mg	IV	J9210
GAMMA GLOBULIN	1 cc	IM	J1460
GAMMA GLOBULIN	over 10 cc	IM	J1560
GAMMAGARD LIQUID®	500 mg	IV	J1569
GAMMAGARD® S/D	500 mg	IV	J1566
GAMMAKED®	500 mg	IV	J1561
GAMMAPLEX®	500 mg	IV	J1557
GAMUNEX-C®	500 mg	IV	J1561
GANCICLOVIR SODIUM	500 mg	IV	J1570
GANCICLOVIR SODIUM (MADE BY EXELA)	500 mg	IV	J1574
GANCICLOVIR, IMPLANT	4.5 mg	OTH	J7310
GARAMYCIN®	up to 80 mg	IV, IM	J1580
GAZYVA®	10 mg	IV	J9301
GEFITINIB	250 mg	ORAL	J8565
GEL-ONE®	dose	OTH	J7326
GEL-SYN®	0.1 mg	VAR	J7328
GEMCITABINE HYDROCHLORIDE (INFUGEM®)	100 mg	IV	J9198
GEMCITABINE HYDROCHLORIDE (MADE BY ACCORD)	200 mg	IV	J9199
GEMCITABINE HYDROCHLORIDE, NOS	200 mg	IV	J9201
GEMTUZUMAB OZOGAMICIN	0.1 mg	IV	J9203
GENGRAF®	100 mg	ORAL	J7502
GENGRAF®	25 mg	ORAL	J7515
GENTAMICIN (GARAMYCIN®)	up to 80 mg	IV, IM	J1580
GENVISC 850®	1 mg	OTH	J7320
GIVLAARI®	0.5 mg	SC	J0223
GIVOSIRAN	0.5 mg	SC	J0223
GLASSIA®	10 mg	IV	J0257
GLATIRAMER ACETATE	20 mg	SC	J1595
GLOFITAMAB-GXBM	2.5 mg	IV	J9286
GLUCAGEN®	1 mg	IV, IM, SC	J1610
GLUCAGON HYDROCHLORIDE	1 mg	IV, IM, SC	J1610
GLUCAGON HYDROCHLORIDE (MADE BY FRESENIUS KABI)	1 mg	IV, IM, SC	J1611
GLYCOPYRROLATE	0.1 mg	IV, IM	J1596
GLYCOPYRROLATE (GLYRX®-PF)	0.1 mg	IV, IM	J1597
GLYCOPYRROLATE (MADE BY FRESENIUS KABI), NOT THERAPEUTICALLY EQUIVALENT TO J1596	0.1 mg	IV, IM	J1598
GLYCOPYRROLATE, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7642
GLYCOPYRROLATE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7643
GLYRX®-PF	0.1 mg	IV, IM	J1597
GOLD SODIUM THIOMALATE	up to 50 mg	IM	J1600
GOLIMUMAB	1 mg	IV	J1602
GOLODIRSEN	10 mg	IM	J1429

Drug	Amount	Route	Code
GONADORELIN HYDROCHLORIDE	100 mcg	IV, SC	J1620
GOSERELIN ACETATE IMPLANT	3.6 mg	OTH	J9202
GRANISETRON HYDROCHLORIDE	100 mcg	IV	J1626
GRANISETRON, EXTENDED RELEASE	0.1 mg	IV	J1627
GRANIX®	1 mcg	SC	J1447
GUSELKUMAB	1 mg	SC	J1628
HAEGARDA®	10 IU	SC	J0599
HALAVEN®	0.1 mg	IV	J9179
HALDOL DECANOATE®	50 mg	IM	J1631
HALDOL®	up to 5 mg	IV, IM	J1630
HALOPERIDOL	up to 5 mg	IV, IM	J1630
HALOPERIDOL DECANOATE	50 mg	IM	J1631
HECTOROL®	1 mcg	IV	J1270
HELIXATE FS®	1 IU	IV	J7192
HEMADY®	0.25 mg	ORAL	J8541
HEMGENIX®	per therapeutic dose	IV	J1411
HEMIN	1 mg	IV	J1640
HEMLIBRA®	0.5 mg	SC	J7170
HEMOFIL-M®	1 IU	IV	J7190
HEMOPHILIA CLOTTING FACTOR, NOT OTHERWISE CLASSIFIED	1 IU	IV	J7199
HEPAGAM B®	0.5 ml	IM	J1571
HEPAGAM B®	0.5 ml	IM	J1573
HEPARIN SODIUM	1,000 IU	IV, SC	J1644
HEPARIN SODIUM (HEPARIN LOCK FLUSH)	10 IU	IV	J1642
HEPARIN SODIUM (MADE BY PFIZER)	1000 units	IV, SC	J1643
HEPZATO KIT™	1 mg	OTH	J9248
HERCEPTIN HYLECTA®	10 mg	SC	J9356
HERCEPTIN®	10 mg	IV	J9355
HISTRELIN ACETATE	10 mcg	OTH	J1675
HISTRELIN IMPLANT (SUPPRELIN LA®)	50 mg	OTH	J9226
HISTRELIN IMPLANT (VANTAS®)	50 mg	OTH	J9225
HIZENTRA®	100 mg	SC	J1559
HUMATE-P®	1 IU	IV	J7187
HYALGAN®	dose	OTH	J7321
HYALURONAN OR DERIVATIVE, DUROLANE®	1 mg	OTH	J7318
HYALURONAN OR DERIVATIVE, EUFLEXXA®	dose	OTH	J7323
HYALURONAN OR DERIVATIVE, GEL-ONE®	dose	OTH	J7326
HYALURONAN OR DERIVATIVE, GENVISC 850®	1 mg	OTH	J7320
HYALURONAN OR DERIVATIVE, HYALGAN®	dose	OTH	J7321
HYALURONAN OR DERIVATIVE, HYMOVIS®	1 mg	OTH	J7322

Drug	Amount	Route	Code
HYALURONAN OR DERIVATIVE, MONOVISC®	dose	OTH	J7327
HYALURONAN OR DERIVATIVE, ORTHOVISC®	dose	OTH	J7324
HYALURONAN OR DERIVATIVE, SUPARTZ®	dose	OTH	J7321
HYALURONAN OR DERIVATIVE, SYNOJOYNT®	1 mg	OTH	J7331
HYALURONAN OR DERIVATIVE, SYNVISC®	1 mg	OTH	J7325
HYALURONAN OR DERIVATIVE, SYNVISC-ONE®	1 mg	OTH	J7325
HYALURONAN OR DERIVATIVE, TRILURON®	1 mg	OTH	J7332
HYALURONAN OR DERIVATIVE, TRIVISC®	1 mg	OTH	J7329
HYALURONAN OR DERIVATIVE, VISCO-3®	dose	OTH	J7321
HYALURONAN OR DERIVITIVE, GEL-SYN®	0.1 mg	VAR	J7328
HYALURONIDASE	up to 150 IU	IV, SC	J3470
HYALURONIDASE, OVINE, PRESERVATIVE FREE	up to 999 IU	SC	J3471
HYALURONIDASE, OVINE, PRESERVATIVE FREE	1000 IU	SC	J3472
HYALURONIDASE, RECOMBINANT	1 usp	VAR	J3473
HYCAMTIN®	0.25 mg	ORAL	J8705
HYCAMTIN®	0.1 mg	IV	J9351
HYDRALAZINE HCL	up to 20 mg	IV, IM	J0360
HYDROCORTISONE ACETATE	up to 25 mg	IV, IM, SC	J1700
HYDROCORTISONE SODIUM PHOSPHATE	up to 50 mg	IV, IM, SC	J1710
HYDROCORTISONE SODIUM SUCCINATE	up to 100 mg	IV, IM, SC	J1720
HYDROMORPHONE	0.1 mg	IM, SC	J1171
HYDROXOCOBALAMIN	25 mg	IV	J3424
HYDROXOCOBALAMIN	10 mcg	IM	J3425
HYDROXYPROGESTERONE CAPROATE, MAKENA®	10 mg	IM, SC	J1726
HYDROXYPROGESTERONE CAPROATE, NOT OTHERWISE SPECIFIED	10 mg	IV	J1729
HYDROXYZINE HCL	up to 25 mg	IM	J3410
HYLENEX®	1 usp	VAR	J3473
HYMOVIS®	1 mg	OTH	J7322
HYOSCYAMINE SULFATE	up to 0.25 mg	IV, IM, SC	J1980
HYPERRHO S/D FULL DOSE®	1 dose package, 300 mcg	IM	J2790
HYPERRHO S/D MINI DOSE®	50 mcg	IM	J2788
HYPERTET S/D®	up to 250 IU	IM	J1670
HYPERTONIC SALINE SOLUTION	1 ml	IV	J7131
HYQVIA®	100 mg	SC	J1575
IBALIZUMAB-UIYK	10 mg	IV	J1746
IBANDRONATE SODIUM	1 mg	IV	J1740
IBUPROFEN	100 mg	IV	J1741
IBUTILIDE FUMARATE	1 mg	IV	J1742
ICATIBANT	1 mg	SC	J1744
IDAMYCIN PFS®	5 mg	IV	J9211
IDARUBICIN HCL	5 mg	IV	J9211
IDELVION®	1 IU	IV	J7202
IDURSULFASE	1 mg	IV	J1743
IFEX®	1 g	IV	J9208
IFOSFAMIDE	1 g	IV	J9208
ILARIS®	1 mg	SC	J0638
ILOPROST	0.1 mcg	IV	J1749
ILUMYA®	1 mg	SC	J3245
ILUVIEN®	0.01 mg	OTH	J7313
IMDELLTRA™	1 mg	IV	J9026
IMETELSTAT	1 mg	IV	J0870
IMFINZI®	10 mg	IV	J9173
IMIGLUCERASE	10 IU	IV	J1786
IMIPENEM AND CILASTATIN	250 mg	IV, IM	J0743
IMIPENEM, CILASTATIN, RELEBACTAM	various	IV	J0742
IMITREX®	6 mg	SC	J3030
IMJUDO®	1 mg	IV	J9347
IMLYGIC®	1 million PFU	OTH	J9325
IMMPHENTIV®	20 mcg	IV	J2373
IMMUNE GLOBULIN (ALYGLO™)	500 mg	IV	J1552
IMMUNE GLOBULIN, ASCENIV™	500 mg	IV	J1554
IMMUNE GLOBULIN, BIVIGAM®	500 mg	IV	J1556
IMMUNE GLOBULIN, CUTAQUIG®	100 mg	SC	J1551
IMMUNE GLOBULIN, CUVITRU®	100 mg	SC	J1555
IMMUNE GLOBULIN, FLEBOGAMMA® /FLEBOGAMMA DIF®	500 mg	IV	J1572
IMMUNE GLOBULIN, GAMMAGARD LIQUID®	500 mg	IV	J1569
IMMUNE GLOBULIN, GAMMAPLEX®	500 mg	IV	J1557
IMMUNE GLOBULIN, GAMUNEX-C® /GAMMAKED®	500 mg	IV	J1561
IMMUNE GLOBULIN, HEPATITIS B, HEPAGAM B®	0.5 ml	IM	J1571
IMMUNE GLOBULIN, HEPATITIS B, HEPAGAM B®	0.5 ml	IM	J1573
IMMUNE GLOBULIN, HIZENTRA®	100 mg	SC	J1559
IMMUNE GLOBULIN, LYOPHILIZED	500 mg	IV	J1566
IMMUNE GLOBULIN, NON-LYOPHILIZED	500 mg	IV	J1599
IMMUNE GLOBULIN, NON-LYOPHILIZED, PANZYGA®	500 mg	IV	J1576
IMMUNE GLOBULIN, OCTAGAM®	500 mg	IV	J1568
IMMUNE GLOBULIN, PRIVIGEN®	500 mg	IV	J1459

Drug	Amount	Route	Code
IMMUNE GLOBULIN, RHOPHYLAC®	100 IU	IV, IM	J2791
IMMUNE GLOBULIN, VIVAGLOBIN®	100 mg	IV	J1562
IMMUNE GLOBULIN, XEMBIFY®	100 mg	SC	J1558
IMMUNE GLOBULIN/ HYALURONIDASE (HYQVIA®)	100 mg	SC	J1575
IMMUNOSUPPRESSIVE DRUG, NOT OTHERWISE CLASSIFIED	-	-	J7599
INCLISIRAN	1 mg	SC	J1306
INCOBOTULINUM TOXIN A	1 IU	IM	J0588
INCRELEX®	1 mg	SC	J2170
INEBILIZUMAB-CDON	1 mg	IV	J1823
INFED®	50 mg	IV	J1750
INFLIXIMAB, (EXCLUDES BIOSIMILAR)	10 mg	IV	J1745
INFLIXIMAB-DYYB (ZYMFENTRA™)	10 mg	SC	J1748
INFUGEM®	100 mg	IV	J9198
INFUMORPH®	10 mg	OTH	J2274
INJECTAFER®	1 mg	IV	J1439
INOTUZUMAB OZOGAMICIN	0.1 mg	IV	J9229
INSULIN	5 IU	SC	J1815
INSULIN (ADMINISTERED THROUGH DME)	50 IU	SC	J1817
INSULIN (FIASP®)	per 5 units	INJ	J1812
INSULIN (FIASP®) (ADMINISTERED THROUGH DME)	per 50 units	OTH	J1811
INSULIN (LYUMJEV®)	per 5 units	INJ	J1814
INSULIN (LYUMJEV®) (ADMINISTERED THROUGH DME)	per 50 units	OTH	J1813
INTERFERON ALFA-2A, RECOMBINANT	3 million IU	SC	J9213
INTERFERON ALFA-2B, RECOMBINANT	1 million IU	VAR	J9214
INTERFERON ALFA-N3 (HUMAN LEUKOCYTE DERIVED)	250,000 IU	IV	J9215
INTERFERON ALPHACON-1, RECOMBINANT	1 mcg	SC	J9212
INTERFERON BETA-1A	30 mcg	IM	J1826
INTERFERON BETA-1B	0.25 mg	SC	J1830
INTERFERON GAMMA-1B	3 million IU	SC	J9216
INTRON A®	1 million IU	VAR	J9214
INVANZ®	500 mg	IV, IM	J1335
INVEGA HAFYERA™	1 mg	IM	J2427
INVEGA SUSTENNA®	1 mg	IM	J2426
INVEGA TRINZA®	1 mg	IM	J2427
IPILIMUMAB	1 mg	IV	J9228
IPRATROPIUM BROMIDE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7645
IPRATROPIUM BROMIDE, UNIT DOSE FORM, NON-COMPOUNDED	1 mg	INH	J7644
IRESSA®	250 mg	ORAL	J8565
IRINOTECAN	20 mg	IV	J9206
IRINOTECAN LIPOSOME	1 mg	IV	J9205
IRON DEXTRAN	50 mg	IV	J1750
IRON SUCROSE	1 mg	IV	J1756
ISATUXIMAB-IRFC	10 mg	IV	J9227
ISAVUCONAZONIUM	1 mg	IV	J1833
ISOETHARINE HCL, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7647
ISOETHARINE HCL, CONCENTRATED FORM, NON-COMPOUNDED	1 mg	INH	J7648
ISOETHARINE HCL, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7650
ISOETHARINE HCL, UNIT DOSE FORM, NON-COMPOUNDED	1 mg	INH	J7649
ISOPROTERENOL HCL, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7657
ISOPROTERENOL HCL, CONCENTRATED FORM, NON-COMPOUNDED	1 mg	INH	J7658
ISOPROTERENOL HCL, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7660
ISOPROTERENOL HCL, UNIT DOSE FORM, NON-COMPOUNDED	1 mg	INH	J7659
ISTODAX®	0.1 mg	IV	J9319
ITRACONAZOLE	50 mg	IV	J1835
IXABEPILONE	1 mg	IV	J9207
IXEMPRA KIT®	1 mg	IV	J9207
IXINITY®	1 IU	IV	J7213
JELMYTO®	1 mg	OTH	J9281
JEMPERLI®	10 mg	IV	J9272
JESDUVROQ® (FOR ESRD)	1 mg	ORAL	J0889
JEVTANA KIT®	1 mg	IV	J9043
JIVI®	1 IU	IV	J7208
JYLAMVO®	2.5 mg	ORAL	J8611
KADCYLA®	1 mg	IV	J9354
KALBITOR®	1 mg	SC	J1290
KANUMA®	1 mg	IV	J2840
KCENTRA®	1 IU	IV	J7168
KENALOG®	10 mg	VAR	J3301
KEPIVANCE®	50 mcg	IV	J2425
KEPPRA®	10 mg	IV	J1953
KESIMPTA®	10 mg	SC	J9303
KETOROLAC TROMETHAMINE	15 mg	IV, IM	J1885
KEYTRUDA®	1 mg	IV	J9271
KHAPZORY®	0.5 mg	IV	J0642
KIMYRSA™	10 mg	IV	J2406
KINEVAC®	5 mcg	IV	J2805
KITABIS PAK®	300 mg	INH	J7682
KOATE®	1 IU	IV	J7190
KOGENATE FS®	1 IU	IV	J7192

Drug	Amount	Route	Code
KOVALTRY®	1 IU	IV	J7211
KRYSTEXXA®	1 mg	IV	J2507
KYLEENA®	19.5 mg	OTH	J7296
KYPROLIS®	1 mg	IV	J9047
LABETALOL HYDROCHLORIDE	5 mg	IV	J1920
LABETALOL HYDROCHLORIDE (MADE BY HIKMA)	5 mg	IV	J1921
LACTATED RINGERS	up to 1,000 cc	IV	J7120
LACTATED RINGERS WITH DEXTROSE 5%	up to 1,000 cc	IV	J7121
LAETRILE, AMYGDALIN, VITAMIN B17	dose	VAR	J3570
LAMZEDE®	1 mg	IV	J0217
LANADELUMAB-FLYO	1 mg	SC	J0593
LANOXIN®	up to 0.5 mg	IV, IM	J1160
LANREOTIDE	1 mg	SC	J1930
LANREOTIDE (MADE BY CIPLA)	1 mg	SC	J1932
LANTHANUM CARBONATE, (FOR ESRD ON DIALYSIS)	5 mg	ORAL	J0607
LANTHANUM CARBONATE, POWDER, NOT THERAPEUTICALLY EQUIVALENT TO J0607 (FOR ESRD ON DIALYSIS)	5 mg	ORAL	J0608
LARONIDASE	0.1 mg	IV	J1931
LECANEMAB-IRMB	1 mg	IV	J0174
LEFAMULIN	1 mg	IV	J0691
LEMTRADA®	1 mg	IV	J0202
LENACAPAVIR	1 mg	SC	J1961
LEPIRUDIN	50 mg	IV	J1945
LEQEMBI®	1 mg	IV	J0174
LEUCOVORIN CALCIUM	50 mg	IV, IM	J0640
LEUKINE®	50 mcg	IV	J2820
LEUPROLIDE ACETATE	1 mg	IM	J9218
LEUPROLIDE ACETATE, (FOR DEPOT SUSPENSION (FENSOLVI®)	0.25 mg	SC	J1951
LEUPROLIDE ACETATE, (FOR DEPOT SUSPENSION)	3.75 mg	IM	J1950
LEUPROLIDE ACETATE, (FOR DEPOT SUSPENSION)	7.5 mg	IM	J9217
LEUPROLIDE ACETATE, (FOR DEPOT SUSPENSION) (MADE BY CIPLA)	7.5 mg	IM	J1954
LEUPROLIDE ACETATE, IMPLANT	65 mg	OTH	J9219
LEUPROLIDE MESYLATE (CAMCEVI®)	1 mg	SC	J1952
LEVALBUTEROL, CONCENTRATED FORM, COMPOUNDED	0.5 mg	INH	J7607
LEVALBUTEROL, CONCENTRATED FORM, NON-COMPOUNDED	0.5 mg	INH	J7612
LEVALBUTEROL, UNIT DOSE, COMPOUNDED	0.5 mg	INH	J7615
LEVALBUTEROL, UNIT DOSE, NON-COMPOUNDED	0.5 mg	INH	J7614

Drug	Amount	Route	Code
LEVETIRACETAM	10 mg	IV	J1953
LEVOCARNITINE	1 g	IV	J1955
LEVOFLOXACIN	250 mg	IV	J1956
LEVOLEUCOVORIN (KHAPZORY®)	0.5 mg	IV	J0642
LEVOLEUCOVORIN, NOT OTHERWISE SPECIFIED	0.5 mg	IV	J0641
LEVONORGESTREL IMPLANT	each	OTH	J7306
LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, KYLEENA®	19.5 mg	OTH	J7296
LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, LILETTA®	52 mg	OTH	J7297
LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, MIRENA®	52 mg	OTH	J7298
LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, SKYLA®	13.5 mg	OTH	J7301
LEVORPHANOL TARTRATE	up to 2 mg	IV, SC	J1960
LEVOTHYROXINE SODIUM (MADE BY FRESENIUS KABI) NOT THERAPEUTICALLY EQUIVALENT TO J0650	10 mcg	IV, IM	J0651
LEVOTHYROXINE SODIUM (MADE BY HIKMA) NOT THERAPEUTICALLY EQUIVALENT TO J0650	10 mcg	IV, IM	J0652
LEVOTHYROXINE SODIUM, NOT OTHERWISE SPECIFIED	10 mcg	IV, IM	J0650
LEVSIN®	up to 0.25 mg	IV, IM, SC	J1980
LEVULAN KERASTICK®	unit dose (354 mg)	OTH	J7308
LIBTAYO®	1 mg	IV	J9119
LIDOCAINE HCL IN 5% DEXTROSE	1 mg	IV	J2002
LIDOCAINE HCL WITH EPINEPHRINE	1 mg	IV	J2004
LIDOCAINE HYDROCHLORIDE	1 mg	IV	J2003
LILETTA®	52 mg	OTH	J7297
LINCOCIN®	up to 300 mg	IV	J2010
LINCOMYCIN	up to 300 mg	IV	J2010
LINEZOLID	200 mg	IV	J2020
LINEZOLID (MADE BY HOSPIRA)	200 mg	IV	J2021
LIORESAL®	10 mg	IT	J0475
LIORESAL®	50 mcg	IT	J0476
LONCASTUXIMAB TESIRINE-LPYL	0.075 mg	IV	J9359
LORAZEPAM	2 mg	IV, IM	J2060
LOVENOX®	10 mg	SC	J1650
LOVOTIBEGLOGENE AUTOTEMCEL, PER TREATMENT	per treatment	IV	J3394
LOXAPINE (FOR INHALATION)	1 mg	OTH	J2062
LUCENTIS®	0.1 mg	OTH	J2778
LUMASIRAN	0.5 mg	SC	J0224
LUMIZYME®	10 mg	IV	J0221

Drug	Amount	Route	Code
LUMOXITI®	0.01 mg	IV	J9313
LUNSUMIO™	1 mg	IV	J9350
LUPRON DEPOT®	3.75 mg	IM	J1950
LUPRON DEPOT®	1 mg	IM	J9218
LURBINECTEDIN	0.1 mg	IV	J9223
LUSPATERCEPT-AAMT	0.25 mg	SC	J0896
LUTRATE DEPOT KIT®	7.5 mg	IM	J9217
LUXTURNA®	1 billion vector genomes	OTH	J3398
LYMPHOCYTE IMMUNE GLOBULIN, ANTI-THYMOCYTE GLOBULIN, EQUINE	250 mg	IV	J7504
LYMPHOCYTE IMMUNE GLOBULIN, ANTI-THYMOCYTE GLOBULIN, RABBIT	25 mg	IV	J7511
LYUMJEV®	per 5 units	INJ	J1814
LYUMJEV® (ADMINISTERED THROUGH DME)	per 50 units	OTH	J1813
MACI®	each	OTH	J7330
MAGNESIUM SULFATE	500 mg	IV, IM	J3475
MAKENA®	10 mg	IM, SC	J1726
MANNITOL	25% in 50 ml	IV	J2150
MANNITOL	5 mg	INH	J7665
MARGETUXIMAB-CMKB	5 mg	IV	J9353
MATGENZA®	5 mg	IV	J9353
MAXIPIME®	500 mg	IV	J0692
MECASERMIN	1 mg	SC	J2170
MECHLORETHAMINE HCL (NITROGEN MUSTARD), HN2	10 mg	IV	J9230
MEDROL®	4 mg	ORAL	J7509
MEDROXYPROGESTERONE ACETATE	1 mg	IM	J1050
MELOXICAM	1 mg	IV	J1738
MELPHALAN	2 mg	ORAL	J8600
MELPHALAN (EVOMELA®)	50 mg	IV	J9246
MELPHALAN (HEPZATO KIT™)	1 mg	OTH	J9248
MELPHALAN (MADE BY APOTEX)	1 mg	IV	J9249
MELPHALAN FLUFENAMIDE	1 mg	IV	J9247
MELPHALAN HCL	50 mg	IV	J9245
MEPERIDINE AND PROMETHAZINE HCL	up to 50 mg	IV, IM	J2180
MEPERIDINE HYDROCHLORIDE	100 mg	IV, IM, SC	J2175
MEPIVACAINE HCL	10 ml	VAR	J0670
MEPOLIZUMAB	1 mg	SC	J2182
MEPSEVII®	1 mg	IV	J3397
MEROPENEM	100 mg	IV	J2185
MEROPENEM (MADE BY B. BRAUN)	100 mg	IV	J2184
MEROPENEM (MADE BY WG CRITICAL CARE), NOT THERAPEUTICALLY EQUIVALENT TO J2185	100 mg	IV	J2183
MEROPENEM AND VABORBACTAM	10mg/10mg	IV	J2186
MERREM®	100 mg	IV	J2185
MESNA	200 mg	IV	J9209
MESNEX®	200 mg	IV	J9209
METAPROTERENOL SULFATE, CONCENTRATED FORM, COMPOUNDED	10 mg	INH	J7667
METAPROTERENOL SULFATE, CONCENTRATED FORM, NON-COMPOUNDED	10 mg	INH	J7668
METAPROTERENOL SULFATE, UNIT DOSE FORM, COMPOUNDED	10 mg	INH	J7670
METAPROTERENOL SULFATE, UNIT DOSE FORM, NON-COMPOUNDED	10 mg	INH	J7669
METARAMINOL BITARTRATE	10 mg	IV, IM, SC	J0380
METHACHOLINE CHLORIDE	1 mg	INH	J7674
METHADONE HCL	up to 10 mg	IM, SC	J1230
METHERGINE®	UP TO 0.2 mg	IV, IM	J2210
METHOCARBAMOL	up to 10 ml	IV, IM	J2800
METHOTREXATE	2.5 mg	ORAL	J8610
METHOTREXATE (JYLAMVO®)	2.5 mg	ORAL	J8611
METHOTREXATE (MADE BY ACCORD)	50 mg	IV, IM, IT, IA	J9255
METHOTREXATE (XATMEP®)	2.5 mg	ORAL	J8612
METHOTREXATE SODIUM	50 mg	IV, IM, IT, IA, SC	J9260
METHYL AMINOLEVULINATE, TOPICAL, 16.8%	1 g	OTH	J7309
METHYLDOPATE HCL	up to 250 mg	IV	J0210
METHYLERGONOVINE MALEATE	UP TO 0.2 mg	IV, IM	J2210
METHYLNALTREXONE	0.1 mg	SC	J2212
METHYLPREDNISOLONE ACETATE	1 mg	IA, IM	J1010
METHYLPREDNISOLONE SODIUM SUCCINATE	5 mg	OTH	J2919
METHYLPREDNISOLONE, ORAL	4 mg	ORAL	J7509
METOCLOPRAMIDE HCL	up to 10 mg	IV	J2765
METRONIDAZOLE	10 mg	IV	J1836
MIACALCIN®	up to 400 IU	IM, SC	J0630
MICAFUNGIN IN SODIUM (MADE BY BAXTER), NOT THERAPEUTICALLY EQUIVALENT TO J2248	1 mg	IV	J2246
MICAFUNGIN SODIUM	1 mg	IV	J2248

Drug	Amount	Route	Code
MICAFUNGIN SODIUM (MADE BY PAR PHARM)	1 mg	IV	J2247
MICRHOGAM®	50 mcg	IM	J2788
MIDAZOLAM IN 0.9% SODIUM CHLORIDE	1 mg	IV	J2251
MIDAZOLAM (SEIZALAM®)	1 mg	IM	J2253
MIDAZOLAM HCL	1 mg	IV, IM	J2250
MIDAZOLAM IN 0.8% SODIUM CHLORIDE, INTRAVENOUS, NOT THERAPEUTICALLY EQUIVALENT TO J2250	1 mg	IV	J2252
MIGLUSTAT	65 mg	ORAL	J1202
MILRINONE LACTATE	5 mg	IV	J2260
MINOCIN®	1 mg	IV	J2265
MINOCYCLINE HYDROCHLORIDE	1 mg	IV	J2265
MIRCERA® (FOR ESRD)	1 mcg	IV, SC	J0887
MIRCERA® (NON-ESRD USE)	1 mcg	IV, SC	J0888
MIRENA®	52 mg	OTH	J7298
MIRIKIZUMAB-MRKZ	1 mg	SC	J2267
MIRVETUXIMAB SORAVTANSINE-GYNX	1 mg	IV	J9063
MITIGO™	10 mg	OTH	J2274
MITOMYCIN	5 mg	IV	J9280
MITOMYCIN PYELOCALYCEAL	1 mg	OTH	J9281
MITOMYCIN, OPTHALMIC	0.2 mg	OTH	J7315
MITOSOL®	0.2 mg	OTH	J7315
MITOXANTRONE HCL	5 mg	IV	J9293
MOGAMULIZUMAB-KPKC	1 mg	IV	J9204
MOMETASONE FUROATE SINUS IMPLANT, (SINUVA™)	10 mcg	OTH	J7402
MONJUVI®	2 mg	IV	J9349
MONOFERRIC®	10 mg	IV	J1437
MONONINE®	1 IU	IV	J7193
MONOVISC®	dose	OTH	J7327
MORPHINE SULFATE	up to 10 mg	IV, IM, SC	J2270
MORPHINE SULFATE	10 mg	OTH	J2274
MORPHINE SULFATE (MADE BY FRESENIUS KABI)	up to 10 mg	IV, IM, SC	J2272
MOSUNETUZUMAB-AXGB	1 mg	IV	J9350
MOTIXAFORTIDE	0.25 mg	SC	J2277
MOXETUMOMAB PASUDOTOX-TDFK	0.01 mg	IV	J9313
MOXIFLOXACIN	100 mg	IV	J2280
MOXIFLOXACIN (MADE BY FRESENIUS KABI)	100 mg	IV	J2281
MOZOBIL®	1 mg	SC	J2562
MUROMONAB-CD3, PARENTERAL	5 mg	IV	J7505
MUSE®	each	OTH	J0275
MYCAMINE®	1 mg	IV	J2248
MYCOPHENOLATE MOFETIL	250 mg	ORAL	J7517
MYCOPHENOLATE MOFETIL	10 mg	IV	J7519
MYCOPHENOLATE MOFETIL (MYHIBBIN™)	100 mg	ORAL	J7514
MYCOPHENOLIC ACID, ORAL	180 mg	ORAL	J7518
MYHIBBIN™	100 mg	ORAL	J7514
MYLOTARG®	0.1 mg	IV	J9203
MYOBLOC®	100 IU	IM	J0587
MYOZYME®	10 mg	IV	J0220
NABILONE	1 mg	ORAL	J8650
NADOFARAGENE FIRADENOVEC-VNCG	per therapeutic dose	OTH	J9029
NAFCILLIN SODIUM	20 mg	IV, IM	J2290
NAGLAZYME®	1 mg	IV	J1458
NALBUPHINE HCL	10 mg	IV, IM, SC	J2300
NALOXONE HCL	1 mg	IV, IM, SC	J2310
NALOXONE HCL (ZIMHI™)	1 mg	IM	J2311
NALTREXONE (DEPOT FORM)	1 mg	IM	J2315
NANDROLONE DECANOATE	up to 50 mg	IM	J2320
NAROPIN®	1 mg	OTH	J2795
NASAL VACCINE INHALATION	dose	INH	J3530
NATALIZUMAB	1 mg	IV	J2323
NAXITAMAB-GQGK	1 mg	IV	J9348
NEBUPENT®	300 mg	INH	J2545
NECITUMUMAB	1 mg	IV	J9295
NELARABINE	50 mg	IV	J9261
NEMBUTAL SODIUM®	50 mg	IV, IM	J2515
NEORAL®	100 mg	ORAL	J7502
NEORAL®	25 mg	ORAL	J7515
NEOSTIGMINE METHYLSULFATE	up to 0.5 mg	IV, IM, SC	J2710
NESIRITIDE	0.1 mg	IV	J2325
NETUPITANT AND PALONOSETRON	300 mg	ORAL	J8655
NEULASTA®	0.5 mg	SC	J2506
NEUPOGEN®	1 mcg	IV, SC	J1442
NEXPLANON®	each	OTH	J7307
NEXTERONE®	30 mg	IV	J0283
NICARDIPINE	0.1 mg	IV	J2404
NIPENT®	10 mg	IV	J9268
NITHIODOTE®	1 dose	IV	J0211
NITROGLYCERIN	5 mg	IV	J2305
NIVOLUMAB	1 mg	IV	J9299
NIVOLUMAB AND RELATLIMAB-RMBW	3 mg/1 mg	IV	J9298
NOGAPENDEKIN ALFA INBAKICEPT-PMLN	1 mcg	OTH	J9028
NONCHEMOTHERAPEUTIC, NOT OTHERWISE SPECIFIED	-	ORAL	J8499
NOT OTHERWISE CLASSIFIED DRUG, FDA APPROVED PRESCRIPTION	-	-	J0799
NOT OTHERWISE CLASSIFIED DRUGS	-	INH	J7699

Drug	Amount	Route	Code
NOT OTHERWISE CLASSIFIED DRUGS, ADMINISTERED THROUGH DME	-	OTH	J7799
NOT OTHERWISE CLASSIFIED DRUGS, CHEMOTHERAPEUTIC	-	ORAL	J8999
NOT OTHERWISE CLASSIFIED DRUGS, IMMUNOSUPPRESSIVE	-	-	J7599
NOT OTHERWISE CLASSIFIED DRUGS, NONCHEMOTHERAPEUTIC	-	ORAL	J8499
NOVAREL®	1,000 IU	IM	J0725
NOVOEIGHT®	1 IU	IV	J7182
NOVOSEVEN RT®	1 mcg	IV	J7189
NUCALA®	1 mg	SC	J2182
NULOJIX®	1 mg	IV	J0485
NUSINERSEN	0.1 mg	OTH	J2326
NUWIQ®	1 IU	IV	J7209
NUZYRA®	1 mg	IV	J0121
OBINUTUZUMAB	10 mg	IV	J9301
OBIZUR®	1 IU	IV	J7188
OCRELIZUMAB	1 mg	IV	J2350
OCREVUS®	1 mg	IV	J2350
OCRIPLASMIN	0.125 mg	OTH	J7316
OCTAGAM®	500 mg	IV	J1568
OCTREOTIDE, DEPOT FORM	1 mg	IM	J2353
OCTREOTIDE, NON-DEPOT FORM	25 mcg	IV, SC	J2354
OFATUMUMAB	10 mg	IV	J9302
OLANZAPINE	1 mg	IM	J2358
OLANZAPINE	0.5 mg	IM	J2359
OLARATUMAB	10 mg	IV	J9285
OLIPUDASE ALFA-RPCP	1 mg	IV	J0218
OMACETAXINE MEPESUCCINATE	0.01 mg	SC	J9262
OMADACYCLINE	1 mg	IV	J0121
OMALIZUMAB	5 mg	SC	J2357
OMIDRIA®	1 ml	OTH	J1097
ONABOTULINUM TOXIN A	1 IU	IM	J0585
ONASEMNOGENE ABEPARVOVEC-XIOI	up to $5x10^{15}$ vector genomes	IV	J3399
ONCASPAR®	single dose vial	IV, IM	J9266
ONDANSETRON HCL	1 mg	IV	J2405
ONIVYDE®	1 mg	IV	J9205
ONPATTRO®	0.1 mg	IV	J0222
OPDIVO®	1 mg	IV	J9299
OPRELVEKIN	5 mg	SC	J2355
ORBACTIV®	10 mg	IV	J2407
ORENCIA®	10 mg	IV	J0129
ORITAVANCIN	10 mg	IV	J2407
ORITAVANCIN (KIMYRSA™)	10 mg	IV	J2406
ORPHENADRINE CITRATE	up to 60 mg	IV, IM	J2360
ORTHOVISC®	dose	OTH	J7324
OTIPRIO®	6 mg	OTH	J7342
OXACILLIN SODIUM	up to 250 mg	IV, IM	J2700
OXALIPLATIN	0.5 mg	IV	J9263
OXLUMO®	0.5 mg	SC	J0224
OXYMORPHONE HCL	up to 1 mg	IV, IM, SC	J2410
OXYTETRACYCLINE HCL	up to 50 mg	IM	J2460
OXYTOCIN	up to 10 IU	IV, IM	J2590
OZURDEX®	0.1 mg	OTH	J7312
PACLITAXEL	1 mg	IV	J9267
PACLITAXEL PROTEIN BOUND PARTICLES	1 mg	IV	J9264
PADCEV®	0.25 mg	IV	J9177
PALIFERMIN	50 mcg	IV	J2425
PALIPERIDONE PALMITATE, EXTENDED RELEASE	1 mg	IM	J2426
PALIPERIDONE PALMITATE, EXTENDED RELEASE (INVEGA HAFYERA™ OR INVEGA TRINZA®)	1 mg	IM	J2427
PALONOSETRON HCL	25 mcg	IV	J2469
PALONOSETRON HYDROCHLORIDE (POSFREA™)	25 mcg	IV	J2468
PAMIDRONATE DISODIUM	30 mg	IV	J2430
PANHEMATIN®	1 mg	IV	J1640
PANITUMUMAB	10 mg	IV	J9303
PANTOPRAZOLE (MADE BY HIKMA), NOT THERAPEUTICALLY EQUIVALENT TO J2470	40 mg	IV	J2471
PANTOPRAZOLE SODIUM	40 mg	IV	J2470
PANTOPRAZOLE SODIUM IN SODIUM CHLORIDE (MADE BY BAXTER)	40 mg	IV	J2472
PANZYGA®	500 mg	IV	J1576
PAPAVERINE HCL	up to 60 mg	IV, IM	J2440
PARICALCITOL	1 mcg	IV, IM	J2501
PARSABIV®	0.1 mg	IV	J0606
PASIREOTIDE, LONG ACTING	1 mg	IM	J2502
PATISIRAN	0.1 mg	IV	J0222
PEDMARK®	100 mg	IV	J0208
PEGADEMASE BOVINE	25 IU	IM	J2504
PEGAPTANIB SODIUM	0.3 mg	OTH	J2503
PEGASPARGASE	single dose vial	IV, IM	J9266
PEGCETACOPLAN (INTRAVITREAL)	1 mg	OTH	J2781
PEGFILGRASTIM, EXCLUDES BIOSIMILAR	0.5 mg	SC	J2506
PEGINESATIDE (FOR ESRD)	0.1 mg	IV, SC	J0890
PEGLOTICASE	1 mg	IV	J2507
PEGUNIGALSIDASE ALFA-IWXJ	1 mg	IV	J2508
PEMBROLIZUMAB	1 mg	IV	J9271

Drug	Amount	Route	Code
PEMETREXED (MADE BY ACCORD)	10 mg	IV	J9296
PEMETREXED (MADE BY AVYXA), NOT THERAPEUTICALLY EQUIVALENT TO J9305	10 mg	IV	J9292
PEMETREXED (MADE BY BLUEPOINT)	10 mg	IV	J9322
PEMETREXED (MADE BY HOSPIRA)	10 mg	IV	J9294
PEMETREXED (MADE BY SANDOZ)	10 mg	IV	J9297
PEMETREXED (MADE BY TEVA)	10 mg	IV	J9314
PEMETREXED (PEMFEXY®)	10 mg	IV	J9304
PEMETREXED (PEMRYDI RTU®)	10 mg	IV	J9324
PEMETREXED DITROMETHAMINE	10 mg	IV	J9323
PEMETREXED, NOT OTHERWISE SPECIFIED	10 mg	IV	J9305
PEMFEXY®	10 mg	IV	J9304
PEMRYDI RTU®	10 mg	IV	J9324
PENICILLIN G BENZATHINE	100,000 IU	IM	J0561
PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE	100,000 IU	IM	J0558
PENICILLIN G POTASSIUM	up to 600,000 IU	IV, IM	J2540
PENICILLIN G PROCAINE, AQUEOUS	up to 600,000 IU	IV, IM	J2510
PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, NON-COMPOUNDED	300 mg	INH	J2545
PENTAMIDINE, COMPOUNDED	300 mg	INH	J7676
PENTASTARCH, 10% SOLUTION	100 ml	IV	J2513
PENTAZOCINE	30 mg	IV, IM, SC	J3070
PENTOBARBITAL SODIUM	50 mg	IV, IM	J2515
PENTOSTATIN	10 mg	IV	J9268
PERAMIVIR	1 mg	IV	J2547
PERFOROMIST®	20 mcg	INH	J7606
PERJETA®	1 mg	IV	J9306
PERPHENAZINE	up to 5 mg	IV, IM	J3310
PERSERIS®	0.5 mg	SC	J2798
PERTUZUMAB	1 mg	IV	J9306
PERTUZUMAB, TRASTUZUMAB, AND HYALURONIDASE-ZZXF	10 mg	SC	J9316
PFIZERPEN®	up to 600,000 IU	IV, IM	J2540
PHENOBARBITAL SODIUM	up to 120 mg	IV, IM	J2560
PHENOBARBITAL SODIUM (SEZABY™)	1 mg	IV	J2561
PHENTOLAMINE MESYLATE	up to 5 mg	IV, IM	J2760
PHENYLEPHRINE AND KETOROLAC	1 ml	OTH	J1097
PHENYLEPHRINE HYDROCHLORIDE	20 mcg	IV	J2371
PHENYLEPHRINE HYDROCHLORIDE (BIORPHEN®)	20 mcg	IV	J2372
PHENYLEPHRINE HYDROCHLORIDE (IMMPHENTIV®)	20 mcg	IV	J2373
PHENYTOIN SODIUM	50 mg	IV, IM	J1165
PHESGO®	10 mg	SC	J9316
PHOTOFRIN®	75 mg	IV	J9600
PHYTONADIONE, VITAMIN K	1 mg	IV, IM, SC	J3430
PIPERACILLIN/TAZOBACTAM SODIUM	1.125 g	IV	J2543
PITOCIN®	up to 10 IU	IV, IM	J2590
PLASMINOGEN, HUMAN-TVMH	1 mg	IV	J2998
PLAZOMICIN	5 mg	IV	J0291
PLERIXAFOR	1 mg	SC	J2562
PLICAMYCIN	2,500 mcg	IV	J9270
POLATUZUMAB VEDOTIN-PIIQ	1 mg	IV	J9309
POLIVY®	1 mg	IV	J9309
POLOCAINE MPF®	10 ml	VAR	J0670
POLOCAINE®	10 ml	VAR	J0670
PORFIMER SODIUM	75 mg	IV	J9600
PORTRAZZA®	1 mg	IV	J9295
POSTREA™	25 mcg	IV	J2468
POTASSIUM CHLORIDE	2 mEq	IV	J3480
POTELIGEO®	1 mg	IV	J9204
POZELIMAB-BBFG	1 mg	IV, SC	J9376
PRALATREXATE	1 mg	IV	J9307
PRALIDOXIME CHLORIDE	up to 1 g	IV, IM, SC	J2730
PREDNISOLONE ACETATE	up to 1 ml	IM	J2650
PREDNISOLONE, ORAL	5 mg	ORAL	J7510
PREDNISONE, IMMEDIATE OR DELAYED RELEASE, ORAL	1 mg	ORAL	J7512
PREMARIN®	25 mg	IV, IM	J1410
PRIALT®	1 mcg	OTH	J2278
PRIMAXIN®	250 mg	IV, IM	J0743
PRIVIGEN®	500 mg	IV	J1459
PROCAINAMIDE HCL	up to 1 g	IV, IM	J2690
PROCHLORPERAZINE	up to 10 mg	IV, IM	J0780
PROCRIT®	1,000 IU	IV, SC	J0885
PROFILNINE SD®	1 IU	IV	J7194
PROGESTERONE	50 mg	IM	J2675
PROGRAF®	1 mg	ORAL	J7507
PROGRAF®	5 mg	IV	J7525
PROLASTIN-C®	10 mg	IV	J0256
PROLEUKIN®	single use vial	IV	J9015
PROLIA®	1 mg	SC	J0897
PROMAZINE HCL	up to 25 mg	IM	J2950
PROMETHAZINE HCL	up to 50 mg	IV, IM	J2550
PROPOFOL	10 mg	IV	J2704
PROPRANOLOL	up to 1 mg	IV	J1800
PROTAMINE SULFATE	10 mg	IV	J2720

Drug	Amount	Route	Code
PROTEIN C CONCENTRATE (HUMAN)	10 IU	IV	J2724
PROTHROMBIN COMPLEX CONCENTRATE (HUMAN), KCENTRA®	1 IU	IV	J7168
PROTHROMBIN COMPLEX CONCENTRATE, HUMAN-LANS, PER I.U. OF FACTOR IX ACTIVITY	per i.u.	IV	J7165
PROTIRELIN	250 mcg	IV	J2725
PROVOCHOLINE®	1 mg	INH	J7674
PULMICORT®	0.5 mg	INH	J7626
PULMOZYME®	1 mg	OTH	J7639
PYRIDOXINE HCL	100 mg	IV, IM	J3415
QALSODY®	1 mg	OTH	J1304
QUINUPRISTIN/DALFOPRISTIN	500 mg (150/350)	IV	J2770
QUTENZA®	per sq cm	OTH	J7336
QUZYTTIR®	0.5 mg	IV	J1201
RADICAVA®	1 mg	IV	J1301
RAMUCIRUMAB	5 mg	IV	J9308
RANIBIZUMAB	0.1 mg	OTH	J2778
RANIBIZUMAB (SUSVIMO™)	0.1 mg	OTH	J2779
RAPAMUNE®	1 mg	ORAL	J7520
RAPIVAB®	1 mg	IV	J2547
RASBURICASE	0.5 mg	IV	J2783
RAVULIZUMAB-CWVZ	10 mg	IV	J1303
REBIF®	30 mcg	IM	J1826
REBINYN®	1 IU	IV	J7203
REBLOZYL®	0.25 mg	SC	J0896
RECARBRIO®	various	IV	J0742
RECLAST®	1 mg	IV	J3489
REGADENOSON	0.1 mg	IV	J2785
RELISTOR®	0.1 mg	SC	J2212
REMICADE®	10 mg	IV	J1745
REMIMAZOLAM	1 mg	IV	J2249
REMODULIN®	1 mg	IV, SC	J3285
RENAGEL®	20 mg	ORAL	J0603
RENVELA®	20 mg	ORAL	J0601
RENVELA®	20 mg	ORAL	J0602
RESLIZUMAB	1 mg	IV	J2786
RETAVASE®	18.1 mg	IV	J2993
RETEPLASE	18.1 mg	IV	J2993
RETIFANLIMAB-DLWR	1 mg	IV	J9345
RETISERT®	0.01 mg	OTH	J7311
RETROVIR®	10 mg	IV	J3485
REVEFENACIN, INHALATION SOLUTION	1 mcg	INH	J7677
REZAFUNGIN	1 mg	IV	J0349
REZZAYO™	1 mg	IV	J0349
RHO(D) IMMUNE GLOBULIN, HUMAN, FULL DOSE	1 dose package, 300 mcg	IM	J2790
RHO(D) IMMUNE GLOBULIN, HUMAN, MINI DOSE	50 mcg	IM	J2788
RHO(D) IMMUNE GLOBULIN, HUMAN, RHOPHYLAC®	100 IU	IV, IM	J2791
RHO(D) IMMUNE GLOBULIN, HUMAN, SOLVENT DETERGENT	100 IU	IV, IM	J2792
RHOGAM®	1 dose package, 300 mcg	IM	J2790
RHOPHYLAC®	100 IU	IV, IM	J2791
RIASTAP®	1mg	IV	J7178
RIBOFLAVIN 5'-PHOSPHATE, OPHTHALMIC SOLUTION	up to 3ml	OTH	J2787
RILONACEPT	1 mg	SC	J2793
RIMABOTULINUM TOXIN B	100 IU	IM	J0587
RIMSO-50®	50%, 50 ml	OTH	J1212
RINGERS LACTATE INFUSION	up to 1,000 cc	IV	J7120
RISANKIZUMAB-RZAA	1 mg	IV, SC	J2327
RISPERDAL CONSTA®	0.5 mg	IM	J2794
RISPERIDONE (PERSERIS®)	0.5 mg	SC	J2798
RISPERIDONE (RISPERDAL CONSTA®)	0.5 mg	IM	J2794
RISPERIDONE (RYKINDO®)	0.5 mg	IM	J2801
RISPERIDONE (UZEDY™)	1 mg	SC	J2799
RITUXAN HYCELA®	10 mg	SC	J9311
RITUXAN®	10 mg	IV	J9312
RITUXIMAB	10 mg	IV	J9312
RITUXIMAB AND HYALURONIDASE	10 mg	SC	J9311
RIXUBIS®	1 IU	IV	J7200
ROBAXIN®	up to 10 ml	IV, IM	J2800
ROCTAVIAN™	2×10^{13} vector genomes	IV	J1412
ROLAPITANT	0.5 mg	IV	J2797
ROLAPITANT, ORAL	1 mg	ORAL	J8670
ROLVEDON®	0.1 mg	IV	J1449
ROMIDEPSIN, LYOPHILIZED	0.1 mg	IV	J9319
ROMIDEPSIN, NON-LYOPHILIZED	0.1 mg	IV	J9318
ROMIPLOSTIM	1 mcg	SC	J2802
ROMOSOZUMAB-AQQG	1 mg	SC	J3111
ROPIVACAINE HYDROCHLORIDE	1 mg	OTH	J2795
ROZANOLIXIZUMAB-NOLI	1 mg	IV	J9333
RUCONEST®	10 IU	IV	J0596
RYBREVANT®	2 mg	IV	J9061
RYKINDO®	0.5 mg	IM	J2801
RYLAZE™	0.1 mg	IM	J9021
RYSTIGGO®	1 mg	IV	J9333
RYTELO™	1 mg	IV	J0870
SACITUZUMAB GOVITECAN-HZIY	2.5 mg	IV	J9317
SALINE SOLUTION, HYPERTONIC	1 ml	IV	J7131
SALINE SOLUTION, NORMAL	infusion, 1,000 cc	IV	J7030

Drug	Amount	Route	Code
SALINE SOLUTION, NORMAL	infusion, 250 cc	IV	J7050
SALINE SOLUTION, NORMAL DEXTROSE 5%	500 ml = 1 unit	IV	J7042
SALINE SOLUTION, STERILE	500 ml = 1 unit	IV	J7040
SANDIMMUNE®	100 mg	ORAL	J7502
SANDIMMUNE®	25 mg	ORAL	J7515
SANDIMMUNE®	250 mg	IV	J7516
SANDOSTATIN LAR DEPOT®	1 mg	IM	J2353
SANDOSTATIN®	25 mcg	IV, SC	J2354
SARCLISA®	10 mg	IV	J9227
SARGRAMOSTIM (GM-CSF)	50 mcg	IV	J2820
SCENESSE®	1 mg	OTH	J7352
SEBELIPASE ALFA	1 mg	IV	J2840
SECRETIN, SYNTHETIC, HUMAN	1 mcg	IV	J2850
SECUKINUMAB	1 mg	IV	J3247
SEGESTERONE ACETATE AND ETHINYL ESTRADIOL; YEARLY VAGINAL SYSTEM	each	OTH	J7294
SEIZALAM®	1 mg	IM	J2253
SEVELAMER CARBONATE (RENVELA® OR THERAPEUTICALLY EQUIVALENT), (FOR ESRD ON DIALYSIS)	20 mg	ORAL	J0601
SEVELAMER CARBONATE (RENVELA® OR THERAPEUTICALLY EQUIVALENT), POWDER, (FOR ESRD ON DIALYSIS)	20 mg	ORAL	J0602
SEVELAMER HYDROCHLORIDE (RENAGEL® OR THERAPEUTICALLY EQUIVALENT), (FOR ESRD ON DIALYSIS)	20 mg	ORAL	J0603
SEVENFACT®	1 IU	IV	J7212
SEZABY™	1 mg	IV	J2561
SIGNIFOR LAR®	1 mg	IM	J2502
SILTUXIMAB	10 mg	IV	J2860
SIMPONI ARIA®	1 mg	IV	J1602
SIMULECT®	20 mg	IV	J0480
SINCALIDE	5 mcg	IV	J2805
SINUVA™	10 mcg	OTH	J7402
SIROLIMUS	1 mg	ORAL	J7520
SIROLIMUS PROTEIN-BOUND PARTICLES	1 mg	IV	J9331
SIVEXTRO®	1 mg	IV	J3090
SKYLA®	13.5 mg	OTH	J7301
SODIUM FERRIC GLUCONATE COMPLEX IN SUCROSE®	12.5 mg	IV	J2916
SODIUM NITRITE AND SODIUM THIOSULFATE (NITHIODOTE®)	3 mg/125 mg	IV	J0211
SODIUM THIOSULFATE (MADE BY HOPE PHARMACEUTICALS)	100 mg	IV	J0209
SODIUM THIOSULFATE (PEDMARK®)	100 mg	IV	J0208
SOLIRIS®	10 mg	IV	J1300
SOLU-CORTEF®	up to 100 mg	IV, IM, SC	J1720
SOMATREM	1 mg	SC	J2940
SOMATROPIN	1 mg	SC	J2941
SOMATULINE DEPOT®	1 mg	SC	J1930
SPECTINOMYCIN HCL	up to 2 g	IM	J3320
SPESOLIMAB-SBZO	1 mg	IV	J1747
SPEVIGO®	1 mg	IV	J1747
SPINRAZA®	0.1 mg	OTH	J2326
STELARA® IV	1 mg	IV	J3358
STELARA® SUBCUTANEOUS	1 mg	SC	J3357
STREPTOKINASE	250,000 IU	IV	J2995
STREPTOMYCIN	up to 1 g	IM	J3000
STREPTOZOCIN	1 g	IV	J9320
SUBLIMAZE®	0.1 mg	IV, IM	J3010
SUCCINYLCHOLINE CHLORIDE	up to 20 mg	IV, IM	J0330
SUCROFERRIC OXYHYDROXIDE, (FOR ESRD ON DIALYSIS)	5 mg	ORAL	J0605
SUMATRIPTAN SUCCINATE	6 mg	SC	J3030
SUNLENCA®	1 mg	SC	J1961
SUPARTZ®	dose	OTH	J7321
SUPPRELIN LA®	10 mcg	OTH	J1675
SUPPRELIN LA®	50 mg	OTH	J9226
SUSTOL®	0.1 mg	IV	J1627
SUSVIMO™	0.1 mg	OTH	J2779
SUTIMLIMAB-JOME	10 mg	IV	J1302
SYLVANT®	10 mg	IV	J2860
SYNERCID®	500 mg	IV	J2770
SYNOJOYNT®	1 mg	OTH	J7331
SYNRIBO®	0.01 mg	SC	J9262
SYNVISC®	1 mg	OTH	J7325
SYNVISC-ONE®	1 mg	OTH	J7325
TACROLIMUS, ORAL, EXTENDED RELEASE, ASTAGRAF XL®	0.1 mg	ORAL	J7508
TACROLIMUS, ORAL, EXTENDED RELEASE, ENVARSUS XR®	0.25 mg	ORAL	J7503
TACROLIMUS, ORAL, IMMEDIATE RELEASE	1 mg	ORAL	J7507
TACROLIMUS, PARENTERAL	5 mg	IV	J7525
TAFASITAMAB-CXIX	2 mg	IV	J9349
TAGRAXOFUSP-ERZS	10 mcg	IV	J9269
TAKHZYRO®	1 mg	SC	J0593
TALIGLUCERACE ALFA	10 IU	IV	J3060
TALIMOGENE LAHERPAREPVEC	1 million PFU	OTH	J9325
TALQUETAMAB-TGVS	0.25 mg	SC	J3055
TARLATAMAB-DLLE	1 mg	IV	J9026
TAUROLIDINE AND HEPARIN SODIUM (CENTRAL VENOUS CATHETER LOCK FOR ADULT PATIENTS RECEIVING CHRONIC HEMODIALYSIS)	1.35 mg and 100 units	OTH	J0911
TAXOTERE®	1 mg	IV	J9171
TAZICEF®	500 mg	IV, IM	J0713

Drug	Amount	Route	Code
TBO-FILGRASTIM	1 mcg	SC	J1447
TEBENTAFUSP-TEBN	1 microgram	IV	J9274
TECENTRIQ™	10 mg	IV	J9022
TECLISTAMAB-CQYV	0.5 mg	SC	J9380
TECVAYLI®	0.5 mg	SC	J9380
TEDIZOLID PHOSPHATE	1 mg	IV	J3090
TEFLARO®	10 mg	IV	J0712
TELAVANCIN	10 mg	IV	J3095
TEMODAR®	5 mg	ORAL	J8700
TEMODAR®	1 mg	IV	J9328
TEMOZOLOMIDE	5 mg	ORAL	J8700
TEMOZOLOMIDE	1 mg	IV	J9328
TEMSIROLIMUS	1 mg	IV	J9330
TENECTEPLASE	1 mg	IV	J3101
TEPEZZA®	10 mg	IV	J3241
TEPLIZUMAB-MZWV	5 mcg	IV	J9381
TEPROTUMUMAB-TRBW	10 mg	IV	J3241
TERBUTALINE SULFATE	up to 1 mg	IV, SC	J3105
TERBUTALINE SULFATE, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7680
TERBUTALINE SULFATE, UNIT DOSE FORM, COMPOUNDED	1 mg	INH	J7681
TERIPARATIDE	10 mcg	SC	J3110
TESTOSTERONE CYPIONATE	1 mg	IM	J1071
TESTOSTERONE ENANTHATE	1 mg	IM	J3121
TESTOSTERONE UNDECANOATE	1 mg	IM	J3145
TETANUS IMMUNE GLOBULIN, HUMAN	up to 250 IU	IM	J1670
TETRACYCLINE	up to 250 mg	IV, IM	J0120
TEZEPELUMAB-EKKO	1 mg	SC	J2356
THEOPHYLLINE	40 mg	IV	J2810
THIAMINE HCL	100 mg	IV, IM	J3411
THIETHYLPERAZINE MALEATE	up to 10 mg	IV, IM	J3280
THIOTEPA	15 mg	IV	J9340
THROMBATE III®	1 IU	IV	J7197
THYMOGLOBULIN®	25 mg	IV	J7511
THYROGEN®	0.9 mg	IM, SC	J3240
THYROTROPIN ALFA	0.9 mg	IM, SC	J3240
TICE BCG®	1 mg	OTH	J9030
TIGAN®	up to 200 mg	IM	J3250
TIGECYCLINE	1 mg	IV	J3243
TIGECYCLINE (MADE BY ACCORD)	1 mg	IV	J3244
TILDRAKIZUMAB-ASMN	1 mg	SC	J3245
TINZAPARIN SODIUM	1,000 IU	SC	J1655
TIROFIBAN HCL	0.25 mg	IV, IM	J3246
TISLELIZUMAB-JSGR	1mg	IV	J9329
TISOTUMAB VEDOTIN-TFTV	1 mg	IV	J9273
TNKASE®	1 mg	IV	J3101
TOBI®	300 mg	INH	J7682

Drug	Amount	Route	Code
TOBRAMYCIN SULFATE	up to 80 mg	IV, IM	J3260
TOBRAMYCIN, UNIT DOSE, COMPOUNDED	300 mg	INH	J7685
TOBRAMYCIN, UNIT DOSE, NON-COMPOUNDED	300 mg	INH	J7682
TOCILIZUMAB	1 mg	IV	J3262
TOFERSEN	1 mg	OTH	J1304
TOLAZOLINE HCL	up to 25 mg	IV	J2670
TOPOTECAN	0.25 mg	ORAL	J8705
TOPOTECAN	0.1 mg	IV	J9351
TORIPALIMAB-TPZI	1 mg	IV	J3263
TORISEL®	1 mg	IV	J9330
TORSEMIDE	10 mg/ml	IV	J3265
TRABECTEDIN	0.1 mg	IV	J9352
TRASTUZUMAB AND HYALURONIDASE-OYSK	10 mg	SC	J9356
TRASTUZUMAB, EXCLUDES BIOSIMILAR	10 mg	IV	J9355
TRAVOPROST, INTRACAMERAL IMPLANT	1 mcg	OTH	J7355
TRELSTAR DEPOT®	3.75 mg	IM	J3315
TREMELIMUMAB-ACTL	1 mg	IV	J9347
TREMFYA®	1 mg	SC	J1628
TREPROSTINIL	1 mg	IV, SC	J3285
TREPROSTNIL, UNIT DOSE, COMPOUND	1.74 mg	INH	J7686
TRETTEN®	1 IU	IV	J7181
TREXALL®	2.5 mg	ORAL	J8610
TRIAMCINOLONE ACETONIDE (XIPERE®)	1 mg	OTH	J3299
TRIAMCINOLONE ACETONIDE XR	1 mg	VAR	J3304
TRIAMCINOLONE ACETONIDE, NOT OTHERWISE SPECIFIED	10 mg	VAR	J3301
TRIAMCINOLONE ACETONIDE, PRESERVATIVE FREE	1 mg	VAR	J3300
TRIAMCINOLONE DIACETATE	5 mg	IM	J3302
TRIAMCINOLONE HEXACETONIDE	5 mg	IV	J3303
TRIAMCINOLONE, CONCENTRATED FORM, COMPOUNDED	1 mg	INH	J7683
TRIAMCINOLONE, UNIT DOSE, COMPOUNDED	1 mg	INH	J7684
TRIFERIC AVNU®	0.1 mg of iron	IV	J1445
TRIFERIC®	0.1 mg of iron	IV	J1443
TRIFLUPROMAZINE HCL	up to 20 mg	IV, IM	J3400
TRILACICLIB	1 mg	IV	J1448
TRILURON®	1 mg	OTH	J7332
TRIMETHOBENZAMIDE HCL	up to 200 mg	IM	J3250
TRIMETREXATE GLUCURONATE	25 mg	IV	J3305
TRIPTODUR®	3.75 mg	IM	J3316
TRIPTORELIN PAMOATE	3.75 mg	IM	J3315
TRIPTORELIN, EXTENDED-RELEASE	3.75 mg	IM	J3316

Drug	Amount	Route	Code
TRISENOX®	1 mg	IV	J9017
TRIVISC®	1 mg	OTH	J7329
TRODELVY®	2.5 mg	IV	J9317
TROGARZO®	10 mg	IV	J1746
TRUVADA®	various	ORAL	J0750
TYSABRI®	1 mg	IV	J2323
TYVASO®	1.74 mg	INH	J7686
TZIELD®	5 mcg	IV	J9381
UBLITUXIMAB-XIIY	1 mg	IV	J2329
ULTOMIRIS®	10 mg	IV	J1303
UNASYN®	1.5 g	IV, IM	J0295
UNCLASSIFIED BIOLOGICS	dose	VAR	J3590
UNCLASSIFIED DRUG OR BIOLOGICAL USED FOR ESRD ON DIALYSIS	dose	IV	J3591
UNCLASSIFIED DRUGS	-	-	J3490
UNSPECIFIED DRUG ADMINISTERED THROUGH A METERED DOSE INHALER	dose	INH	J3535
UNSPECIFIED VACCINE, NASAL INHALATION	dose	INH	J3530
UPLIZNA®	1 mg	IV	J1823
UREA	up to 40 g	IV	J3350
UROFOLLITROPIN	75 IU	SC	J3355
UROKINASE	5,000 IU vial	IV	J3364
UROKINASE	250,000 IU vial	IV	J3365
USTEKINUMAB IV	1 mg	IV	J3358
USTEKINUMAB SUBCUTANEOUS	1 mg	SC	J3357
UZEDY™	1 mg	SC	J2799
VABOMERE®	10mg/10mg	IV	J2186
VACCINE, NASAL INHALATION	dose	INH	J3530
VADADUSTAT, (FOR ESRD ON DIALYSIS)	1 mg	ORAL	J0901
VALOCTOCOGENE ROXAPARVOVEC-RVOX	2×10^{13} vector genomes	IV	J1412
VALRUBICIN, INTRAVESICAL	200 mg	OTH	J9357
VALSTAR®	200 mg	OTH	J9357
VANCOMYCIN HCL	500 mg	IV, IM	J3370
VANCOMYCIN HCL (MADE BY MYLAN)	500 mg	IV, IM	J3371
VANCOMYCIN HCL (MADE BY XELLIA)	500 mg	IV, IM	J3372
VANTAS®	50 mg	OTH	J9225
VARUBI®	1 mg	ORAL	J8670
VASOPRESSIN	1 unit	IV	J2598
VASOPRESSIN (MADE BY AMERICAN REGENT)	1 unit	IV	J2599
VASOPRESSIN (MADE BY BAXTER)	1 unit	IV, IM, SC	J2601
VECTIBIX®	10 mg	IV	J9303
VEDOLIZUMAB	1 mg	IV	J3380
VELAGLUCERASE ALFA	100 IU	IV	J3385
VELMANASE ALFA-TYCV	1 mg	IV	J0217
VENOFER®	1 mg	IV	J1756
VERTEPORFIN	0.1 mg	IV	J3396
VESTRONIDASE ALFA-VJBK	1 mg	IV	J3397
VFEND®	10 mg	IV	J3465
VIBATIV®	10 mg	IV	J3095
VIDAZA®	1 mg	IV, SC	J9025
VILTEPSO®	10 mg	IV	J1427
VILTOLARSEN	10 mg	IV	J1427
VIMIZIM®	1 mg	IV	J1322
VINBLASTINE SULFATE	1 mg	IV	J9360
VINCRISTINE SULFATE	1 mg	IV	J9370
VINORELBINE TARTRATE	10 mg	IV	J9390
VISCO-3®	dose	OTH	J7321
VISUDYNE®	0.1 mg	IV	J3396
VITAMIN B1	100 mg	IV, IM	J3411
VITAMIN B-12, CYANOCOBALAMIN	up to 1,000 mcg	IM, SC	J3420
VITAMIN B17	dose	VAR	J3570
VITAMIN K, PHYTONADIONE	1 mg	IV, IM, SC	J3430
VITRASE®	up to 999 IU	SC	J3471
VITRASE®	1,000 IU	SC	J3472
VIVAGLOBIN®	100 mg	IV	J1562
VIVIMUSTA®	1 mg	IV	J9056
VIVITROL®	1 mg	IM	J2315
VON WILLEBRAND FACTOR (RECOMBINANT), VONVENDI®	1 IU	IV	J7179
VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE®	1 IU	IV	J7183
VON WILLEBRAND FACTOR COMPLEX, HUMATE-P®	1 IU	IV	J7187
VONVENDI®	1 IU	IV	J7179
VORETIGENE NEPARVOVEC-RZYL	1 billion vector genomes	OTH	J3398
VORICONAZOLE	10 mg	IV	J3465
VPRIV®	100 IU	IV	J3385
VUTRISIRAN	1 mg	SC	J0225
VYEPTI®	1 mg	IV	J3032
VYJUVEK™	5×10^9 pfu/ml vector genomes, per 0.1 ml	Topical	J3401
VYONDYS 53®	10 mg	IV	J1429
VYXEOS®	1 mg/2.27 mg	IV	J9153
WILATE®	1 IU	IV	J7183
XATMEP®	2.5 mg	ORAL	J8612
XEMBIFY®	100 mg	SC	J1558
XENLETA®	1 mg	IV	J0691
XENPOZYME®	1 mg	IV	J0218
XEOMIN®	1 IU	IM	J0588
XERAVA®	1 mg	IV	J0122
XGEVA®	1 mg	SC	J0897

Drug	Amount	Route	Code
XIAFLEX®	0.01 mg	OTH	J0775
XIPERE®	1 mg	OTH	J3299
XOLAIR®	5 mg	SC	J2357
XOPENEX®	0.5 mg	INH	J7612
XOPENEX®	0.5 mg	INH	J7614
XYNTHA®	1 IU	IV	J7185
YERVOY®	1 mg	IV	J9228
YONDELIS®	0.1 mg	IV	J9352
YUPELRI®	1 mcg	INH	J7677
YUTIQ®	0.01 mg	OTH	J7314
ZALTRAP®	1 mg	IV	J9400
ZANOSAR®	1 g	IV	J9320
ZEMAIRA®	10 mg	IV	J0256
ZEMDRI®	5 mg	IV	J0291
ZEMPLAR®	1 mcg	IV, IM	J2501
ZEPZELCA®	0.1 mg	IV	J9223
ZERBAXA®	50 mg/25 mg	IV	J0695
ZICONOTIDE	1 mcg	OTH	J2278
ZIDOVUDINE	10 mg	IV	J3485
ZILRETTA®	1 mg	VAR	J3304
ZIMHI™	1 mg	IM	J2311
ZINACEF®	750 mg	IV, IM	J0697
ZINPLAVA®	10 mg	IV	J0565
ZIPRASIDONE MESYLATE	10 mg	IM	J3486
ZITHROMAX®	500 mg	IV	J0456
ZIV-AFLIBERCEPT	1 mg	IV	J9400
ZOFRAN®	1 mg	IV	J2405
ZOLADEX®	3.6 mg	OTH	J9202
ZOLEDRONIC ACID	1 mg	IV	J3489
ZOLGENSMA®	up to 5 x1015 vector genomes	IV	J3399
ZORTRESS®	0.25 mg	ORAL	J7527
ZULRESSO®	1 mg	IV	J1632
ZYMFENTRA™	10 mg	SC	J1748
ZYNYZ™	1 mg	IV	J9345
ZYPREXA®	1 mg	IM	J2358
ZYVOX®	200 mg	IV	J2020

Appendix B
HCPCS Level II Modifiers, Lay Descriptions, and Tips

Mod	Modifier Description, Definition, Explanation, and Tips
A1	**Dressing for one wound** **Definition:** Append modifier A1 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of a single wound. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A1 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of one wound. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with Healthcare Common Procedure Coding System, or HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the surgical dressing. Incorrect use may lead to denial or underpayment.
A2	**Dressing for two wounds** **Definition:** Append modifier A2 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of two wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A2 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of two wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A3	**Dressing for three wounds** **Definition:** Append modifier A3 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of three wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A3 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of three wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A4	**Dressing for four wounds** **Definition:** Append modifier A4 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of four wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A4 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of four wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.

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Mod	Modifier Description, Definition, Explanation, and Tips
A5	**Dressing for five wounds** **Definition:** Append modifier A5 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of five wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A5 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of five wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A6	**Dressing for six wounds** **Definition:** Append modifier A6 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of six wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A6 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of six wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A7	**Dressing for seven wounds** **Definition:** Append modifier A7 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of seven wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A7 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of seven wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
A8	**Dressing for eight wounds** **Definition:** Append modifier A8 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of eight wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A8 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of eight wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.

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Mod	Modifier Description, Definition, Explanation, and Tips
A9	**Dressing for nine or more wounds** **Definition:** Append modifier A9 to identify a surgical dressing that a provider or a surgical supplier uses for dressing of nine or more wounds. **Explanation:** This modifier indicates that a particular surgical supply that the provider uses is a dressing on a wound. It also indicates the number of wounds on which the provider is using the dressing, or the number of wounds for which a durable medical equipment supplier is providing a supply. Use A9 with the appropriate HCPCS code when the provider uses a surgical supply for dressing of nine or more wounds. The modifier number corresponds to the number of wounds a surgical dressing is applied to, meaning A1 is for one wound, A2 is for two wounds, A3 for three wounds and so on. The modifier a provider uses corresponds to the number of wounds on which the provider is using the dressing, not the total number of wounds that the provider treats. **Tips:** It is important to use modifier A1 to A9 appropriately with HCPCS codes according to the number of surgical or debrided wounds for which the supplier is providing the dressing. Incorrect use may lead to denial or underpayment.
AA	**Anesthesia services performed personally by anesthesiologist** **Definition:** Append this modifier to anesthesia service codes when the provider personally performs the entire anesthesia service. **Explanation:** This modifier documents the service of the provider who personally provides the anesthesia during the entire surgical procedure. This modifier is also applicable when the provider is continuously supervising a student anesthetist during the procedure or when the procedure involves the provider with one resident. To report modifier AA, the provider continuously monitors a single case. The provider must remain physically present in the operating room during the entire procedure when billing the personally performed modifier AA. **Tips:** If the provider does not continuously monitor the single case, use another appropriate modifier such as AD, Medical supervision by a physician: more than four concurrent anesthesia procedures.
AB	**Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary** **Definition:** Append modifier AB to the code for a nonacute hearing assessment furnished by an audiologist without an order. **Explanation:** Append this modifier to the code for an audiology service that the audiologist provides personally without an order from a treating physician or nonphysician practitioner (NPP). The service should be a nonacute hearing assessment not related to disequilibrium (imbalance) or hearing aid services. The patient may have the service with this modifier appended once per 12 months.
AD	**Medical supervision by a physician: more than four concurrent anesthesia procedures** **Definition:** An anesthesiologist provides medical supervision for more than four procedures that overlap each other. **Explanation:** When a physician performs medical supervision of more than four concurrent procedures with anesthesia services by others, such as CRNAs, the physician appends modifier AD. Concurrent means that there is some degree of overlap in the procedures. Depending on payer rules, one minute of overlap may be enough for procedures to be considered concurrent. **Tips:** Check payer rules regarding use of modifier AD. The payer may recognize an additional time unit if the physician can document she was present at induction for general anesthesia.
AE	**Registered dietician** **Definition:** Append this modifier to indicate the services of a nutrition professional. **Explanation:** This modifier indicates the services of a nutrition professional or a registered dietician on claims with medical nutrition therapy codes such as 97802 to 97804, and G0270 to G0271. This code may also be applicable to Diabetes outpatient self management training services, or DSMT, reportable under G0108 individual, per 30 minutes and G0109, group session, 2 or more, per 30 minutes. **Tips:** Use this modifier to represent the professional services of a nutrition professional or a registered dietician in a critical access hospital, or CAH. An all inclusive rate payment methodology applies in the case of a CAH.
AF	**Specialty physician** **Definition:** Append this modifier to indicate the services of a specialty physician in a physician scarcity area. **Explanation:** Modifier AF is a Medicare use only modifier that represents the services of a specialty physician in a physician scarcity area, or a geographic area with a shortage of primary care doctors or specialists available to the Medicare population in that area. Use of this modifier provides for a quarterly bonus payment along with claim payment. Behavioral Medicine, Oncology, Endocrinology, Neurology, Neurosurgery, and Orthopedics, are some examples of specialty physicians. **Tips:** Use this modifier to represent professional services of a specialty physician in a physician scarcity area in a critical access hospital.

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Mod	Modifier Description, Definition, Explanation, and Tips
AG	**Primary physician** **Definition:** Append this modifier to indicate the services of a primary care physician in a physician scarcity area. **Explanation:** Modifier AG is a Medicare use only modifier that represents the services of a primary care physician in a physician scarcity area, or a geographic area with a shortage of primary care doctors or specialists available to the Medicare population in that area. Use of this modifier provides for a quarterly bonus payment along with claim payment. A primary care physician is typically defined as a general practitioner, family practice practitioner, general internist, pediatrician, obstetrician, or gynecologist. **Tips:** Use this modifier to represent professional services of a primary physician in a physician scarcity area in a critical access hospital.
AH	**Clinical psychologist** **Definition:** Append this modifier to indicate the services of a clinical psychologist. **Explanation:** This modifier indicates the services the provider is reporting are for a qualified clinical psychologist for the psychiatric therapeutic procedures that he performs for a patient in a facility. The modifier indicates that a clinical psychologist, who qualifies as per Medicare guidelines to provide these services, is performing the service the facility is reporting under the CPT® code for the procedure. **Tips:** When the facility uses this modifier with any CPT® code, it lets the payer know that a qualified clinical psychologist handled the services and reimbursement can be made as per Medicare payment guidelines. If you fail to append the right modifier to the CPT® code, it may lead to incorrect payments and fraudulent claims.
AI	**Principal physician of record** **Definition:** Append this modifier to the initial hospital and nursing home visit codes to show that the provider is responsible for the overall care of the patient. **Explanation:** This modifier indicates the service by the admitting or attending provider who oversees the patient's care, as distinct from other providers who may furnish specialty care. The principal provider of record shall append modifier AI to the initial visit code. The primary purpose of this modifier is to identify the principal provider of record on the initial hospital and nursing home visit codes. **Tips:** Remember that modifier AI is for inpatient use only, not for outpatient evaluation and management, or E/M, codes. Modifier AI is informational only and does not impact the payment.
AJ	**Clinical social worker** **Definition:** Append this modifier to indicate the services of a clinical social worker. **Explanation:** This modifier indicates the services of a qualified clinical social worker for therapeutic procedures that he performs in the facility. The modifier indicates that a clinical social worker, who qualifies as per Medicare guidelines to provide these services, is performing the service the facility is reporting under the CPT® code for the procedure. **Tips:** When the facility uses this modifier with any CPT® code, it lets the payer know that a qualified clinical social worker handled the services and reimbursement can be made as per CMS payment guidelines. If you fail to append the right modifier to the CPT® code, it may lead to incorrect payments and fraudulent claims.
AK	**Non participating physician** **Definition:** Append this modifier to indicate the services of a non participating physician. **Explanation:** This modifier indicates the services of a non participating provider who chooses not to participate in the Medicare fee schedule reimbursement, meaning he does not accept the Medicare approved amount as full payment for covered service. Medicare does not reimburse non participating physicians directly. Instead Medicare reimburses the patient for the allowable costs. The provider has to arrange for payment directly from the patient. **Tips:** Use this modifier to represent the services of a non participating physician in a critical access hospital.
AM	**Physician, team member service** **Definition:** Append this modifier to indicate the services of a member of a provider's team, usually a physician assistant who is part of the provider's team. **Explanation:** Append modifier AM if a physician assistant or other team member of the provider's team renders service. Usually, the supervising provider bills these services and the provider uses this modifier to indicate that his team member performs the service. **Tips:** This modifier is informational only and should not impact reimbursement. It just identifies that during the procedure the provider is not rendering the actual service but he is supervising the service.

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Mod	Modifier Description, Definition, Explanation, and Tips
AO	**Alternate payment method declined by provider of service** **Definition:** Append this modifier to each line of service on a claim if the provider prefers to decline participation in an alternate payment method by the payer. **Explanation:** Modifier AO indicates that the provider declines an alternate payment methodology and wants to continue with the original method of reimbursement. Use this modifier if you do not prefer to participate in bundled payment program for example for a care improvement initiative under the Affordable care act and you would continue to receive the reimbursement according to regular fee for service payment rules. **Tips:** If the provider does not report the AO modifier on each line of service on the claim then the provider receives the claim back as unprocessable with instruction to rebill the services on separate claims.
AP	**Determination of refractive state was not performed in the course of diagnostic ophthalmological examination** **Definition:** Append this modifier to eye examination codes to indicate that reimbursement of the code does not include a fee for determination of a refractive state, or the process that the provider performs to determine the patient's refractive error and need for glasses or contact lenses. **Explanation:** This is an informational modifier that indicates that determination of a refractive state was not part of the work effort that the provider puts in diagnostic ophthalmological examination and the overall value of the eye examination codes such as 92004, 92014, 92002, 92012, do not include the value of refraction. **Tips:** Modifier AP became unnecessary when the values for the eye exam codes no longer included payment for refraction. If an ophthalmologist performed an eye exam without refraction, he would append modifier AP to show that the fee did not include refraction. CPT® gave refraction its own code, 92015, Determination of refractive state, which Medicare will not reimburse for, and excluded that work from the value of the eye exam codes. Since Medicare does not consider refraction an intrinsic part of any code, modifier AP is no longer necessary.
AQ	**Physician providing a service in an unlisted health professional shortage area (HPSA)** **Definition:** Append this modifier to represent the services that the provider renders in zip code areas that do not fall within a listed health professional shortage area, or HPSA. **Explanation:** Modifier AQ represents the provider's service in a health professional shortage area that is not listed in Medicare's annual file for automated HPSA bonus payment. CMS posts a file annually of ZIP codes, within which the HPSA bonus payment is made automatically. An unlisted health professional shortage area includes zip code areas that fall partially within a full county HPSA but is not considered to be in that county based on the United States Postal Service dominance decision; is a zip code area that falls partially within a non full county HPSA; is a zip code area that was not included in the automated file of HPSA areas based on the date the file was run, and zip code areas that do not fall entirely in a designated full county HPSA. **Tips:** Do not use this modifier if the provider does not render the service in the health professional shortage area. Do not use this modifier with codes that represent only a technical component.
AR	**Physician provider services in a physician scarcity area** **Definition:** Append this modifier to represent the services of a physician provider in a physician scarcity area. **Explanation:** Modifier AR represents the services that a provider performs in a physician scarcity area, or an area which has a shortage of health professionals. It was a previously effective code until June of 2008 and was used by the provider to obtain a physician scarcity area bonus payment. **Tips:** Use this modifier only for dates of service January 1, 2005, through June 30, 2008.
AS	**Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery** **Definition:** Append this modifier to represent the services of a healthcare professional acting as an assistant during a surgery. **Explanation:** Healthcare professionals like a physician assistant, nurse practitioner, or clinical nurse specialist who acts as an assistant during a surgery reports the identical procedure as the primary surgeon with a modifier AS. These professionals report these services under a surgeons' provider number. The main surgeon should clearly specify in the medical record the medical necessity for utilizing the service of an assistant.
AT	**Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)** **Definition:** Append this modifier with specific chiropractic manipulative treatment, or CMT, spinal codes when the provider performs treatment of the acute or chronic spinal subluxation. **Explanation:** The provider uses modifier AT with chiropractic manipulative treatment codes such as 98940 to 98942 to indicate the acute or active nature of treatment. The patient's medical record should also support the active nature of chiropractic treatment in that the record should reflect the anticipated result of the chiropractic manipulation is either an improvement in, or a complete arrest of the progression, of the patient's condition. **Tips:** This modifier is not applicable when the medical records suggest that the provider is performing a maintenance chiropractic service to maintain or further prevent deterioration of a chronic condition.

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Mod	Modifier Description, Definition, Explanation, and Tips
AU	**Item furnished in conjunction with a urological, ostomy, or tracheostomy supply** **Definition:** Append this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that identify the supply associated with urological, ostomy, or tracheostomy procedures. **Explanation:** Use this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for supplies associated with a urological procedure, or those for the male and female urinary tract system and the male reproductive organs; an ostomy, or a surgically created opening in a patient's body for the discharge of body wastes; or for a tracheostomy, an opening made in the patient's neck into the trachea, or windpipe to create an airway or to remove secretions from the patient's lungs. **Tips:** Use modifier AU with HCPCS codes such as A4217; Sterile water or saline, 500 ml, A4450; Surgical trays, A4452; Tape, waterproof, per 18 square inches, and A5120; Skin barrier, wipes or swabs, each.
AV	**Item furnished in conjunction with a prosthetic device, prosthetic or orthotic** **Definition:** Append this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that identify the supply associated with a prosthetic device, prosthetic, or orthotic. **Explanation:** Use this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for supplies associated with a prosthetic device, prosthetic or orthotic, meaning an artificial or manmade replacement for a body part or a supportive device. **Tips:** Use modifier AV with HCPCS codes such as: A4450; Tape, non-waterproof, per 18 square inches, A4452; Tape, waterproof, per 18 square inches and A5120; Skin barrier, wipes or swabs, each. Providers can refer to the Medicare Durable Medical Equipment, Prosthetics or Orthotics and Supplies Fee Schedule on the Centers for Medicare and Medicaid Services, or CMS, website to determine which procedures are reportable with modifier AV. Allowable procedure codes for modifier AV appear on the file with modifier AV such as A4450 AV.
AW	**Item furnished in conjunction with a surgical dressing** **Definition:** Append this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that identify the supply associated with a surgical dressing. **Explanation:** Use this modifier with Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for supplies associated with a surgical dressing, meaning a sterile bandage or compress applied to a wound to encourage healing and to prevent infection.
AX	**Item furnished in conjunction with dialysis services** **Definition:** Append this modifier to Healthcare Common Procedure Coding System, or HCPCS codes that identify a supply associated with a dialysis services. **Explanation:** Use this modifier for Healthcare Common Procedure Coding System, or HCPCS codes that a provider reports for items he furnishes that are dialysis supplies or equipment, but are not specifically identified as dialysis supplies or equipment in the code descriptor. Use modifier AX with dialysis supplies such as those codes in the ranges A4215 to A4217, A4244 to A4248, A4450, A4452, A4651 to A4670, A4927, A4928, A4930, A4931, A6216, A6250, A6260, and A6402. Use modifier AX also with dialysis equipment codes such as E0210, E1632, E1637, and E1639. **Tips:** A provider can report this code for items furnished in conjunction with home dialysis services too.
AY	**Item or service furnished to an ESRD patient that is not for the treatment of ESRD** **Definition:** Append this modifier to Healthcare Common Procedure Coding System, or HCPCS codes that represent an item or service she furnishes to an End Stage Renal Disease, or ESRD, patient that is not for the treatment of the ESRD. **Explanation:** This modifier was developed for only Medicare purposes. Under the bundled payment system, a single payment is made for renal dialysis services and other items and services for example, supplies and equipment the provider uses to administer dialysis, and the drugs, biologicals, laboratory tests, and support services related to home dialysis. However, if any End Stage Renal Disease, or ESRD facility provides any items or services to a beneficiary, which do not relate to the treatment of the patient's ESRD condition, then the ESRD facility submits those services using the AY modifier to allow for separate payment outside of ESRD bundled payment system. **Tips:** Use this modifier only when the documents clearly support that the service the provider performs for a reason unrelated to ESRD treatment.

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Mod	Modifier Description, Definition, Explanation, and Tips
AZ	**Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment** **Definition:** Append this modifier to represent the services that a provider renders in zip codes areas that fall within a designated dental health professional shortage area, or HPSA to obtain the electronic health record, or EHR, incentive payment. **Explanation:** Modifier AZ represents the services that a provider performs in a dental physician scarcity area, or a geographic area with a shortage of dental health professionals available to the Medicare population in that area. Append this modifier to report services the provider renders in a dental HPSA when the Zip code does not fully fall within that dental HPSA. Use of this modifier provides for an electronic health record incentive payment, made to eligible providers that adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. **Tips:** This modifier does not impact the payment or calculation of the fee for service geographic quarterly HPSA, or health professional shortage area bonus.
BA	**Item furnished in conjunction with parenteral enteral nutrition (PEN) services** **Definition:** Append modifier BA to represent an item or service a provider furnishes in conjunction with parenteral enteral nutrition, or PEN, services. **Explanation:** A provider reports the BA modifier for items that a provider furnishes for use with parenteral enteral nutrition services. For example, when the provider uses an intravenous, or IV pole in conjunction with parenteral nutrition, and reports E0776, IV pole, the provider appends the BA modifier. **Tips:** Use the BA modifier with E0776 exclusively.
BL	**Special acquisition of blood and blood products** **Definition:** Append this modifier to Healthcare Common Procedure Code System, or HCPCS codes that the provider reports for the actual blood or blood product. **Explanation:** Use this modifier with appropriate blood product Healthcare Common Procedure Code System, or HCPCS codes that a provider uses in an outpatient hospital setting for example when he purchases the products from a community blood bank or when he assess a charge for the blood or blood product that the provider collects in his own blood bank. **Tips:** The provider reports charges for the blood or blood product itself with the date of service, the number of units, and the appropriate blood product HCPCS code and modifier BL. He also reports the processing and storage services on a separate line the same line item date of service, the same number of units, and the same appropriate blood product HCPCS code and modifier BL. This modifier is applicable for blood products payment under the hospital outpatient prospective payment system. There is no requirement for use of this modifier by critical access hospitals, or CAHs.
BO	**Orally administered nutrition, not by feeding tube** **Definition:** Append this modifier to enteral nutrition Healthcare Common Procedure Code System, or HCPCS codes when the provider administers enteral nutrition products by mouth. **Explanation:** A provider appends this modifier with Healthcare Common Procedure Code System, or HCPCS codes that he reports for enteral nutrition therapy. He administers the enteral nutrition products to the patient orally, or by mouth, and not through a feeding tube. This modifier is applicable for enteral nutrients, reportable using HCPCS codes B4149 to B4162. **Tips:** This modifier is applicable for certain Home Health and Hospice services as well.
BP	**The beneficiary has been informed of the purchase and rental options and has elected to purchase the item** **Definition:** Append modifier BP to a code for durable medical equipment where the provider informs the beneficiary of the purchase and rental options and the beneficiary elects to purchase the item. **Explanation:** Modifier BP indicates that the patient chooses to purchase a durable medical equipment, or DME, item after the provider fully informs the recipient at the time the patient receives the item of the purchase and rental options for the item. A provider appends this modifier for durable medical equipment, or DME, items such as parenteral and enteral, or PEN pumps and electric wheelchairs, reportable with HCPCS K0835 thru K0891. **Tips:** Medicare discontinued the use of the following modifiers on claims for most capped rental items outside of those identified above: BP, The beneficiary has been informed of the purchase and rental options and has elected to purchase the item, modifier BR, and modifier BU, The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision. This change was due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.

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Mod	Modifier Description, Definition, Explanation, and Tips
BR	**The beneficiary has been informed of the purchase and rental options and has elected to rent the item** **Definition:** Append modifier BR to a code for durable medical equipment, or DME, items where the provider informs the beneficiary of the differences between purchasing and renting of the DME item and the beneficiary chooses to rent the item. **Explanation:** Modifier BR identifies a code as an item where the beneficiary chooses to rent the item after the provider fully informs the recipient at the time the patient receives the item of the purchase and rental options available. A provider appends this modifier for durable medical equipment, or DME, items such as parenteral and enteral, or PEN pumps and electric wheelchairs, reportable with HCPCS K0835 through K0891. **Tips:** Medicare discontinued the use of the following modifiers on claims for most capped rental items outside of those identified above: BP, The beneficiary has been informed of the purchase and rental options and has elected to purchase the item, modifier BR, and modifier BU, The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision. This change was due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.
BU	**The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision** **Definition:** Append modifier BU to a code for durable medical equipment, or DME, items where the provider informs the beneficiary of the differences between purchasing and renting the item and after 30 days the beneficiary has not informed the supplier of his decision. **Explanation:** Modifier BU identifies a code for a durable medical equipment, or DME, item that a provider fully informs the recipient at the time the patient receives the item of the purchase and rental options available but the beneficiary does not inform the supplier of his decision to rent or purchase the item for 30 days or more. A provider appends this modifier for certain durable medical equipment, or DME, items such as parenteral and enteral, or PEN, pumps and electric wheelchairs regardless of the date of the first rental period, reportable with HCPCS K0835 thru K0891, and on all capped rental items where the first rental period began prior to January 1, 2006. **Tips:** Medicare discontinued the use of the following modifiers on claims for most capped rental items outside of those identified above: BP, The beneficiary has been informed of the purchase and rental options and has elected to purchase the item, modifier BR, and modifier BU, The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision. This change was due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.
CA	**Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission** **Definition:** Append modifier CA when the patient is an outpatient, in an inpatient setting, and the patient passes away without being admitted as an inpatient. **Explanation:** In order to receive payment for the CA modifier with a Healthcare Common Procedure Coding System, or HCPCS code, the patient should be an emergency patient and must be an outpatient, the setting should be an inpatient setting only, and the patient passes away without being admitted as an inpatient. For outpatients who receive inpatient only procedures on an emergency basis and who expire before inpatient admittance to the hospital, the provider receives a specific outpatient Ambulatory Payment Classification, or APC payment as reimbursement for all the services on that day. The assignment of a modifier CA on an inpatient only procedure line identifies the service as such and assigns the specific payment, and turns on a packaging flag for all other line items on that claim with that date of service. Payment is only permissible for one procedure with a modifier of CA. **Tips:** Do not use modifier CA on more than one procedure on a claim. If a provider submits multiple inpatient only procedures with the modifier CA, the payer returns the claim back to the provider. If a provider applies a modifier CA on an inpatient only procedure code for a patient who did not expire, and the patient discharge status code is not 20, Expired, then the provider will also get the claim back.
CB	**Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable** **Definition:** A provider appends modifier CB to identify services ordered by a renal dialysis facility, or RDF, provider as part of the dialysis benefit of an end stage renal disease, or ESRD patient. This is not a part of the composite rate payment, and is separately reimbursable. **Explanation:** A provider appends modifier CB to services related to an ESRD patient's dialysis treatment and ordered by the dialysis facility physician. The test is not a part of the dialysis facility's composite rate payment, and is separately reimbursable. These services may include chest X-rays and other X-rays presumptively considered to be dialysis related and, therefore, appropriate for submission with the CB modifier; along with lab tests such as certain panel tests, urinalysis, and specific electrocardiogram, or ECG, tests and some vascular studies. **Tips:** Modifier CB affects consolidated billing rules for skilled nursing facilities for inpatients. Append modifier CB, only after determining that the patient has ESRD entitlement, he is undergoing the test for dialysis treatment for ESRD, the test is an order of the dialysis facility, the test is not a part of the composite rate, and is separately reimbursable. The patient should be in a Medicare Part A stay, Bill 21X or 22X.

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CC	**Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)** **Definition:** A provider appends modifier CC to report a procedure code change, when the procedure code submitted changes either for administrative reasons, or due to filing of an incorrect code. **Explanation:** A provider appends modifier CC to a service when the procedure code submitted changes either for administrative reasons or due to incorrect code usage. Commonly, a contractor uses this modifier to identify when the procedure code submitted was changed by them. **Tips:** Providers should not use modifier CC. It is an internal modifier that identifies when the Medicare contractor changes the procedure code that the provider submitted.
CD	**AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable** **Definition:** Append modifier CD when the End Stage Renal Disease, or ESRD provider or any provider performs an automated multi channel laboratory test, or AMCC test on an ESRD patient who is undergoing maintenance dialysis. **Explanation:** Use this modifier when an End Stage Renal Disease, or ESRD provider or any provider performs an automated multi channel laboratory test, or AMCC, test on an ESRD patient who is undergoing maintenance dialysis. This modifier indicates that the test is a part of the composite rate and is not separately reimbursable. When a provider reports an individual laboratory code such as 82330, Calcium; ionized, as Monthly Capitation Payment, or MCP requires, rather than reporting the disease panel code, such as 82310, Calcium; total, he appends modifier CD, when the test is part of the composite rate or he appends CE, AMCC test has been ordered by an ESRD facility or MCP provider that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity. **Tips:** Providers billing AMCC ESRD related tests to Medicare must report CD, CE, or CF modifiers for each test. Beginning with dates of service on or after April 1, 2015, ESRD claims will no longer require ESRD facilities to submit theses three modifiers: CD, CE, AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity; or modifier CF, AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.
CE	**AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity** **Definition:** Append modifier CE when the End Stage Renal Disease, ESRD facility or another facility performs an automated multi channel laboratory, or AMCC test on an ESRD patient who is undergoing maintenance dialysis. This modifier indicates that the test is beyond the normal frequency limit the composite reimbursement covers so it is separately payable. **Explanation:** Use this modifier when either the ESRD facility or another facility performs an automated multi channel laboratory, or AMCC test on an ESRD patient who is undergoing maintenance dialysis. This modifier indicates that the test is reasonable and medically necessary, a part of the composite rate, but is beyond the frequency limits and is separately reimbursable. When a provider reports an individual laboratory code such as 82330. Calcium; ionized, as the Monthly Capitation Payment, or MCP requires, rather than reporting the disease panel code, such as 82310, Calcium; total, he appends modifier CD, AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable, or he appends modifier CE when the code is separately reimbursable. **Tips:** Providers billing AMCC ESRD related tests to Medicare must report CD, CE, or CF modifiers for each test. Beginning with dates of service on or after April 1, 2015, ESRD claims will no longer require ESRD facilities to submit theses three modifiers: CD, AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable; or modifier CE; or CF, AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

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Mod	Modifier Description, Definition, Explanation, and Tips
CF	**AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable** **Definition:** Append modifier CF when the End Stage Renal Disease, ESRD facility or an outside facility performs an automated multi channel laboratory, or AMCC, test on an ESRD patient undergoing maintenance dialysis. This modifier indicates that the test is not included in the composite rate and is separately reimbursable. **Explanation:** When submitting claims to Medicare for ESRD related automated multi channel chemistry tests, or AMCC tests, use modifier CF to identify which tests are not inclusive within the ESRD facility composite rate payment. Append modifier CF to identify tests that the provider orders that are not a part of the composite rate. These tests are separately reimbursable. Use modifier CF if the provider orders tests for chronic dialysis for ESRD such as an AMCC test that is not part of the composite rate and is separately billable and has been ordered by an ESRD facility or Monthly Capitation Payment, or MCP physician. You may submit this modifier with any of the AMCC codes. **Tips:** Providers billing AMCC ESRD related tests to Medicare must report CD, CE, or CF modifiers for each test. Beginning with dates of service on or after April 1, 2015, ESRD claims will no longer require ESRD facilities to submit these three modifiers: CD, AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable; or CE, AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity; or modifier CF.
CG	**Policy criteria applied** **Definition:** Append modifier CG to a code to identify a policy criteria applied. **Explanation:** For services reportable as an L3923 orthosis that has a rigid plastic or metal component, you must add the CG modifier. If you bill a claim for L3923 without a CG modifier, it will be denied. Similarly, if a spinal garment for example L0450, L0454, L0621, L0625, or L0628 is made primarily of a nonelastic material, such as canvas, cotton, or nylon, or has a rigid posterior panel, you must add the CG modifier or the service will be rejected or denied for incorrect coding. **Tips:** This modifier is informational only and you may submit it with all procedure codes.
CH	**0 percent impaired, limited or restricted** **Definition:** Append modifier CH to a code for a patient with a zero percent impairment, with limited or restricted movement. **Explanation:** Modifier CH identifies the extent of a patient's impairment. The severity of impairment to assign this modifier is zero percent impaired, with limited or restricted movement. CH is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.

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Mod	Modifier Description, Definition, Explanation, and Tips
CI	**At least 1 percent but less than 20 percent impaired, limited or restricted** **Definition:** Append modifier CI to a code for a patient with an impairment of one to 20 percent, with limited or restricted movement. **Explanation:** Modifier CI identifies the extent of impairment in a patient. The severity of impairment may range from one percent to 20 percent, with limited or restricted movement. CI is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the DOS for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CJ	**At least 20 percent but less than 40 percent impaired, limited or restricted** **Definition:** Append modifier CJ to a code for a patient with an impairment of 20 to 40 percent, with limited or restricted movement. **Explanation:** Modifier CJ identifies the extent of impairment in a patient. The severity of impairment may range from 20 percent to 40 percent, with limited or restricted movement. CJ is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CK	**At least 40 percent but less than 60 percent impaired, limited or restricted** **Definition:** Append modifier CK to a code for a patient with an impairment of 40 to 60 percent, with limited or restricted movement. **Explanation:** Modifier CK identifies the extent of impairment in a patient. The severity of impairment may range from 40 percent to 60 percent, with limited or restricted movement. CK is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.

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Mod	Modifier Description, Definition, Explanation, and Tips
CL	**At least 60 percent but less than 80 percent impaired, limited or restricted** **Definition:** Append modifier CL to a code for a patient with an impairment of 60 to 80 percent, with limited or restricted movement. **Explanation:** Modifier CL identifies the extent of impairment in a patient. The severity of impairment may range from 60 percent to 80 percent, with limited or restricted movement. CL is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CM	**At least 80 percent but less than 100 percent impaired, limited or restricted** **Definition:** Append modifier CM to a code for a patient with an impairment of 80 to 100 percent, with limited or restricted movement. **Explanation:** Modifier CM identifies the extent of impairment in a patient. The severity of impairment may range from 80 percent to 100 percent, with limited or restricted movement. CM is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.
CN	**100 percent impaired, limited or restricted** **Definition:** Append modifier CN to a code for a patient with an impairment of 100 percent, with limited or restricted movement. **Explanation:** Modifier CN identifies the extent of impairment in a patient. The severity of impairment is 100 percent, with limited or restricted movement. CN is a severity modifier that a provider uses on specific therapy claims. Report only one functional limitation for each related therapy plan of care, or POC. In situations where a provider completes reporting on the first reportable functional limitation and the need for treatment continues, he reports a second functional limitation using another set of G codes. Functional reporting is necessary, at the beginning of a therapy episode of care, or on the date of service, or DOS, for the initial therapy service; at least once every ten treatment days; on the same DOS that a provider reports an evaluative or re evaluative on a claim; at the time of patient discharge from a therapy episode of care; and on the same DOS the reporting of a particular functional limitation ends, when further therapy is necessary. **Tips:** Use this modifier to report the severity or complexity for the functional measure for each non payable therapy G code. The severity modifiers reflect the patient's percentage of functional impairment as determined by the therapist, physician, or nonphysician practitioner who provides the therapy services. The appropriate severity modifiers report a patient's current status, the anticipated goal status, and the discharge status.

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Mod	Modifier Description, Definition, Explanation, and Tips
CO	**Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant** **Definition:** Append modifier CO to codes for outpatient occupational therapy (OPT) when an OPT assistant performs all or a portion of the service. **Explanation:** Modifier CO denotes that some or all of a patient's outpatient occupational therapy (OPT) was performed by an OPT assistant. The OPT assistant performs the therapy in an outpatient setting, and the diagnosis code must be consistent with a condition that requires occupational therapy. OPT helps injured, ill, or disabled patients develop, recover, and improve skills needed for activities of daily living (ADLs),such as eating, bathing, dressing, toileting, and walking, and work-related activities, such as lifting, bending, sorting, and other skills depending on the type of work the patient performs. **Tips:** Append modifier CO only with codes on the list of applicable therapy services for occupational therapy and that are part of the plan of care for that patient.
CQ	**Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant** **Definition:** Append modifier CQ to codes for outpatient physical therapy (PT) when an PT assistant performs all or a portion of the service. **Explanation:** Modifier CQ denotes that some or all of a patient's outpatient physical therapy (PT) was performed by a PT assistant. The PT assistant performs the therapy in an outpatient setting, and the diagnosis code must be consistent with a condition that requires occupational therapy. Physical therapy uses therapeutic exercises and equipment to help patients with physical dysfunction regain or improve their physical abilities. **Tips:** Append modifier CQ only with codes on the list of applicable therapy services for physical therapy and that are part of the plan of care for that patient.
CR	**Catastrophe/disaster related** **Definition:** Append modifier CR to a code for services related to an emergency or disaster related condition. **Explanation:** Modifier CR identifies the services given to victims in the case of an emergency or disaster related condition such as a hurricane. In the event of a disaster or emergency, the Centers for Medicare and Medicaid Services, or CMS, issues specific guidance for use of this modifier. CMS provides information such as the geographic area the code is applicable to, and the beginning and end dates that apply to the use of the modifier and its related bill condition code, DR, Disaster related, which a provider also reports to identify the services are or may be impacted by specific policies related to a national or regional disaster. **Tips:** Use this modifier to code for catastrophe, disaster or emergency claims. You may use CR modifier for institutional or non institutional billing. One may use this modifier in case of an emergency disaster related condition and there is a condition levied on the payment of Medicare.
CS	**Cost-sharing waived for specified covid-19 testing-related services that result in and order for or administration of a covid-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in rural health clinics and federally qualified health centers during the covid-19 public health emergency** **Definition:** Append modifier CS to indicate cost-sharing is waived for specified COVID-19 testing-related services. Rural health clinics and federally qualified health centers also use modifier CS to distinguish telehealth services that have cost-sharing waived during the COVID-19 public health emergency. **Explanation:** Modifier CS is appropriate with codes for specified COVID-19 test-related services, including applicable telehealth services, if those services meet certain requirements for waiving cost-sharing. Examples of requirements include codes for evaluation and management (E/M) services that result in an order for, or administration of, a COVID-19 lab test during the public health emergency. **Tips:** Payer rules may vary for use of this modifier. Medicare states cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that are furnished between March 18, 2020, and the end of the COVID-19 public health emergency (PHE); result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following E/M categories: office and other outpatient services; hospital observation services; emergency department services; nursing facility services; domiciliary, rest home, or custodial care services; home services; and online digital evaluation and management services. Medicare provides lists of codes that modifier CS may apply to. For Medicare, cost-sharing does not apply to the specified medical visit services for which payment is made to hospital outpatient departments paid under the Outpatient Prospective Payment System (OPPS), physicians and other professionals under the Physician Fee Schedule, Critical Access Hospitals (CAHs), RHCs, and FQHCs. RHCs and FQHCs append CS to G2025 (Distant site telehealth services Rural Health Clinics or Federally Qualified Health Centers (RHC/FQHC)) when the code represents one of the services where coinsurance is waived. Providers who use modifier CS should not charge patients co-insurance and/or deductible amounts for those services.

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Mod	Modifier Description, Definition, Explanation, and Tips
CT	**Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard** **Definition:** Append modifier CT when a provider renders computed tomography (CT) with equipment that doesn't meet the National Electrical Manufacturers' Association standard. **Explanation:** The National Electrical Manufacturers' Association (NEMA) represents U.S. electrical equipment and medical imaging manufacturers. These manufacturers produce products that generate and transmit electricity and can be used for medical, commercial, and industrial purposes. Modifier CT appended to a code indicates that CT equipment was used for the patient's services, but that equipment does not comply with NEMA standards.
DA	**Oral health assessment by a licensed health professional other than a dentist** Summary: Append modifier DA to a code for an oral health assessment that a licensed health professional, other than a dentist, performs. **Explanation:** Modifier DA identifies an oral health assessment for a patient with dental or oral health problems. A licensed health professional other than a dentist performs this assessment. An oral health assessment determines the level of a patient's oral hygiene such as healthy or unhealthy oral cleanliness, condition of the lips, tongue, saliva, gums and tissue, and caries risk, meaning the patient's risk of tooth decay. **Tips:** This modifier is informational only and may be submitted with any appropriate HCPCS code.
E1	**Upper left, eyelid** **Definition:** Append modifier E1 when the provider performs a procedure on the left upper eyelid of a patient. **Explanation:** Modifier E1 illustrates a procedure that the provider performs on a patient's left upper eyelid. A provider uses modifier E1 to identify the left upper eyelid, instead of using modifier LT, Left side, which identifies a procedure the provider performs on the left side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, you may need to repeat the HCPCS code on another line with the appropriate Level II modifier. When modifier E1 applies to the service, use it before selecting modifiers LT, RT, or 59, Distinct procedural service.
E2	**Lower left, eyelid** **Definition:** Append modifier E2 when the provider performs a procedure on the left lower eyelid of a patient. **Explanation:** Modifier E2 illustrates a procedure that the provider performs on the patient's left lower eyelid. A provider uses modifier E2 to identify the left lower eyelid, instead of using modifier LT, Left side, which identifies a procedure the provider performs on the left side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, you may need to repeat the HCPCS code on another line with the appropriate Level II modifier.
E3	**Upper right, eyelid** **Definition:** Append modifier E3 when the provider performs a procedure on the right upper eyelid of a patient. **Explanation:** Modifier E3 illustrates a procedure that the provider performs on the patient's right upper eyelid. A provider uses modifier E3 to identify the right upper eyelid, instead of using modifier RT, Right side, which identifies a procedure the provider performs on the right side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, repeat the HCPCS code on another line with the appropriate Level II modifier.

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Mod	Modifier Description, Definition, Explanation, and Tips
E4	**Lower right, eyelid** **Definition:** Append modifier E4 when the provider performs a procedure on the right lower eyelid of a patient. **Explanation:** Modifier E4 illustrates a procedure that the provider performs on the patient's right lower eyelid. A provider uses modifier E4 to identify the right lower eyelid, instead of using modifier RT, Right side, which identifies a procedure the provider performs on the right side of the body. HCPCS level II modifiers apply to codes for procedures that the provider performs on paired organs, like eyelids, fingers, or toes. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** If more than one modifier needs to be applied, you may need to repeat the HCPCS code on another line with the appropriate Level II modifier.
EA	**Erythropoietic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy** **Definition:** Append modifier EA when the provider administers an agent that stimulates red blood cell production. The provider administers an erythropoietic stimulating agent, or ESA to treat anemia, a condition of a lower than normal hemoglobin, or red blood cell count in the blood of a patient taking anti cancer chemical compounds or drugs. **Explanation:** Modifier EA depicts administration of erythropoietic stimulating agent, or ESA, to a patient who has taken or is taking anti cancer drugs. The provider administers ESA to enhance the stimulation of red blood cells to treat anemia or low hemoglobin. The medical record should justify the diagnosis that corresponds to the administration of ESA as well as the nature or extent of the anemia. **Tips:** If the provider administers ESA to treat anemia due to anticancer radiotherapy, append modifier EB, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer radiotherapy. If the provider administers ESA to treat anemia, not due to anti cancer radiotherapy or chemotherapy, append modifier EC, Erythropoietic stimulating agent or ESA, administered to treat anemia not due to anti cancer radiotherapy or anti cancer chemotherapy.
EB	**Erythropoietic stimulating agent (ESA) administered to treat anemia due to anti-cancer radiotherapy** **Definition:** Append modifier EB when the provider administers an agent that stimulates red blood cell production. The provider administers an erythropoietic stimulating agent, or ESA to treat anemia, a condition of a lower than normal hemoglobin, or red blood cells count in the blood of a patient taking anti cancer radiotherapy. **Explanation:** Modifier EB identifies administration of erythropoietic stimulating agent, or ESA, to a patient who has received or is receiving anti cancer radiotherapy. The provider administers ESA to enhance the stimulation of red blood cells to treat anemia or low hemoglobin. The medical record should justify the diagnosis that corresponds to the administration of ESA as well as the nature or extent of the anemia. **Tips:** If the provider administers ESA to treat anemia due to anticancer chemotherapy, append modifier EA, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer chemotherapy. If the provider administers ESA to treat anemia, not due to anti cancer radiotherapy or chemotherapy, append modifier EC, Erythropoietic stimulating agent or ESA administered to treat anemia not due to anti cancer radiotherapy or anti cancer chemotherapy.
EC	**Erythropoietic stimulating agent (ESA) administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy** **Definition:** Append modifier EC when the provider administers an agent that stimulates red blood cell production. The provider administers an erythropoietic stimulating agent, or ESA to treat anemia, a condition of a lower than normal red blood cell count or hemoglobin in the blood of a patient. The anemia is not because of taking anti cancer chemotherapy or radiotherapy. **Explanation:** Modifier EC identifies administration of erythropoietic stimulating agent, or ESA, to a patient to enhance the stimulation of red blood cells to treat anemia or low hemoglobin. The medical record should justify the diagnosis that corresponds to the administration of ESA as well as the nature or extent of the anemia. Append this modifier when anemia does not develop due to anti cancer chemotherapy or radiotherapy. **Tips:** If the provider administers ESA to treat anemia due to anticancer chemotherapy, append modifier EA, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer chemotherapy. If the provider administers ESA to treat anemia due to anticancer radiotherapy, append modifier EB, Erythropoietic stimulating agent or ESA administered to treat anemia due to anti cancer radiotherapy.

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Mod	Modifier Description, Definition, Explanation, and Tips
ED	**Hematocrit level has exceeded 39% (or hemoglobin level has exceeded 13.0 G/dl) for 3 or more consecutive billing cycles immediately prior to and including the current cycle** **Definition:** Append modifier ED to a code for hemodialysis patients when the provider measures the hematocrit level and it exceeds 39 percent or the hemoglobin level exceeds 13.0 g/dl, or grams per deciliter, for three or more consecutive billings immediately prior to and including the current service. **Explanation:** Modifier ED illustrates the measurement of a patient's hematocrit level which exceeds 39 percent or a hemoglobin level, which is greater than 13.0 g/dl, or grams per deciliter, in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's hemoglobin level in hemodialysis patients. He tests for three or more consecutive billing cycles immediately prior to and including the current cycle and appends this modifier when applicable. **Tips:** Requests for payments or claims for ESAs for ESRD patients receiving dialysis in renal dialysis facilities must report modifiers ED or EE, Hematocrit level has not exceeded 39% or hemoglobin level has not exceeded 13.0 g per dl for three or more consecutive billing cycles immediately prior to and including the current cycle. Providers may continue to report modifier GS, Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level, when the provider reports that the hematocrit or hemoglobin levels exceed the monitoring threshold and a dose reduction has occurred. When the GS modifier is on a claim also reporting modifier EE, the claim will be paid in full. The GS modifier, however, has no effect on the 50 percent dosage reduction, on claims reporting modifier ED.
EE	**Hematocrit level has not exceeded 39% (or hemoglobin level has not exceeded 13.0 G/dl) for 3 or more consecutive billing cycles immediately prior to and including the current cycle** **Definition:** Append modifier EE to a code for hemodialysis patients when the provider measures the hematocrit level which does not exceed 39 percent or the hemoglobin level does not exceed 13.0g/dl, or grams per deciliter, for three or more consecutive billings immediately prior to and including the current service. **Explanation:** Modifier EE illustrates the measurement of the hematocrit level which does not exceed 39 percent or a hemoglobin level, which is not greater than 13.0 g per dl, or grams per deciliter, in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's hemoglobin level in hemodialysis patients. He tests for three or more consecutive billing cycles immediately prior to and including the current cycle and appends this modifier when applicable. **Tips:** Requests for payments or claims for ESAs for ESRD patients must report modifiers ED, Hematocrit level has exceeded 39% or hemoglobin level has exceeded 13.0 g per dl for three or more consecutive billing cycles immediately prior to and including the current cycle, or append modifier EE. Providers may continue to report the modifier GS, Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level, when the hematocrit or hemoglobin levels that the provider reports exceed the monitoring threshold and a dose reduction has occurred. When the GS modifier is on a claim also reporting modifier EE, the claim will be paid in full. The GS modifier, however, has no effect on the 50 percent dosage reduction, on claims reporting modifier ED.
EJ	**Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab** **Definition:** Append modifier EJ to a code for subsequent claims for a defined course of EPO, sodium hyaluronate, or infliximab therapy for a patient. **Explanation:** Modifier EJ illustrates the coding of subsequent claims for a defined course of therapy for a patient. The therapy may include EPO, or erythropoietin therapy, a growth factor that stimulates the production of red blood cells; sodium hyaluronate, a substance similar to a joints own natural protection that acts like a lubricant and or cushion when injected directly into a joint such as the knee; or infliximab, a manmade antibody given intravenously to treat various chronic inflammatory diseases. This modifier allows the easy identification of a subsequent claim, which does not require as much information as an initial claim and prevents unnecessary claim inquiries, letters, and questionnaires. One can submit subsequent claims electronically. **Tips:** Modifier EJ is an informational code for Medicare use. Because of this fact, submit this modifier in the last modifier position, after any other modifiers. The biller may also submit this modifier with many HCPCS J codes for injections.

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Mod	Modifier Description, Definition, Explanation, and Tips
EM	**Emergency reserve supply (for ESRD benefit only)** **Definition:** Append modifier EM to a code for an emergency reserve supply of an erythropoiesis stimulating agent, or ESA, for hemodialysis patients with end stage renal disease, or ESRD. **Explanation:** Modifier EM illustrates the measurement of the emergency reserve supply for an ESA, or erythropoiesis stimulating agent in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. Use this code for ESRD patients beginning to self administer an ESA, or erythropoiesis stimulating agents, at home for the treatment of anemia due to the disease and who receive an extra month supply of the drug, this one month reserve supply is reportable on the claim line with modifier EM. **Tips:** Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
EP	**Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program** **Definition:** Append modifier EP to a code for a service that the provider gives as part of the Medicaid early periodic screening diagnosis and treatment, or EPSDT program. **Explanation:** Modifier EP illustrates billing of the service that the provider delivers as part of the Medicaid early periodic screening diagnosis and treatment, or EPSDT, program. This includes preventive health checkups and treatments to children from birth to young adults. A few of the types of early preventative health screening and treatments include immunization, administration and health screenings for hearing and vision problems. Modifier EP can be appended to several of the immunization administration codes, and preventive medicine, periodic and interperiodic assessments. **Tips:** Only providers delivering EPSDT medical services should use the EP modifier code for billing purposes. The claim form must contain the procedure code to represent the type of medical service that the provider gives along with the EP modifier to show this was an early preventative service office visit.
ER	**Items and services furnished by a provider-based, off-campus emergency department** **Definition:** Append modifier ER to codes for outpatient hospital services and items, such as drugs or bandages, furnished in an off-campus provider-based emergency department (ED). **Explanation:** Modifier ER denotes that an item or outpatient hospital service was provided by an off-campus provider-based emergency department. Off campus means a location physically separate from the immediate area of the hospital facility and or in a building located more than 250 yards away from the main hospital buildings. **Tips:** Critical access hospitals are not required to append this modifier. Modifier ER is used for informational purposes at its institution in 2019 and does not impact payment, but like other modifiers previously introduced for tracking outpatient services provided in other off-campus provider-based departments (PBDs), it may at some point affect payment. Individual providers should not append modifier ER and instead should use the appropriate place of service code to indicate outpatient services furnished in an on-campus, remote, or satellite location of a hospital or in an off-campus, provider-based hospital setting.
ET	**Emergency services** **Definition:** Append modifier ET to a code for the emergency services, including hospital emergency services, for multiple service dates, where the ER encounter spans more than one service date. **Explanation:** Modifier ET illustrates billing for the hospital emergency room, or ER, services when the provider delivers emergency services to a patient in that setting. This includes emergency department services for multiple service dates. ER services that a patient receives in a hospital are excluded from SNF Consolidated Billing, or SNF CB, for beneficiaries that are in a skilled Part A SNF stay. This code flags the service to bypass SNF Consolidated Billing, or CB, claim edits for the ER related service line items identified by the modifier ET. This code is not applicable for the services a patient receives in the Part A skilled nursing facility, or SNF. Append modifier ET with codes such as 99070, 99218, 99281 to 99285, and 99291 and 99292. **Tips:** Append modifier ET every time the patient visits the hospital emergency room, or ER. The services given in a hospital emergency room excludes the skilled nursing facility care. The service extends to multiple dates of service. Append this modifier to a code for an emergency dental procedures as well.
EX	**Expatriate beneficiary** **Definition:** This modifier designates a non-U.S. citizen working in his home country. **Explanation:** The Centers for Medicare and Medicaid Services (CMS) identify expatriates as insureds who are non-U.S. citizens working in their home country.

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Mod	Modifier Description, Definition, Explanation, and Tips
EY	**No physician or other licensed healthcare provider order for this item or service** **Definition:** Append modifier EY to items or services without an order or prescription from the treating provider. This informational modifier notifies insurer that the provider is requesting a denial for secondary billing. For Medicare this is under the Coordination of Benefit, or COB guidelines. A provider appends this code when they issue durable medical equipment, prosthetic and orthotic supplies, or DMEPOS, without an order. **Explanation:** For Coordination of Benefit, or COB, purposes, the suppliers use the modifier EY, No licensed healthcare provider order for this item or service, on each line item on the claim and report their own name and National Provider Identifier, or NPI, as the ordering or referring provider. This is done to obtain a Medicare denial, under COB guidelines, which is where two or more insurances work together to pay for a service when a patient has more than one health insurance plan. Failure to include the EY modifier with all codes results in the return of the claim as unprocessable. If a provider has an order for some, but not all, of the items or services the provider furnishes to the Medicare beneficiary, the provider submits a separate claim for the items the provider dispenses to the patient without the treating physician's order. **Tips:** Medicare coverage requires an order by the provider, with the exception of some preventive screenings, or else the service is denied.
F1	**Left hand, second digit** **Definition:** Append modifier F1 when the provider performs a procedure on the second digit, or finger, of the left hand. **Explanation:** Modifier F1 identifies a procedure that the provider performs on the second, or index, finger of the left hand. This modifier is appropriate for surgical and diagnostic services but is not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F2	**Left hand, third digit** **Definition:** Append modifier F2 when the provider performs a procedure on the third digit, or finger of the left hand. **Explanation:** Modifier F2 illustrates a procedure that the provider performs on the third digit of the left hand. This modifier is appropriate for surgical and diagnostic services but is not appropriate for Evaluation and Management, or E/M services.. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F3	**Left hand, fourth digit** **Definition:** Append modifier F3 when the provider performs a procedure on the fourth digit, or finger, of the left hand. **Explanation:** Modifier F3 illustrates a procedure that the provider performs on the fourth finger of the left hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

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Mod	Modifier Description, Definition, Explanation, and Tips
F4	**Left hand, fifth digit** **Definition:** Append modifier F4 when the provider performs a procedure on the fifth digit, or finger of the left hand. **Explanation:** Modifier F4 illustrates a procedure that the provider performs on the fifth finger of the left hand. This modifier is applicable usually to surgical and diagnostic services but not appropriate for Evaluation and Management, or EM, services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F5	**Right hand, thumb** **Definition:** Append modifier F5 when the provider performs a procedure on the thumb of the right hand. **Explanation:** Modifier F5 illustrates a procedure that the provider performs on the thumb of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and management, or E/M, services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F6	**Right hand, second digit** **Definition:** Append modifier F6 when the provider performs a procedure on the second digit, or finger, of the right hand. **Explanation:** Modifier F6 illustrates a procedure that the provider performs on the second finger of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F7	**Right hand, third digit** **Definition:** Append modifier F7 when the provider performs a procedure on the third digit, or finger, of the right hand. **Explanation:** Modifier F7 illustrates a procedure that the provider performs on the third finger of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
F8	**Right hand, fourth digit** **Definition:** Append modifier F8 when the provider performs a procedure on the fourth digit, or finger, of the right hand. **Explanation:** Modifier F8 illustrates a procedure that the provider performs on the fourth digit of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

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Mod	Modifier Description, Definition, Explanation, and Tips
F9	**Right hand, fifth digit** **Definition:** Append modifier F9 when the provider performs a procedure on the fifth digit, or finger, of the right hand. **Explanation:** Modifier F9 illustrates a procedure that the provider performs on the fifth digit of the right hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
FA	**Left hand, thumb** **Definition:** Append modifier FA when the provider performs a procedure on the thumb of the left hand. **Explanation:** Modifier FA illustrates a procedure that the provider performs on the thumb of the left hand. This modifier is appropriate for surgical and diagnostic services but not appropriate for Evaluation and Management, or E/M, services. **Tips:** Modifier FA represents the thumb of the left hand, and modifiers F1 through F4 represent the 2nd through 5th digits (fingers) of the left hand, respectively. Modifier F5 represents the thumb of the right hand, and modifiers F6 through F9 represent the 2nd through 5th digits (fingers) of the right hand, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
FB	**Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)** **Definition:** Append modifier FB with the facility charge for a surgery when a provider furnishes a device at no cost or when there is a full credit for a replacement device. This modifier triggers a reduced Ambulatory Payment Classification, or APC, payment when a provider reports the code on claims subject to the outpatient prospective payment system, or OPPS. **Explanation:** Modifier FB identifies the replacement of an implanted item or device with a device for which the provider incurs no cost or when the provider replaces an implanted device with a device for which they receive a full credit in the amount of the cost of the replaced device. Modifier FB may extend to nuclear medicine procedures when the provider obtains the associated diagnostic radiopharmaceutical at no cost. Append this modifier only when the supplier or provider makes the item available without cost or the facility receives an entire credit for the cost of the item. Always append modifier FB to the surgical procedure code, and not the item code. If the provider reports the modifier with the device code instead of the procedure code, the entire claim will be returned. **Tips:** Report modifier FC when the facility does not receive full credit for the cost of the item but receives a partial credit for the replaced device.
FC	**Partial credit received for replaced device** **Definition:** Append modifier FC when a facility furnishes a device and does not incur the full cost of the device such as when the provider receives a manufacturer credit of 50 percent or more of the cost of the device. **Explanation:** Modifier FC identifies that the provider receives a partial credit of 50 percent or more of the cost of a device for a replaced device. A provider appends this modifier for a new replacement device where the provider receives a discount of at least half or more of the cost of an item such as those under warranty, recall, or field action. Always append modifier FB to the surgical procedure code, and not the item code. At the time of device replacement, the provider may not know the amount of credit the manufacturer will provide for the device, or whether he will provide any discount at all. The facility has the option of either submitting the claim immediately without the FC modifier, or submitting a claim adjustment with the FC modifier at a later date once the credit determination is made. Or the facility may hold the claim until it is sure of the status of the credit. **Tips:** Medicare reduces their payment by 50 percent of the estimated cost of the device included in the procedure payment in cases in which the facility reports that it receives a credit of 50 percent or more of the cost of the new replacement device by appending the FC modifier to the device implantation procedure HCPCS code.

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Mod	Modifier Description, Definition, Explanation, and Tips
FP	**Service provided as part of family planning program** **Definition:** Append modifier FP to a code when reporting an annual family planning examination. **Explanation:** Modifier FP identifies that the services the provider furnishes is part of a family planning program. As a rule, providers append modifier FP only when reporting for the annual family planning examination. The provider reports the FP modifier with the code he reports for the family planning service. **Tips:** A provider omits modifier FP when reporting for all other family planning services, such as evaluation and management services, laboratory services, and anesthesia services.
FQ	**The service was furnished using audio-only communication technology** **Definition:** Append modifier FQ to indicate a service rendered to a patient used audio–only technology. The technology allows for two–way, real–time communication. **Explanation:** Modifier FQ indicates the provider rendered a healthcare service using an audio–only communication technology. The technology allows the patient and provider to communicate in real time. An example is a telephone call using sound without video visualization of the patient. This may occur when the patient is unable to use, does not wish to use, or does not have access to two–way, audio/video technology. **Tips:** See payer guidelines regarding services that are eligible for modifier FQ. An example may be treatment of a patient with a mental health condition who is calling the provider from home.
FR	**The supervising practitioner was present through two-way, audio/video communication technology** **Definition:** Append modifier FR to indicate the provider supervising the service was present through two–way communication technology with both audio and video. **Explanation:** Modifier FR indicates that the provider supervising the healthcare service was present virtually via technology rather than being physically present. The technology must allow two–way communication and must include both audio and video. **Tips:** See payer guidelines regarding services that are eligible for modifier FR.
FS	**Split (or shared) evaluation and management visit** **Definition:** Append modifier FS to indicate the service was a split or shared evaluation and management (E/M) visit. **Explanation:** Modifier FS indicates that an evaluation and management (E/M) service meets the definition of a split or shared visit. This modifier was created for Medicare use, but other payers may accept it. For Medicare, a split or shared service is an E/M service in a facility setting performed in part by a physician and in part by a nonphysician practitioner (NPP) in the same group, in accordance with applicable guidelines and regulations. **Tips:** See payer guidelines regarding services that are eligible for modifier FS. For instance, follow Medicare's definition of a split or shared visit when reporting to Medicare. Other payers may not accept this modifier or may not use Medicare's definition of a split or shared visit.
FT	**Unrelated evaluation and management (e/m) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated)** **Definition:** Append modifier FT to report an unrelated evaluation and management (E/M) service during the postoperative period of a procedure or on the same day of another E/M service. **Explanation:** Modifier FT indicates that an evaluation and management (E/M) service performed during a postoperative period is not related to the operative procedure. Alternatively, appending the modifier may indicate that an E/M service is unrelated to a procedure performed on the same date or that the E/M is unrelated to another E/M on the same date. **Tips:** See payer guidelines regarding services that are eligible for modifier FT. For instance, a payer may indicate the modifier is appropriate for a critical care E/M service code.
FX	**X-ray taken using film** **Definition:** Append modifier FX to a radiology code to indicate that an X-ray is film. **Explanation:** Modifier FX indicates that the provider took an X-ray using film, as opposed to digital radiography, which uses digital X-ray sensors to produce an X-ray image. **Tips:** Append modifier FY to a radiology code to indicate that an X–ray was performed using cassette–based (film) imaging. For any radiology service, be sure to determine if you need to append other modifiers to the radiology code, such as modifiers LT (left), RT (right), 50 (bilateral), 26 (professional component), or TC (technical component). The circumstances of each encounter will dictate appropriate modifier usage, along with each payer's requirements. Be sure to check specific payer guidelines for acceptable modifiers.

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Mod	Modifier Description, Definition, Explanation, and Tips
FY	**X-ray taken using computed radiography technology/cassette-based imaging** **Definition:** Append modifier FY to a radiology code to indicate that a digital image was created using cassette-based imaging, such as a phosphor imaging plate (IP), rather than conventional film. **Explanation:** Providers are required to append modifier FY to a radiology code when the imaging involves cassette-based imaging. Medicare payments for cassette-based imaging are reduced by 7% until 2023 and 10% thereafter. The imaging plate is reusable and requires no chemicals or darkroom. Cassette-based imaging involves using an imaging plate that has a phosphorus layer which, when exposed to X-ray or gamma radiation, captures and stores the image. The plate is placed in a scanner, and the image is released when a laser beam is focused on the plate. The image data is converted into electrical signals which are digitized and displaced on a monitor for the radiologist to read (interpret) the image. The digitized image can be saved like any digital file, and the plate is erased to be reused. **Tips:** Append modifier FY to a radiology code to indicate that imaging was performed using a phosphor imaging plate or cassette-based imaging. For any radiology service, be sure to determine if you need to append other modifiers to the radiology code, such as modifiers LT (left), RT (right), 50 (bilateral), 26 (professional component), or TC (technical component). The circumstances of each encounter will dictate appropriate modifier usage, along with each payer's requirements. Be sure to check specific payer guidelines for acceptable modifiers.
G0	**Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke** **Definition:** Append modifier G0 (G-zero) to codes for diagnosis, evaluation, or treatment of an acute stroke via an audio or video telecommunications system. **Explanation:** Modifier G0 (G-zero) denotes that a provider diagnosed, evaluated, or treated a patient for an acute stroke remotely using an audio and/or video telecommunication system. **Tips:** CMS removed restrictions on geographic locations and types of sites where acute stroke telehealth services can be furnished, so telehealth services for acute stroke may be provided to patients in both rural and urban areas. In addition, mobile stroke units may qualify as originating sites for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Whether an ambulance equipped with an audio and/or video telecommunication system qualifies as a mobile stroke unit is uncertain. Check with CMS and payers if uncertain that a code qualifies for this modifier.
G1	**Most recent URR reading of less than 60** **Definition:** Append modifier G1 to a code for a hemodialysis patient when the provider measures the urea reduction ratio, or URR, and the reading is less than 60. **Explanation:** Modifier G1 illustrates the measurement of the urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, or ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning of treatment and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as the urea reduction ratio, or URR. Use G1 to report a reading of less than 60. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every code, but facilities should be sure to include the modifier on at least one claim line for Medicare. The modifier can affect the processing of the payment of the code. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G1, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading is less than 60. Watch situations where G1 to G5 are not applicable because of the number of dialysis sessions. For example, when modifier G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of the G1 to G5 modifiers due to the number of patient dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly.

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Mod	Modifier Description, Definition, Explanation, and Tips
G2	**Most recent URR reading of 60 to 64.9** **Definition:** Append modifier G2 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is 60 to 64.9. **Explanation:** Modifier G2 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G2 for a reading of 60 to 64.9. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G2, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading ranges from 60 to 64.9. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
G3	**Most recent URR reading of 65 to 69.9** **Definition:** Append modifier G3 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is 65 to 69.9. **Explanation:** Modifier G3 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G3 for a reading of 65 to 69.9. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G3, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading ranges from 65 to 65.9. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.

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Mod	Modifier Description, Definition, Explanation, and Tips
G4	**Most recent URR reading of 70 to 74.9** **Definition:** Append modifier G4 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is 70 to 74.9. **Explanation:** Modifier G4 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G4 for a reading of 70 to 74.9. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G4, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading ranges from 70 to 74.9. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
G5	**Most recent URR reading of 75 or greater** **Definition:** Append modifier G5 to a code for hemodialysis patients when the provider measures the urea reduction ratio and the reading is greater than 75. **Explanation:** Modifier G5 illustrates the measurement of urea reduction ratio, or URR, in a patient undergoing hemodialysis for end stage renal disease, called ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. The provider tests the patient's blood to ensure that the dialysis is removing the waste products effectively. The provider takes two blood samples, one at the beginning and the second at the end of dialysis, and compares them. Any reduction in urea due to dialysis is known as urea reduction ratio, URR. Use G5 for a reading greater than 75. **Tips:** Select the proper modifier from G1 to G5 based on the reading. When using modifier G5, you should remember that the provider measures the ratio of urea reduction in a patient undergoing hemodialysis, and the reading is greater than 75. Watch for when G6, ESRD patient for whom less than six dialysis sessions have been provided in a month, applies for Medicare claims instead of G1 to G5 based on the number of dialysis sessions. Medicare requires all hemodialysis claims to show the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.
G6	**ESRD patient for whom less than six dialysis sessions have been provided in a month** **Definition:** Append modifier G6 to a code to show that the patient has had fewer than six sessions of dialysis in a month. Use this modifier for patients with end stage renal disease, or ESRD. **Explanation:** Modifier G6 represents that a patient has undergone fewer than six sessions of dialysis in a month for ESRD. When the kidneys fail to perform their function, dialysis becomes important to remove waste products from the blood. **Tips:** If the provider confirms the patient had dialysis on fewer than six days in a month, modifier G6 applies. Watch for when G6 applies for Medicare claims instead of G1 to G5 for urea reduction ratio based on the number of dialysis sessions. Medicare requires a modifier from G1 to G6 for all hemodialysis claims as part of data collection on the most recent urea reduction ratio for a patient undergoing dialysis. The dialysis facility should monitor the URR monthly in patients who are admitted in the facility. Monitoring of URR in home patients should take place at least quarterly. Providers most commonly append this modifier to 90999, Unlisted dialysis procedure, inpatient or outpatient. It is not necessary to use the modifier on every claim line, but facilities should be sure to include the modifier on at least one revenue code claim line for Medicare. The modifier can affect the processing of the payment of the code.

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Mod	Modifier Description, Definition, Explanation, and Tips
G7	**Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening** **Definition:** Append modifier G7 to an abortion code in cases of pregnancy that result from rape or incest, or when the provider confirms the pregnancy is dangerous for the patient's life. **Explanation:** Modifier G7 represents pregnancy due to rape or incest, or pregnancy that may pose a threat to the woman's life for reasons such as illness or injury. Medicare covers abortions when the patient's life is in danger, and the medical documentation should justify that the pregnancy was a danger to the patient's life. Medicare also covers abortions in cases of rape or incest. **Tips:** Check payer requirements for the codes to which modifier G7 applies. Typical codes include induced abortion codes 59840 to 59857 and 59866, Multifetal pregnancy reduction. If the provider bills these codes without modifier G7, Medicare will not reimburse the claims. Medicare will not reimburse abortions unless the pregnancy is the result of rape or incest, or the pregnancy is life threatening due to patient illness or condition, which may be the result of the pregnancy.
G8	**Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure** **Definition:** Append modifier G8 when the provider performs monitored anesthesia care, called MAC, for a procedure that is deep complex, complicated, or distinctly invasive. **Explanation:** Modifier G8 depicts monitored anesthesia care, or MAC, for a patient undergoing an invasive and complex surgical procedure. The provider administers MAC during a diagnostic or therapeutic procedure. He regularly monitors the physiologic functions during the administration of MAC. The medical record should justify the diagnosis that corresponds to the administration of monitored anesthesia as well as the complex or particularly invasive nature of the surgical procedure. **Tips:** Payers may define the codes the provider may use this modifier with certain anesthesia codes. Examples may include only certain anesthesia codes, 00300, 00400, and 00920. Check payer policies for specific codes. Providers generally report G8 secondary to modifiers AA, Anesthesia services performed personally by anesthesiologist, and QX, CRNA service: with medical direction by a physician. You should not use modifier QS, Monitored anesthesia care service, along with G8 because the latter indicates that the provider has given MAC.
G9	**Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition** **Definition:** Append modifier G9 when the provider performs monitored anesthesia care, called MAC, for a patient with a severe condition relating to the heart and lungs. **Explanation:** Modifier G9 depicts monitored anesthesia care, or MAC, for a patient who has a history of a severe cardiopulmonary condition. The provider administers MAC during a diagnostic or therapeutic procedure. He regularly monitors the physiologic functions during the administration of MAC. The medical record should justify the diagnosis that corresponds to the administration of monitored anesthesia as well as the nature of the cardiopulmonary condition. **Tips:** You should report this modifier with anesthesia codes when appropriate for the patient. Providers generally report G9 secondary to modifiers AA, Anesthesia service performed personally by anesthesiologist, and QX, CRNA service: with medical direction by a physician. You should not use modifier QS, Monitored anesthesia care service, along with G9 because the latter indicates that the provider has given MAC.
GA	**Waiver of liability statement issued as required by payer policy, individual case** **Definition:** Append modifier GA to a code when a payer requires the provider to present an advance beneficiary notice, or ABN, before the patient receives an item or service the provider expects Medicare not to cover. **Explanation:** The provider appends modifier GA to a code to indicate the patient's receipt of an advance beneficiary notice, or ABN, also known as a waiver of liability, for items or services for which the provider believes Medicare will not consider reasonable and necessary and thus deny payment. Medicare denial may involve services subject to a local coverage determination, or LCD, a denial based on the policies of a particular intermediary or carrier. The intent of the ABN is to inform the patient that Medicare certainly or most probably will not pay for an item or service and will assign financial responsibility to the patient for the charges. **Tips:** You can append modifier GA with a code even when the patient refuses to sign an ABN. Medicare prohibits the routine use of an ABN except for certain services that have a frequency limit on coverage.

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Mod	Modifier Description, Definition, Explanation, and Tips
GB	**Claim being resubmitted for payment because it is no longer covered under a global payment demonstration** **Definition:** Append modifier GB to a code when the provider resubmits a claim for payment because a global payment demonstration, a type of bundling program, does not cover the service anymore. **Explanation:** Modifier GB identifies services for which a provider submits a claim under a global payment demonstration and later determines the patient or the service did not qualify for inclusion, so he resubmits the claim under the traditional fee for service program. Global payment demonstration projects reimburse a package price for a group of services based on the expected costs for an episode of care, as a combined quality improvement and cost reduction measure. The original claim may have been a no pay claim, one that identifies services or items for informational purposes without expectation of reimbursement. **Tips:** If another modifier defines the services more distinctly, use GB as the secondary modifier. Modifier GB is an informational modifier, and the provider may submit it with any HCPCS or CPT® code.
GC	**This service has been performed in part by a resident under the direction of a teaching physician** **Definition:** Append modifier GC to a code when a resident performs any portion of a service under the guidance of a teaching provider. **Explanation:** Modifier GC denotes that a resident, a medical graduate working in a teaching facility and under the supervision of a teaching provider, performs a billable service. The teaching provider must be present during the major part of the service and be readily available for other parts of the service. The medical record must include notes from both the resident and the teaching provider, with the teaching provider's notes commenting on the resident's documentation, attesting to the resident's findings, correcting or elaborating as necessary, also known as an attestation. Both the resident and the teaching provider must sign and date the documentation. **Tips:** Modifier GC is an informational modifier, and the provider may submit it with any CPT® or HCPCS code. A cosignature alone does not satisfy CMS guidelines for documenting the presence and extent of involvement of the teaching provider. You can report a service with modifier GC when the teaching provider assists the resident during an entire procedure and reexamines the patient after the procedure, as well. Medicare does not consider a lab pathologist as a teaching provider.
GE	**This service has been performed by a resident without the presence of a teaching physician under the primary care exception** **Definition:** Append modifier GE to a code when a resident sees a patient in an outpatient, or primary care, setting in the absence of a teaching provider. **Explanation:** Modifier GE denotes that the resident renders the services under Medicare's primary care exception rule, which reduces the restrictions on the physical presence requirement for teaching providers. Under certain conditions, Medicare will pay for the three lowest levels of Evaluation and Management, or E/M, services for outpatients seen by a resident without the presence of a teaching provider. The medical record has to demonstrate that the resident observes and appropriately documents the patient's present illness and physical examination and follows a plan of care. The resident must sign the medical documentation. Although the resident provides the E/M service in the absence of the teaching provider, the teaching provider reviews the patient's records and discusses the case with the resident.
GF	**Non-physician (e.g., nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified registered nurse (CRN), clinical nurse specialist (CNS), physician assistant (PA)) services in a critical access hospital** **Definition:** Append modifier GF to a code when a nonphysician provider performs a service in a critical access hospital. **Explanation:** Modifier GF denotes that a nonphysician provider, such as a nurse practitioner, certified registered nurse anesthetist, certified registered nurse, clinical nurse practitioner, or a physician assistant, renders a service in critical access hospital, a facility Medicare certifies under different conditions of participation in the Medicare program than an acute care facility. The nonphysician provider delivers the service in the absence of a physician provider. The medical record must show adequate documentation of the patient's present illness and physical examination and follow a plan of care. The nonphysician provider must sign the medical documentation. **Tips:** Modifier GF is an informational modifier, and the provider may submit it with any CPT® or HCPCS codes. Medicare reimburses 85 percent of the actual service charges to a nonphysician provider. The guidelines for reporting the services of a certified registered nurse anesthetist, or CRNA, may change, so check with your payer for specific information.

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Mod	Modifier Description, Definition, Explanation, and Tips
GG	**Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day** **Definition:** Append modifier GG to a code when the provider performs two distinct mammograms, both screening and diagnostic, on a patient on the same date of service. **Explanation:** Modifier GG denotes that the provider performs screening mammography, an X-ray of the breast done for early detection of breast cancer, and during that exam detects an abnormality for which he performs diagnostic mammography on the same date of service to confirm the presence of cancer or any other defect. The provider does not require a separate order from the treating provider to perform the diagnostic mammography. **Tips:** If the provider converts a screening mammography to a diagnostic mammography but does not perform separate mammography exams, append to the relevant code modifier GH, Diagnostic mammogram converted from screening mammogram on same day. Medicare reimburses both screening and diagnostic mammography services as the modifier is for the purpose of discovering any abnormality in the breast. Medicare denies reimbursement for an add on code if the provider bills it without an appropriate mammography code. Both mammography codes with the appropriate add on code should appear on the same claim. Also, Medicare does not reimburse the service if the provider performs the second mammography only as a quality check or because of a system failure. If the screening services are self referred, the provider should give his own national provider identifier, or NPI, and not the referring provider's NPI for the service to be reimbursable. If the provider takes additional views on the same date of service because of the presence of an implant, payers may consider it as diagnostic views done on the same date. Payers may restrict the codes the provider may use with this modifier to certain mammography codes. Check payer policies for specific codes.
GH	**Diagnostic mammogram converted from screening mammogram on same day** **Definition:** Append modifier GH to a code when the provider performs a single mammogram that begins as a screening mammogram but converts it to a diagnostic mammogram. **Explanation:** Modifier GH denotes that the provider converts a screening mammography, an X-ray of the breast done for early detection of breast cancer, to a diagnostic mammography in a patient on the same date of service as a single exam This may occur if the patient presents for a screening mammogram due to an abnormality, and the provider changes the study from screening to diagnostic. The provider does not take any additional views during the exam. **Tips:** Append modifier GH to a single diagnostic mammography code. Medicare will pay for the diagnostic mammography only and not the screening mammography. If separate mammograms are performed on the same date of service, both screening and diagnostic, due to the discovery of an abnormality on a screening mammogram that requires further delineation, for example, report both exams and append modifier GG to the add on mammography code. Payers may restrict the use of this modifier to certain mammography codes. Check payer policies for specific codes.
GJ	**"Opt-out" physician or practitioner emergency or urgent service** **Definition:** Append modifier GJ to a code when a provider who has elected not to participate in the Medicare program renders services to a patient who presents with an emergency situation. **Explanation:** Modifier GJ denotes a service by a provider rendering emergency treatment to a Medicare patient and has no personal contract with the patient. The provider must submit the claim to Medicare on the patient's behalf and may not bill the patient more than Medicare's limiting charge. Medicare reimburses the patient directly for an unassigned claim. To submit an assigned claim, a provider can complete a CMS855 enrollment without impact on his opt out status for other services. The medical documentation must justify the emergency or urgent nature of the services to the patient. **Tips:** If the opt out provider asks the patient to return for a followup visit, he must ask the patient to sign a personal contract for these services in order to charge the patient for services Medicare will not pay. However, if the patient requires followup of the emergency care, Medicare would continue to pay until the time the patient no longer requires such care.

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Mod	Modifier Description, Definition, Explanation, and Tips
GK	**Reasonable and necessary item/service associated with a GA or GZ modifier** **Definition:** Append modifier GK to a code, in addition to modifier GA or GZ, for upgrades to durable medical equipment, or DME, items or services that the provider deems medically necessary but exceed medical necessity under Medicare's coverage requirements. **Explanation:** The provider appends modifier GK to a code for an item or service associated with modifier GA, Carrier judgment Waiver of liability statement issued as required by payer policy, individual case, or GZ, Item or service expected to be denied as not reasonable and necessary, such as an upgrade to DME. If the provider expects to bill the patient for the difference in the cost, he presents an advance beneficiary notice, or ABN, to the patient and submits the claim with both modifiers. Medicare automatically denies the claim line with modifier GA on the basis of medical necessity but processes the claim line with modifier GK to allow the provider to bill the usual and customary fee for the upgraded items he supplies. Use modifier GZ in association with GK when an ABN is neither obtained nor required. **Tips:** If the provider doesn't intend to charge the patient for the difference in the cost of an upgrade, append modifier GL, Medically unnecessary upgrade provided instead of nonupgraded item, no charge, no advance beneficiary notice, or ABN. Do not use modifier GK for institutional claims that include the use of equipment and supplies, lab and radiology services, and other included items or services. You should append HCPCS modifiers in order on the claim, with GA or GZ before the use of GK. Always give a detailed description of the DME along with the manufacturer and the model number in the claim. Individual payers may specify use of modifier KX, Requirements specified in the medical policy have been met, along with modifier GK. Check with the payer to be sure. Medicare will reject a claim with modifier GK when modifier GA or GZ does not accompany it.
GL	**Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no advance beneficiary notice (ABN)** **Definition:** Append modifier GL to a code for an upgrade to durable medical equipment, or DME, items that the provider deems medically necessary but exceed medical necessity under Medicare's coverage requirements. The provider does not charge the patient for the difference in cost and does not present an advance beneficiary notice, or ABN. **Explanation:** Modifier GL denotes that the provider upgrades a DME item but does not plan to charge the patient for the difference in the cost. The provider essentially bills Medicare for the cost of a nonupgraded item instead of the item he actually provides. The provider adds modifier GL to the HCPCS code that represents the nonupgraded item. **Tips:** Modifier GL does not require submission of an ABN. Individual payers may specify use of modifier KX, Requirements specified in the medical policy have been met, along with modifier GK. Check with the payer to be sure.
GM	**Multiple patients on one ambulance trip** **Definition:** Append modifier GM to a code for the transport of a patient by an ambulance that transports additional patients during the same trip. **Explanation:** Modifier GM denotes the situation in which an ambulance transports multiple patients during a single trip. The medical documentation must include the total number of patients and the particulars of each. The provider should submit the number of miles traveled by each patient along with the origin and destination modifier in the primary position and append modifier GM as the secondary modifier. **Tips:** You should append modifier GM only with ambulance transport claims. Append modifier GM even when only one of the transported patients is a Medicare beneficiary.
GN	**Services delivered under an outpatient speech language pathology plan of care** **Definition:** Append modifier GN to a code when the provider renders services that are part of a speech and language pathology plan of care for an outpatient. **Explanation:** Modifier GN denotes services that are part of an outpatient speech and language pathology plan of care. The provider carries out the service in an outpatient setting. The medical documentation must include a diagnosis code that indicates the patient is suffering from a speech disorder. **Tips:** Append modifier GN only with codes on the list of applicable therapy services for speech and language pathology and that are part of the plan of care for that patient. Medicare pays for services with modifier GN only when the patient receives these services as an outpatient.

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Mod	Modifier Description, Definition, Explanation, and Tips
GO	**Services delivered under an outpatient occupational therapy plan of care** **Definition:** Append modifier GO to a code when the provider renders services that are part of an occupational therapy plan of care for an outpatient. **Explanation:** Modifier GO denotes services that are part of an outpatient occupational therapy plan of care. The provider carries out the service in an outpatient setting. The medical documentation must include a diagnosis code that is consistent with a condition that requires occupational therapy. **Tips:** Append modifier GO only with codes on the list of applicable therapy services for occupational therapy and that are part of the plan of care for that patient. Medicare pays for services with modifier GO only when the patient receives these services as an outpatient.
GP	**Services delivered under an outpatient physical therapy plan of care** **Definition:** Append modifier GP to a code when the provider renders services that are part of a physical therapy plan of care for an outpatient. **Explanation:** Modifier GP denotes services that are part of an outpatient physical therapy plan of care. The provider carries out the service in an outpatient setting. The medical documentation must include a diagnosis code that is consistent with a condition that requires physical therapy. **Tips:** Append modifier GP only with codes on the list of applicable therapy services for physical therapy and that are part of the plan of care for that patient. Medicare pays for services with modifier GP only when the patient receives these services as an outpatient.
GQ	**Via asynchronous telecommunications system** **Definition:** Append modifier GQ for services rendered to a patient via an asynchronous telecommunications system, one that does not involve live two way communication. **Explanation:** Modifier GQ denotes healthcare services provided via an asynchronous communication method. Asynchronous communication does not take place in real time. An example of delivery of a service via asynchronous communication includes a provider at a distant location, even in another state, who receives X-ray images transmitted across a secure network and then transmits the report of his reading of the images for later review by the patient's primary care provider. An exchange of email between a patient and a provider also constitute asynchronous telecommunication services. **Tips:** See payer guidelines for specific codes that require or are eligible for the GQ modifier.
GR	**This service was performed in whole or in part by a resident in a department of veterans affairs medical Centers or clinic, supervised in accordance with VA policy** **Definition:** Append modifier GR to codes for services rendered to a patient by a resident provider in a Veterans Administration, or VA, facility. **Explanation:** Modifier GR denotes services rendered in a VA facility by a resident provider, a medical graduate working under the supervision of an attending provider. The VA facility appends modifier GR to the appropriate HCPCS code for the service and submits the claim under the name of the attending provider. **Tips:** Modifier GR on VA claims has the same consequences as modifier GC, This service has been performed in part by a resident under the direction of a teaching physician, and modifier GE, This service has been performed by a resident without the presence of a teaching physician under the primary care exception. VA claims do not use modifier GC, This service has been performed in part by a resident under the direction of a teaching physician, or modifier GE, This service has been performed by a resident without the presence of a teaching physician under the primary care exception modifiers.
GS	**Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level** **Definition:** Append modifier GS to a code when the provider reduces and maintains the dosage of erythropoietin, a hormone that stimulates the production of red blood cells, in response to an elevation in the level of hematocrit or hemoglobin in a patient with anemia of chronic kidney disease. **Explanation:** Modifier QS denotes a reduction in the dose of erythropoietin, or EPO, in response to an elevation in hematocrit, which measures the volume of red blood cells, or hemoglobin, which measures the amount of hemoglobin, a protein in red blood cells, for the treatment of anemia of chronic kidney disease. Medicare closely monitors the administration of erythropoietin stimulating agents, or ESAs, which at higher levels than necessary are ineffective and lead to complications, such as blood clots. **Tips:** Payers may designate only specific codes the provider may use with this modifier, such as injection codes J0881, J0882, J0885, and Q4081. Check payer policies for specific codes. Reimbursement depends upon the dosage reported, but Medicare automatically reduces reimbursement by 25 percent if the provider submits the claim without modifier GS.

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Mod	Modifier Description, Definition, Explanation, and Tips
GT	**Via interactive audio and video telecommunication systems** **Definition:** Append modifier GT for telehealth, the use of an interactive audio and video communication system between a distant provider and the patient to execute a plan of care. **Explanation:** Modifier GT denotes a telehealth system, real time audiovisual conferencing between a patient and provider, in which a provider at a distant site provides healthcare services for a patient at a different location, including an examination. The patient must be an active participant in a telehealth visit, but it is not necessary for the provider to personally perform all portions of a telehealth service, as his clinical staff may provide some services. **Tips:** Check payer policy to determine whether the payer allows use of modifier GT. For instance, the payer may limit use of the modifier to certain settings.
GU	**Waiver of liability statement issued as required by payer policy, routine notice** **Definition:** Append modifier GU to a code when a payer requires the provider to present an advance beneficiary notice, or ABN, as a routine notice before the patient receives an item or service the provider expects Medicare not to cover. **Explanation:** Modifier GU indicates the patient's receipt of an advance beneficiary notice, or ABN, also known as a waiver of liability, as a routine notice for items or services that the provider believes Medicare will not consider reasonable and necessary and thus deny payment. The intent of the ABN is to inform the patient that Medicare certainly or most probably will not pay for an item or service and will assign financial responsibility to the patient for the charges. Medicare generally prohibits routine notices except for items and services that are experimental, subject to frequency limitations for coverage, or always denied for medical necessity. Durable medical equipment and supplies without a supplier number also fall under this exception. **Tips:** For an ABN issued for a specific item or service, rather than as a routine notice, report modifier GA, Waiver of liability statement issued as required by payer policy, individual case.
GV	**Attending physician not employed or paid under arrangement by the patient's hospice provider** **Definition:** A provider appends modifier GV to report that the patient's attending physician, is not an employee, or is not volunteering at the hospice provider of the patient. The attending physician may be a doctor specialized in a particular field, or a nurse practitioner. **Explanation:** A provider appends modifier GV when a provider performs a service related to the problem for which a patient was admitted into hospice. This provider is not a part of the hospice provider or their employee and provides services independently of the hospice. **Tips:** A patient, who opts for hospice coverage, waives his Medicare Part B payment for any treatment of terminal illness during the hospice period. However, there is an exception for the provider who attends the patient, referred to as attending physician in the modifier descriptor, who is not an employee of the hospice and is in no way attached to the hospice. The attending provider may also include a nurse practitioner, besides specific specialty providers.
GW	**Service not related to the hospice patient's terminal condition** **Definition:** A provider appends modifier GW to identify a service that the provider renders to a patient that is not related to the patient's terminal condition. **Explanation:** A provider appends modifier GW when the provider delivers a service, not related to the problem for which the patient was admitted into the hospice. This provider is not a part of the hospice or an employee of the hospice and provides the services independently. **Tips:** For Medicare payment, report modifier GW, if the patient's condition for hospice care is not related to the service.
GX	**Notice of liability issued, voluntary under payer policy** **Definition:** Append modifier GX to report issuance of a voluntary, or optional, advance beneficiary notice, or ABN, for any service not covered. **Explanation:** Modifier GX indicates the patient's receipt of a notice of liability, usually in the form of an advance beneficiary notice, or ABN, that is not required by payer policy, to let the patient know of his financial responsibility for items or services that Medicare never covers. The provider can bill the patient for items and services not subject to Medicare coverage whether or not the provider issues an ABN. **Tips:** Medicare reimburses modifier GX only if it is used secondary to modifier TS, Followup service, or modifier GY, Item or service statutorily excluded, does not meet the definition of any Medicare benefit, or for nonMedicare insurers, is not a contract benefit. If the patient has a secondary insurance that pays for the service, Medicare denies the reimbursement so that the provider can then submit the claim to the second payer. Medicare denies the reimbursement of modifier GX if the service is not covered by medical necessity.

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Mod	Modifier Description, Definition, Explanation, and Tips
GY	**Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for Non-Medicare insurers, is not a contract benefit** **Definition:** Append modifier GY to report services and supplies excluded by Medicare regulations or which are not a contract benefit for other payers. **Explanation:** Modifier GY denotes items or services not covered by Medicare under any circumstance, and the provider expects a denial. Medicare does not require the provider to present an advance beneficiary notice, or ABN, to bill the patient for these items or services. Some examples of items and services statutorily excluded by Medicare include acupuncture, cosmetic surgery, hearing aids, and most types of dental care. **Tips:** Modifier GY indicates that a particular service is not covered by Medicare. There is no need to submit an ABN to use modifier GY. You should not use modifier GY with add on codes.
GZ	**Item or service expected to be denied as not reasonable and necessary** **Definition:** Append modifier GZ when the provider expects a Medicare denial for an item or service as not a medical necessity but does not provide the patient with an advance beneficiary notice, or ABN. **Explanation:** Modifier GZ denotes an item or service for which the provider expects Medicare to deny reimbursement as not meeting the requirements of Medicare for medical necessity but for which the provider does not present the patient with an ABN. The provider may not bill the patient for the denied charges but can request a review. **Tips:** This is an informational modifier. Medicare processes claims with modifier GZ just like other claims. If the provider appends both modifier GZ and modifier GA, Waiver of liability statement issued as required by payer policy, individual case, on the same claim line, it is invalid and the claim is not reimbursable.
H9	**Court-ordered** **Definition:** Append modifier H9 to a code to indicate that a particular service was ordered by the court. **Explanation:** Modifier H9 denotes any service a patient undergoes by court order, such as a psychiatric evaluation, substance abuse treatment, foster care services, and others. **Tips:** For court ordered medical testimony, append modifier H9 to 99075, Medical testimony.
HA	**Child/adolescent program** **Definition:** Append modifier HA to designate the delivery of services through a program specifically designed for children and or adolescents. **Explanation:** Modifier HA denotes services a provider renders to a child or adolescent as part of a program designed specifically for children and or adolescents. Medicare does not cover this modifier, but Medicaid programs typically require modifier HA to indicate services provided to a child or adolescent. Specific use of the HA modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HA modifier.
HB	**Adult program, non-geriatric** **Definition:** Append modifier HB to designate the delivery of services to adult individuals, not including the elderly, as part of a care program for adults. **Explanation:** Modifier HB denotes services rendered to an adult participant a medical or psychiatric care program designed for adults. These include programs funded by Medicaid and other agencies. Use of the HB modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HB modifier.
HC	**Adult program, geriatric** **Definition:** Append modifier HC to designate services given to adult participants in a care program specifically designed for the elderly. **Explanation:** Modifier HC denotes services rendered to adults in a geriatric medical or psychiatric care program. These include programs funded by Medicaid and other agencies. Use of the HC modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HC modifier.
HD	**Pregnant/parenting women's program** **Definition:** A provider appends modifier HD to services designed for pregnant women or women with dependent children. **Explanation:** A provider appends this modifier to identify the services that he provides as a part of a program for women who are pregnant or women who have children. The services may include treatment for postpartum depression screening, or antepartum visits as well as alcohol and or drug detoxification, and behavioral health. **Tips:** Modifier HD is not payable by Medicare.

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Mod	Modifier Description, Definition, Explanation, and Tips
HE	**Mental health program** **Definition:** Append modifier HE when the provider provides a particular service through a program specifically designed for the provision of mental health services. **Explanation:** Modifier HE denotes a service provided to a participant in a mental health services program, including those administered by state and local agencies. Use of the HE modifier may vary depending upon the program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HE modifier.
HF	**Substance abuse program** **Definition:** Append modifier HF when the provider performs services for a participant in a substance abuse program. **Explanation:** Modifier HF denotes services provided to a participant in a substance abuse program. Specific use of the HF modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HF modifier.
HG	**Opioid addiction treatment program** **Definition:** Append modifier HG when the provider performs services for a participant in an opioid addiction treatment program. **Explanation:** Modifier HG denotes services provided to a participant in an opioid addiction treatment program, including long term residential programs, outpatient programs, and methadone clinics. Specific use of the HG modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HG modifier.
HH	**Integrated mental health/substance abuse program** **Definition:** Append modifier HH when the provider performs services for a participant in a combined mental health and substance abuse program. **Explanation:** Modifier HH denotes services provided to a participant in an integrated mental health and substance abuse program, including long term residential programs, outpatient programs, and others. Specific use of the HH modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HH modifier.
HI	**Integrated mental health and intellectual disability/developmental disabilities program** **Definition:** Append modifier HI when the provider performs services for a participant in a program specifically for individuals with intellectual and or developmental disabilities. **Explanation:** Modifier HI denotes services provided to a participant in an intellectual disability and or developmental disabilities program. Specific use of the HI modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require or are eligible for the HI modifier.
HJ	**Employee assistance program** **Definition:** Append modifier HJ when the provider performs services for a participant in an employee assistance program. **Explanation:** Modifier HJ denotes services provided to a participant in an employee assistance program, or EAP. Specific use of the HJ modifier varies depending upon the EAP and its sponsoring agency and payer, which may be a state Medicaid program. **Tips:** See payer guidelines for specific codes that require or are eligible for the HJ modifier.
HK	**Specialized mental health programs for high-risk populations** **Definition:** Append modifier HK when the provider performs services for a participant in a mental health program designed for groups of people who are at greater risk for mental illness. **Explanation:** Modifier HK denotes services provided to individuals who participate in a specialized mental health program for high risk populations, such as the elderly, low income families, substance abusers, and people with a history of mental illness. Specific use of the HK modifier varies depending upon the program and its sponsoring agency and payer. **Tips:** See payer guidelines for specific codes that require the HK modifier.

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Mod	Modifier Description, Definition, Explanation, and Tips
HL	**Intern** **Definition:** Append modifier HL to the code when an intern performs a behavioral health service. **Explanation:** Append this modifier to a behavioral health service code to show that the provider is an intern. The condition of the patient may require an intern to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of a provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers may base payment for services on the provider's education level.
HM	**Less than bachelor degree level** **Definition:** Append modifier HM to the code when a provider with less than a bachelor's degree level of education performs a behavioral health service. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds less than a bachelor's degree level of education. The condition of the patient may require a provider with less than a bachelor's degree level of education to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of a provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers may base payment for services on the provider's education level.
HN	**Bachelor's degree level** **Definition:** Append modifier HN to the code when a provider who holds a bachelor's degree performs a behavioral health service. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds a bachelor's degree. The condition of the patient may require a provider with a bachelor's degree level of education to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of a provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers may base payment for services on the provider's education level.
HO	**Master's degree level** **Definition:** Append modifier HO to the bill for any behavioral health service by a provider with a master's degree. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds a master's degree. The condition of the patient may require the provider of master's degree level to render the service. **Tips:** HCPCS modifiers HL through HP identify the level of education of the provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers do base payment for services on the provider's education level. If the provider is an intern, use modifier HL, Intern. If the provider holds less than a bachelor's degree, append modifier HM, Less than bachelor degree level. If the provider holds a bachelor's degree, append modifier HN, Bachelors degree level. If the provider is of a doctoral level, use modifier HP, Doctoral level. You should append modifier HO with the code H2011, Crisis intervention service, per 15 minutes. This code includes crisis intervention in an emergency setting for patients and the families of patients who exhibit extreme mental duress with disturbed thoughts, mood, or behavior.
HP	**Doctoral level** **Definition:** Append modifier HP to a bill for any behavioral health service that a provider with a doctoral degree, e.g., PhD, provides to the patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider holds a doctoral level degree, i.e., PhD. The medical documentation should justify the treatment by a provider who holds a doctoral degree. The condition of the patient may require the provider of doctoral level to render the service. The doctoral level provider offers services to improve the mental health of the patient. **Tips:** HCPCS modifiers HL through HP identify the level of education of the provider who performs psychological or psychiatric services. These codes are not covered by Medicare, but some carriers do base payment for services on the provider's education level. When using the modifier HP, you should remember that the provider, who renders the service for behavioral health, must be of doctoral level. If the provider is an intern, use modifier HL, Intern. If the provider holds less than a bachelor's degree, append modifier HM, Less than bachelor degree level. If the provider holds a bachelor's degree, append modifier HN, Bachelors degree level. If the provider is of a masters degree level, use modifier HO, Masters degree level.

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Mod	Modifier Description, Definition, Explanation, and Tips
HQ	**Group setting** **Definition:** Append modifier HQ to a service when the provider renders service for behavioral care to patients in a group setting. **Explanation:** Append this modifier to a behavioral health service code to show that the provider rendered the behavioral health services in a group setting. The medical documentation should justify the treatment of the patients in a group setting by a provider who is not a physician. The patient's condition may necessitate the service for behavioral healthcare. The provider offers this service to improve the mental and behavioral health of the patient in a group setting. **Tips:** You should append modifier HQ with codes that include services such as comprehensive community support, psychosocial rehabilitation, family training, developmental therapy, or group supported living.
HR	**Family/couple with client present** **Definition:** Append modifier HR to a service in which the provider renders therapy to the family or couples in the presence of a client. **Explanation:** Append this modifier to a behavioral health service code to show that the provider offers therapy to a family or couple in the presence of a client. The medical documentation must justify the mental health therapy for the family or couple with the client present. The client refers to the patient who requires the therapy. The provider offers mental health therapy to the patient in the presence of his family. The provider renders this service to improve the mental and behavioral health of the patient. **Tips:** If the patient is not present at the therapy session, use modifier HS. You should append modifier HR to the services that include services such as mental health therapy, psychiatry, activity therapy, or other health services.
HS	**Family/couple without client present** **Definition:** Append modifier HR to a service in which the provider renders therapy to the family or couple in the absence of a client. **Explanation:** Append this modifier to a behavioral health service code to show that the provider met with the family or partner of a client without the client present. The medical documentation must justify the mental health therapy of the families or couple in the absence of a client. The client refers to the patient who needs the therapy. The provider renders this service to improve the mental and behavioral health of the patient. **Tips:** If the patient is present for the therapy session, use the modifier HR, Family or couple with client present. You should append modifier HS to the services that include services such as mental health therapy, psychiatry, activity therapy, or other health services.
HT	**Multi-disciplinary team** **Definition:** Append modifier HT to a service when a multidisciplinary team renders service for behavioral care to the patient. **Explanation:** Append this modifier to a behavioral health service code to show that a team of providers with different areas of expertise treated the patient. The medical documentation should justify the treatment of the patients by a multidisciplinary team of providers, who are not physicians. The patient's condition may necessitate the service for behavioral healthcare. The multidisciplinary team refers to the group of individuals from different fields and come together for assessment and consultations of patients. The providers offer this service to improve the mental and behavioral health of the patient in a multidisciplinary team. **Tips:** You should append modifier HT with codes that include services such as comprehensive community support, psychosocial rehabilitation, family training, developmental therapy, or group supported living.

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Mod	Modifier Description, Definition, Explanation, and Tips
HU	**Funded by child welfare agency** **Definition:** Append modifier HU to the service when the provider receives funds from a child welfare agency for therapy provided to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a child welfare agency for therapy that he provides patients. The medical documentation must validate that the child welfare agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from a child welfare agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HU, you should remember that the child welfare agency funds the service. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HV	**Funded state addictions agency** **Definition:** Append modifier HV to the service when the provider receives funds from a state addictions agency, to offer therapy to the patients. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a state addictions agency for therapy that he offers patients. The medical documentation must validate that the state addictions agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from a state addictions agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HV, you should remember that the state addictions agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HW	**Funded by state mental health agency** **Definition:** Append modifier HW to the service when the provider receives funds from a state mental health agency to provide therapy for a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a state mental health agency for therapy that he provides patients. The medical documentation must validate that the state mental health agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from state mental health agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HW, you should remember that the state mental health agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.

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Mod	Modifier Description, Definition, Explanation, and Tips
HX	**Funded by county/local agency** **Definition:** Append modifier HX to the service when the provider receives funds from a county or local agency to provide therapy to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a county or local agency for therapy that he provides patients. The medical documentation must validate that the county or local agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from county or local agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HX, you should remember that the county or local agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HY	**Funded by juvenile justice agency** **Definition:** Append modifier HY to the service when the provider receives funds from a juvenile justice agency to provide therapy to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a juvenile justice agency for therapy that he provides patients. The medical documentation must validate that the juvenile justice agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from juvenile justice agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HY, you should remember that the juvenile justice agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the criminal justice agency funds the service code, use modifier HZ, Funded by criminal justice agency.
HZ	**Funded by criminal justice agency** **Definition:** Append modifier HZ to the service when the provider receives funds from the criminal justice agency to provide therapy to a patient. **Explanation:** Append this modifier to a behavioral health service code to show that the provider receives funds from a criminal justice agency for therapy that he provides patients. The medical documentation must validate that the criminal justice agency funds the treatment service for the patient. It is the agency that arranges the financing for the therapy that the patient undergoes. The provider utilizes the resources from criminal justice agency and offers mental and behavioral healthcare to the patient. **Tips:** HCPCS modifiers HU through HZ identify government and other agency funding for mental health services. When using the modifier HZ, you should remember that the criminal justice agency funds the service. If the child welfare agency funds the service code, use modifier HU, Funded by child welfare agency. If the state addictions agency funds the service code, use modifier HV, Funded state addictions agency. If the provider receives funds from state mental health agency, use modifier HW, Funded by state mental health agency. If the county or local agency finances the service code, append modifier HX, Funded by county or local agency. If the juvenile justice agency offers money for the service code, append modifier HY, Funded by juvenile justice agency.

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Mod	Modifier Description, Definition, Explanation, and Tips
J1	**Competitive acquisition program no-pay submission for a prescription number** **Definition:** Providers enrolled in the Competitive Acquisition Program, or CAP, for drugs and biologicals append modifier J1 to the code for a drug, along with number of prescriptions. **Explanation:** The medical documentation should justify the number of prescriptions of a drug that the provider administers to the patient. Modifier J1 indicates that the drug is a no pay item and the provider obtains it through CAP. This reflects that the patient does not pay for the drug. Competitive Acquisition Program refers to a program in which the provider buys and bills for certain drugs and biologicals obtained from approved CAP vendors and administer them to the beneficiary patient. Although this modifier is still active, the CAP program was suspended at the end of 2008. **Tips:** When using modifier J1, the provider who prescribes the drug must be enrolled in the Competitive Acquisition Program. You can combine the modifier J1 with modifier J2, Competitive Acquisition Program, restocking of emergency drugs after emergency administration, on the same line. The CAP is an alternative to the average sales price, or ASP, methodology for acquiring certain Part B drugs administered in physicians' offices. Participating CAP providers must obtain all CAP drugs from an Approved CAP Vendor. Drugs that are not available through the CAP can be purchased through the ASP methodology. The CAP program was suspended on December 31, 2008.
J2	**Competitive acquisition program, restocking of emergency drugs after emergency administration** **Definition:** Providers enrolled in the Competitive Acquisition Program, or CAP, for drugs and biologicals append modifier J2 when the provider restocks drugs administered in an emergency situation. **Explanation:** The medical documentation should justify that the patient had an immediate requirement for the drug, which the provider administers to the patient. Modifier J2 indicates that the provider needs to restock the emergency drugs for when the vendor cannot deliver the drug on time or when an urgent need for the drug occurs. Competitive Acquisition Program refers to a program in which the provider buys and bills for certain drugs and biologicals obtained from approved CAP vendors and administer them to the beneficiary patient. Although this modifier is still active, the CAP program was suspended at the end of 2008. **Tips:** When using modifier J2, the provider who prescribes the drug must be enrolled in the competitive acquisition program. You can combine the modifier J2 with modifier J1, Competitive acquisition program no pay submission for a prescription number, on the same line. The CAP is an alternative to the average sales price, or ASP, methodology for acquiring certain Part B drugs administered in physicians' offices. Participating CAP providers must obtain all CAP drugs from an Approved CAP Vendor. Drugs that are not available through the CAP can be purchased through the ASP methodology. The CAP program was suspended on December 31, 2008.
J3	**Competitive acquisition program (CAP), drug not available through CAP as written, reimbursed under average sales price methodology** **Definition:** Append modifier J3 when the provider is enrolled in the Competitive Acquisition Program, or CAP, for drugs and biologicals, but the drug is not available from a CAP vendor; reimbursement will be made using the average sales price, or ASP, methodology. **Explanation:** The medical documentation should justify that the drug is not available from the approved CAP vendor, and the CAP enrolled provider orders and purchases the drug or biological from a source other than the approved CAP vendor. Competitive Acquisition Program refers to a program in which the provider buys and bills for certain drugs and biologicals obtained from approved CAP vendors and administer them to the beneficiary patient. Although this modifier is still active, the CAP program was suspended at the end of 2008. **Tips:** When using modifier J3, the provider who prescribes the drug must be enrolled in the Competitive Acquisition Program. You cannot combine modifier J3 with modifier J1, Competitive Acquisition Program no pay submission for a prescription number, or modifier J2, Competitive Acquisition Program, restocking of emergency drugs after emergency administration, on the same line. If the provider orders the drug from an alternate method, i.e., other than the approved CAP vendor, and the patient is a primary Medicare beneficiary, use modifier M2, Medicare secondary payer, MSP. The CAP is an alternative to the average sales price, or ASP, methodology for acquiring certain Part B drugs administered in physicians' offices. Participating CAP physicians must obtain all CAP drugs from an Approved CAP Vendor. Drugs that are not available through the CAP can be purchased through the ASP methodology. The CAP program was suspended on December 31, 2008.

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Mod	Modifier Description, Definition, Explanation, and Tips
J4	**DMEPOS item subject to DMEPOS competitive bidding program that is furnished by a hospital upon discharge** **Definition:** Append modifier J4 when the provider supplies durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, to a Medicare patient upon discharge from the hospital. Report this modifier only if the patient's permanent residence is in a competitive bidding area, or CBA. **Explanation:** Modifier J4 indicates that a Medicare patient received DMEPOS, such as a walker or related accessories, upon discharge from the hospital. Patients may use the equipment in their homes, since part A payment for inpatient hospital services includes the payment for these items. The competitive bidding program covers the changes for certain durable medical equipment, prosthetics, orthotics, and supplies for payment by Medicare to the suppliers. It converts outdated prices to lower and more accurate prices. **Tips:** When using modifier J4, the provider who offers the DMEPOS to the patient on discharge from the hospital cannot be a contract supplier. Providers most commonly append this modifier to HCPCS codes that refer to the use of durable medical equipment. Use the modifier J4 if the patient, who receives the DMEPOS, permanently resides in a competitive bidding area, even if the provider who supplies the equipment is outside the competitive bidding area.
J5	**Off-the-shelf orthotic subject to dmepos competitive bidding program that is furnished as part of a physical therapist or occupational therapist professional service** **Definition:** Append modifier J5 when the provider supplies an off-the-shelf orthotic subject to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Report this modifier when the orthotic is furnished as part of a physical therapist or occupational therapist professional service. **Explanation:** Modifier J5 indicates that a Medicare patient received an off-the-shelf orthotic as a part of a physical therapist or occupational therapist professional service. Off-the-shelf orthotics are prefabricated supplies that require minimal self-adjustment to fit the patient and ensure that the treatment goals are met. Examples are certain leg, arm, back, and neck braces. The orthotic must be subject to the DMEPOS Competitive Bidding Program for the modifier to apply. Under the program, certain items are subject to competitive bidding, and Medicare awards contracts to suppliers who offer the best price and meet quality and financial standards. **Tips:** Medicare identifies the specific off-the-shelf (OTS) orthotic codes included in a competitive bidding program.
JA	**Administered intravenously** **Definition:** CMS encourages providers to append modifier JA to all intravenous injection codes, but especially when the provider administers erythropoiesis stimulating agents, or ESAs, intravenously to patients with end stage renal disease, or ESRD. Modifier JA is informational and does not affect payment. **Explanation:** Use modifier JA to report the administration of drugs covered by HCPCS intravenous injection codes. CMS encourages providers who intravenously administer erythropoiesis stimulating agents to patients with end stage renal disease to append this modifier for tracking purposes. Any claim for erythropoiesis stimulating agents or ESA administration, ESRD facilities must include the hemoglobin and or hematocrit values, the route of administration using the JA or JB modifier code, and the Kt/V, calculated using a specified formula, to indicate the adequacy of dialysis. When the kidneys fail to function, the patient undergoes dialysis to remove waste products from the blood. The provider collects a blood sample to measure the level of hemoglobin and hematocrit before the dialysis treatment. If the patient is found to be anemic, the provider administers intravenous or subcutaneous ESAs. ESAs stimulate red blood cell production in patients with anemia that results from conditions such as chronic kidney failure, chemotherapy, and other treatments. It includes agents like epoetin alfa and darbepoetin alfa. **Tips:** If the provider uses subcutaneous route to administer the ESAs, append modifier JB, Administered subcutaneously, with the code. Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081, Injection, epoetin alfa, 100 units, for ESRD on dialysis, or J0882, Injection, darbepoetin alfa, 1 mcg, for ESRD on dialysis, on a 72X type of bill will result in that bill being returned to the provider.

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Mod	Modifier Description, Definition, Explanation, and Tips
JB	**Administered subcutaneously** **Definition:** CMS encourages providers to append modifier JB to all subcutaneous injection codes, but especially when the provider administers erythropoiesis stimulating agents, or ESAs, intravenously to patients with end stage renal disease, or ESRD. Modifier JB is informational and does not affect payment. **Explanation:** Use modifier JB to report the administration of drugs covered by HCPCS subcutaneous injection codes. CMS encourages providers who subcutaneously administer erythropoiesis stimulating agents to patients with end stage renal disease to append this modifier for tracking purposes. Any claim for erythropoiesis stimulating agents or ESA administration, ESRD facilities must include the hemoglobin and or hematocrit values, the route of administration using the JA or JB modifier code, and the Kt/V, calculated using a specified formula, to indicate the adequacy of dialysis. When the kidneys fail to function, the patient undergoes dialysis to remove waste products from the blood. The provider collects a blood sample to measure the level of hemoglobin and hematocrit before the dialysis treatment. If the patient is found to be anemic, the provider administers intravenous or subcutaneous ESAs. ESAs stimulate red blood cell production in patients with anemia that results from conditions such as chronic kidney failure, chemotherapy, and other treatments. It includes agents like epoetin alfa and darbepoetin alfa. **Tips:** If the provider uses intravenous route to administer the ESAs, append modifier JA, Administered intravenously, with the code. Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081, Injection, epoetin alfa, 100 units, for ESRD on dialysis, or J0882, Injection, darbepoetin alfa, 1 microgram, for ESRD on dialysis, on a 72X type of bill will result in that bill being returned to the provider.
JC	**Skin substitute used as a graft** **Definition:** Append modifier JC to codes when the provider uses a skin substitute as a graft to replace debrided tissue in a wound. **Explanation:** Modifier JC indicates that the provider replaced debrided tissue in a wound with a skin substitute. The medical documentation should justify the use of a skin substitute as a graft to replace the debrided tissue in a wound. The provider implants or inserts the skin substitute into the wound to aid healing, and replace the devitalized or nonviable tissue. **Tips:** Providers most commonly append this modifier to HCPCS codes for skin substitutes when used to treat wounds, infections, or ulcers. The substitute typically replaces the dermal and epidermal layers of the skin. If the provider uses the skin substitute as a covering, and not as a graft, append modifier JD, Skin substitute not used as a graft. Submit HCPCS modifier JC or HCPCS modifier JD with HCPCS codes Q4100, Skin substitute, not otherwise specified as well as Q4101 through Q4121 and Q4136 to Q4137, codes that specify brands or types of skin substitutes.
JD	**Skin substitute not used as a graft** **Definition:** Append modifier JD when the provider uses a skin substitute to cover wound due to inadequate skin available for coverage. **Explanation:** Modifier JD indicates that the provider used a skin substitute because of inadequate skin available to cover the wound. The medical documentation should justify the use of skin substitute to cover the wound. The provider uses the skin substitute as a dressing to cover the wound, to help protect it from contamination, and to replace defective tissue. The provider repairs or replaces the defective tissue with an artificial skin substitute, which aids in the healing process. **Tips:** When using the modifier JD, the skin substitute fits over the wound site. Providers most commonly append this modifier to HCPCS codes for skin substitutes when used to treat wounds, infections, or ulcers. The substitute typically replaces the dermal and epidermal layers of the skin. If the provider uses the skin substitute as a graft, and not as a covering, append modifier JC, Skin substitute used as a graft. Submit HCPCS modifier JC or HCPCS modifier JD with HCPCS codes Q4100, Skin substitute, not otherwise specified as well as Q4101 through Q4121 and Q4136 to Q4137, codes that specify brands or types of skin substitutes.

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Mod	Modifier Description, Definition, Explanation, and Tips
JE	**Administered via dialysate** **Definition:** Append modifier JE when the provider administers drugs and biologicals mixed in the dialysate solution, through any route of dialysate administration, to patients with end stage renal disease, or ESRD. **Explanation:** Modifier JE indicates that the provider administered drugs or biologicals to a patient with end stage renal disease, or ESRD, via the dialysate. The provider compounds the dialysate with injectable drugs and biologicals to administer to the patient. When the kidneys fail to function properly, patients undergo dialysis to remove waste products from the blood. The process of dialysis uses a fluid, called dialysate, which contains soluble substances and helps to remove toxic products from the blood. **Tips:** If the provider administers drugs or biologicals to a patient without ESRD, append modifier AY, Item or service furnished to an ESRD patient that is not for the treatment of ESRD.
JK	**One month supply or less of drug or biological** **Definition:** Append modifier JK to a code when you report a one-month supply or less of a drug or biological. **Explanation:** Append this modifier to a code to indicate to the payer that you are reporting a one-month supply or less of a drug or biological. Check individual payer and contractor reporting rules regarding proper use of this modifier, as rules may vary. **Tips:** The original intent of this modifier was to identify the supply of insulin subject to a coinsurance cap.
JL	**Three month supply of drug or biological** **Definition:** Append modifier JL to a code when you report a three-month supply of a drug or biological. **Explanation:** Append this modifier to a code to indicate to the payer that you are reporting a three-month supply of a drug or biological. Check individual payer and contractor reporting rules regarding proper use of this modifier, as rules may vary. **Tips:** The original intent of this modifier was to identify the supply of insulin subject to a coinsurance cap.
JW	**Drug amount discarded/not administered to any patient** **Definition:** Append modifier JW when billing for a drug or biological for which the provider discards the remainder of a single dose vial after administering a portion of the drug to the patient. **Explanation:** Append this modifier to the drugs and biologicals codes to show that the provider administers the necessary or prescribed amount of a drug supplied in a single dose vial and discards the remaining amount of the drug. The medical documentation must include the amount of the drug that the provider discards, along with the reason for the same. **Tips:** Some drugs are billed by dose, so if the dose administered is less than the amount of a drug supplied in a single use vial, append modifier JW to bill the amount of the drug discarded. You must bill the amount of drug used and the amount discarded separately. Other drugs are billed by units, as specified in the code's official descriptor. For these drugs, if the administered dose is less than the amount specified in the OD, the provider bills for the unit specified in the OD. Do not append the JW modifier in this case because the provider is paid by the unit specified in the OD and not the amount actually administered.
JZ	**Zero drug amount discarded/not administered to any patient** **Definition:** Append modifier JZ to the code for a drug or biological in a single-use vial or single-use package when there is no discarded amount after administering the agent to the patient. **Explanation:** Append this modifier to the supply code for a drug or biological to show that there is no discarded amount to report after administration to the patient. This code applies when the agent is in a single-use vial or single-use package. **Tips:** See modifier JW when the provider discards the remainder of a single-use vial or single-use package after administering a portion to the patient.

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Mod	Modifier Description, Definition, Explanation, and Tips
K0	**Lower extremity prosthesis functional level 0 - does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility** **Definition:** Append modifier K0 to cover the use of lower limb prosthetic device that does not contribute to the patient's ability to move safely with or without any support, nor does the prosthetic device enhance the patient's quality of life or mobility. **Explanation:** Append this modifier to a claim for a lower limb prosthesis to indicate a functional state of zero for the patient for whom the provider supplies the prosthesis. The medical documentation must illustrate that the functional level of the patient, even with the lower limb prosthesis, is zero, i.e., the patient cannot move about independently, or even with assistance, and the prosthesis device does not improve the quality of life of the patient. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prostheses and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K2 indicates that the patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces, typical of the limited community ambulator. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
K1	**Lower extremity prosthesis functional level 1 - has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator** **Definition:** Append modifier K1 to cover the use of lower limb prosthetic device that contributes to the patient's ability to move safely on level surface at a fixed pace, typical of a patient who goes about his normal activities within his home. **Explanation:** Append this modifier to a claim for lower limb prosthesis to indicate a functional state of one for the patient for whom the provider supplies the prosthesis. The medical documentation must illustrate that the functional level of the patient with the lower limb prosthesis is one, i.e., the patient is able to move about independently on level surfaces at a fixed rhythm with the help of the prosthetic device. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient has a functional level of zero, i.e., the patient cannot move about independently, or even with assistance, and the prosthetic device does not improve the quality of life of the patient. Modifier K2 indicates that the patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces, typical of the limited community ambulator. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.

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Mod	Modifier Description, Definition, Explanation, and Tips
K2	**Lower extremity prosthesis functional level 2 - has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces, typical of the limited community ambulator** **Definition:** Append modifier K2 to a code for a lower limb prosthetic device that contributes to the patient's ability to move safely over low level barriers, such as stairs or other uneven surfaces. **Explanation:** Append this modifier to a claim for lower limb prosthesis to indicate a functional state of two for a patient for whom the provider supplies lower limb prosthesis. The medical documentation must illustrate that the functional level of the patient with the lower limb prosthesis is two, i.e., the patient can move about independently over low level surfaces, such as stairs, and even control his motion, with the help of the prosthetic device. CMS requires that support of a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specifically ordered lower limb prosthesis as well as beneficiary's medical conditions that would impact the beneficiary's ability to effectively utilize the specifically ordered lower limb prosthesis in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
K3	**Lower extremity prosthesis functional level 3 - has the ability or potential for ambulation with variable cadence, typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion** **Definition:** Append modifier K3 to the code for a lower limb prosthetic device that contributes to the patient's ability to move safely over most barriers with a variable pace and to perform certain activities that are beyond the use of the device. **Explanation:** Append this modifier to a claim for lower limb prosthesis to identify a functional state of three for a patient for whom the provider supplies lower limb prosthesis. The medical documentation must illustrate that the functional level of the patient with the lower limb prosthesis is three, i.e., the patient can move about independently over most barriers with variable rhythm. The patient employs the prosthetic device to perform activities, such as exercise, vocational activities, and therapeutic activities, as well as ambulation. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K2 indicates that the patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces, typical of the limited community ambulator. Modifier K4 indicates that the patient has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.

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Mod	Modifier Description, Definition, Explanation, and Tips
K4	**Lower extremity prosthesis functional level 4 - has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete** **Definition:** Append modifier K4 to the code for a lower limb prosthetic device that contributes to the patient's ability to move about safely and engage in high energy activities typical of the prosthetic demands of a child, active adult, or athlete. **Explanation:** Append this modifier to a claim for lower limb prosthesis to identify a functional state of four for a patient for whom the provider supplies the lower limb prosthesis. The medical documentation must illustrate that the functional level of the lower limb prosthesis is four, i.e., the patient can move about independently and engage in high energy activities, such as those of a healthy child, active adult, or athlete. CMS requires that documentation for a claim for lower limb prosthesis should accurately reflect the beneficiary's medical conditions that necessitate the use of the specific lower limb prosthesis as well as medical conditions that would impact the beneficiary's ability to effectively utilize the device in achieving a defined functional state. **Tips:** HCPCS modifiers K0 through K4 apply to the supply of lower limb prosthesis and identify the functional level that a patient motivated to ambulate reaches or maintains within a reasonable time period. Modifier K0 indicates that the patient does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance their quality of life or mobility. Modifier K1 indicates that the patient has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator. Modifier K2 indicates that the patient has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces, typical of the limited community ambulator. Modifier K3 indicates that the patient has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
KA	**Add on option/accessory for wheelchair** **Definition:** Append this modifier to wheelchair codes for the supply of accessories and options. **Explanation:** Append modifier KA to show that the provider supplies accessories and options for a wheelchair to a patient. Numerous HCPCS codes exist for wheelchair options and accessories, for purchase or rental. **Tips:** Append this modifier to HCPCS codes E0955, Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each; E0985 through E2378 for wheelchair accessories, with the exception of codes for power wheelchair interfaces for which you would append modifier KC. You may also append modifier KA to K0015, Detachable nonadjustable height armrest and K0070, Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each.
KB	**Beneficiary requested upgrade for ABN, more than 4 modifiers identified on claim** **Definition:** Append modifier KB to a claim for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, when an advanced beneficiary notice, or ABN, applies when there are more than four modifiers on a claim line. **Explanation:** Append this modifier to a claim for DMEPOS items that require an advance beneficiary notice or ABN, for line items that need more than four modifiers on the claim. An Advance Beneficiary Notice refers to a standardized notice that the provider or supplier issues to a Medicare beneficiary before providing certain outpatient or hospice, home health agencies, and religious nonmedical healthcare institutions items or services. An ABN must be issued when the provider believes Medicare may not pay for an item or service that Medicare usually covers and that Medicare may not consider medically reasonable and necessary for the patient in this particular instance. Additional guidelines apply to hospices, home health agencies, and durable medical equipment suppliers. The patient must have original Medicare rather than Medicare Advantage plans. The KB modifier only applies to claims for DMEPOS where the supplier obtained an ABN. If providers or suppliers do not issue a valid ABN to the beneficiary when Medicare requires it, they cannot bill the beneficiary for the service and may be financially liable if Medicare doesn't pay. **Tips:** When reporting the modifier KB, you should remember that an ABN applies when more than four modifiers are present on the claim line. In cases when the supplier does not issue an ABN, and the provider reports more than four modifiers, append modifier 99, Multiple modifiers.

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Mod	Modifier Description, Definition, Explanation, and Tips
KC	**Replacement of special power wheelchair interface** **Definition:** Append modifier KC to a claim for the replacement of the interface for a power mobility device, i.e., the wheelchair, in a multiple competitive bidding product category. **Explanation:** Append this modifier when the interface is used with a competitively bid complex rehabilitative power mobility device base code. Interface refers to the way the patient causes a power wheelchair to move, such as a hand or chin control interface, sip and puff tube, or compact remote joystick. As a patient's physical condition deteriorates, he may require a change in the control interface. CMS added the KC modifier to cover the full cost of a special power wheelchair interface replacement when a change in the patient's medical condition makes the existing interface difficult or impossible for the patient to use or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, when the interface is supplied through competitive bidding complex categories. **Tips:** When using the modifier KC, you should remember that the code identifies only competitive bidding complex categories. If the code covers both competitive and noncompetitive bidding categories, append modifier KE, Bid under round one of the DMEPOS competitive bidding program for use with noncompetitive bid base equipment. Append modifier KC to HCPCS codes for various types of power wheelchair interfaces when the accessory supplied with a competitively bid complex rehabilitative PMD base code. These include E2321 to E2330, Power wheelchair accessories, etc.; E2312, Power wheelchair accessory, hand or chin control interface, mini proportional remote joystick, proportional, including fixed mounting hardware; E2351, Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface; E2373, Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware; E2374, Power wheelchair accessory, hand or chin control interface, standard remote joystick, not including controller, proportional, including all related electronics and fixed mounting hardware, replacement only; and K0835 thru K0864, Power wheelchair, groups two and three.
KD	**Drug or biological infused through DME** **Definition:** Append modifier KD to a code for a drug or biological, which the provider infuses through a durable medical equipment, or DME, such as an implanted infusion pump. **Explanation:** Append this modifier for drugs and biologicals to show that the provider instills the drug through an implanted infusion pump categorized as a DME. Providers surgically implant infusion pumps in patients who need long term medication. The pump can deliver the drug in a measured dose at a continuous rate or intermittently. Medicare covers the intravenous, intraarterial, subcutaneous, intrathecal, or epidural administration of certain drugs via an infusion pump, such as those used for heart failure and pulmonary arterial hypertension, immunoglobulin for primary immune deficiency, insulin for diabetes, antifungals, antivirals, and narcotics to treat severe pain unrelieved by other methods, and chemotherapy, with modifier KD. Append this modifier to drug and biological codes administered via the above routes through an infusion pump. The medical documentation must illustrate that a medically necessary drug is administered via an implanted DME, i.e., an infusion pump.
KE	**Bid under round one of the DMEPOS competitive bidding program for use with non-competitive bid base equipment** **Definition:** Append modifier KE to codes for competitively bid wheelchair accessory claims when the accessory will be used with a noncompetitive bid wheelchair. **Explanation:** Append this modifier to codes for accessory items to be used with a noncompetitive bid base item. The modifier indicates an accessory code that can be billed with either competitive or noncompetitive base items when the accessory is to be used with a noncompetitive bid item. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and noncompetitive bidding product categories. For competitively bid accessories used with competitively bid base equipment supplied to beneficiaries living in competitive bid areas, the supplier should submit modifier KG, DMEPOS item subject to DMEPOS competitive bidding program number one, or KK, DMEPOS item subject to DMEPOS competitive bidding program number two, as appropriate.

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Mod	Modifier Description, Definition, Explanation, and Tips
KF	**Item designated by FDA as class III device** **Definition:** Append modifier KF to a code for a device that the Food and Drug Administration, or FDA, has designated as a class III device. **Explanation:** Append this modifier for durable medical equipment designated as a class III device by the FDA. This pricing modifier identifies class III devices on the durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, fee schedule. Append modifier KF with claims for investigational FDA designated class III devices, such as intraspinal catheter with infusion pump, electrodes of an external defibrillator, stair climbing power wheelchairs, and other devices. Class III devices are investigational devices still in clinical trials. The FDA designates as Class III those devices which cannot be classified into class I, i.e., those subject only to general controls, such as good manufacturing practice regulations, or class II, i.e., those which require additional performance review or postmarket surveillance to assure safety and effectiveness, because insufficient information exists to determine safety and effectiveness. These devices require FDA premarket approval to be released in the market. The FDA designates class III devices as category A for which initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type is safe and effective or category B which the FDA believes to be class I or II type devices for which underlying questions of safety and effectiveness have been resolved or safety and effectiveness have been demonstrated because other manufacturers have obtained FDA approval for that device type. Medicare does not pay for category A devices. The provider participating in the clinical trial must furnish all necessary information concerning the device, the clinical trial, and participating Medicare beneficiaries that the contractor deems necessary for a coverage determination and claims processing. Medicare contractors make the coverage determinations on all FDA approved category B devices by applying Medicare's longstanding criteria and procedures for making coverage decisions. Coverage decisions should be made for FDA approved investigational device exemptions, or IDEs, as they currently are made for FDA approved devices.
KG	**DMEPOS item subject to DMEPOS competitive bidding program number 1** **Definition:** Append modifier KG to a code for a claim for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, which the supplier provides in a multiple competitive bidding product category for a standard product category. **Explanation:** Append this modifier when the supplier delivers the same DMEPOS item in multiple competitive bidding product categories for a standard product category. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract. The KG and KK modifiers are used in the round one rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The modifier KY indicates a claim for a beneficiary who resides in a competitive bidding area and purchases accessories and supplies for use with durable medical equipment. The competitive bidding program includes nine DMEPOS product categories; the number in the descriptor is the round number and indicates an expansion of the program to designated geographical boundaries. These modifiers are described as follows: KG: DMEPOS item subject to DMEPOS competitive bidding program number one. KK: DMEPOS item subject to DMEPOS competitive bidding program number two. KU: DMEPOS item subject to DMEPOS competitive bidding program number three. KW: DMEPOS item subject to DMEPOS competitive bidding program number four. KY: DMEPOS item subject to DMEPOS competitive bidding program number five.
KH	**DMEPOS item, initial claim, purchase or first month rental** **Definition:** Append modifier KH to the code for a claim for the first rental month or purchase option of durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS. The beneficiary may decide to purchase the item at any time during the rental period. **Explanation:** Append this modifier to DMEPOS claims for the first month of a capped rental period. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the equipment. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** You should append the modifier KH with modifier RR, Rental; use the RR modifier when DME is to be rented. The KH modifier may also be used in conjunction with HCPCS modifier NU, New equipment, and UE, Used durable medical equipment. These modifiers do not need to be submitted on claims for oxygen and oxygen equipment.

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Mod	Modifier Description, Definition, Explanation, and Tips
KI	**DMEPOS item, second or third month rental** **Definition:** Append modifier KI to identify the second or third rental month or purchase option for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS. The beneficiary may decide to purchase the item at any time of the rental period. **Explanation:** Append this modifier to DMEPOS claims for the second or third month of the capped rental period. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the equipment. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** Use the modifier KI for the second or third month's rent of the DMEPOS items. You should append the modifier KI with modifier RR, Rental; use the RR modifier when DME is to be rented. These modifiers do not need to be submitted on claims for oxygen and oxygen equipment. For the first month rental period, use modifier KH, DMEPOS item, initial claim, purchase or first month rental. If the rental period continues past the third month, append modifier KJ, DMEPOS item, parenteral enteral nutrition, pen, pump or capped rental, months four to 15.
KJ	**DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen** **Definition:** Append modifier KJ to identify the fourth to 15th rental month purchase option for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS; parenteral enteral nutrition pump rental, or capped rental. The beneficiary may purchase the item at any time of the rental period. **Explanation:** Append this modifier to DMEPOS, parenteral enteral nutrition pump, or capped rental claims for the fourth to 15th month of the capped rental period. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the DMEPOS equipment and up to 15 months for parenteral enteral nutrition pump or other capped rental items. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** Use modifier KJ for each month of rental past the third month and up to the 13th month for DMEPOS items and up to the 15th month for a parenteral enteral nutrition pump. You should append the modifier KJ with modifier RR, Rental; use the RR modifier when DME is to be rented. These modifiers do not need to be submitted on claims for oxygen and oxygen equipment. For the first month rental period, use modifier KH, DMEPOS item, initial claim, purchase or first month rental, and for the second and third rental months, append modifier KI, DMEPOS item, second or third month rental.
KK	**DMEPOS item subject to DMEPOS competitive bidding program number 2** **Definition:** Append modifier KK to code for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, which the supplier provides in a multiple competitive bidding product category for a complex product category. **Explanation:** Append this modifier when the supplier delivers the same DMEPOS item in multiple competitive bidding product categories for a complex product category. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** Modifier KK is a pricing modifier for DMEPOS item claims that the supplier provides the beneficiary. Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract. The KG and KK modifiers are used in the round one rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The modifier KY indicates a claim for a beneficiary who resides in a competitive bidding area and purchases accessories and supplies for use with durable medical equipment. The competitive bidding program includes nine DMEPOS product categories; the number in the descriptor is the round number and indicates an expansion of the program to designated geographical boundaries. These modifiers are described as follows: KG: DMEPOS item subject to DMEPOS competitive bidding program number one. KK: DMEPOS item subject to DMEPOS competitive bidding program number two. KU: DMEPOS item subject to DMEPOS competitive bidding program number three. KW: DMEPOS item subject to DMEPOS competitive bidding program number four. KY: DMEPOS item subject to DMEPOS competitive bidding program number five.

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Mod	Modifier Description, Definition, Explanation, and Tips
KL	**DMEPOS item delivered via mail** **Definition:** Append modifier KL to the claim for a mail order supply of durable medical equipments, prosthetics, orthotics, and supplies, or DMEPOS. **Explanation:** Append this modifier to indicate that the DMEPOS supplies were delivered to the beneficiary's residence through the mail and not from a local supplier storefront. Currently, this modifier applies to claims for only diabetic supply codes that a beneficiary receives through mail order. **Tips:** Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract.
KM	**Replacement of facial prosthesis including new impression/moulage** **Definition:** Append modifier KM to the claim for the fabrication of any replacement of a prosthesis for any part of the face; this includes a new impression or mold, i.e., a moulage, of the face to be treated with the prosthesis. **Explanation:** Append this modifier to the claim for the replacement of a facial prosthesis; this includes the mold or impression if the provider needs one to fabricate the prosthesis, so do not bill the mold separately. **Tips:** If the provider uses a previously created mold to fabricate the replacement facial prosthesis, append modifier KN, Replacement of facial prosthesis using previous master model. Modifiers KM and KN must be appended to claims for replacement of facial prostheses provided by a nonphysician reported with codes L8040 through L8047. These codes include prosthetic procedures over various regions of the face like nasal prosthesis, midfacial prosthesis, orbital prosthesis, and others.
KN	**Replacement of facial prosthesis using previous master model** **Definition:** Append modifier KN to the claim for the fabrication of any replacement prosthesis for any part of the face that the provider fabricated using a previously created mold. **Explanation:** Append this modifier to the claim for a replacement facial prosthesis when the provider uses a previously created mold to fabricate the prosthesis. **Tips:** If the provider uses a new impression or mold of the face to replace a facial prosthesis, append modifier KM, Replacement of facial prosthesis including new impression or moulage. Modifiers KM and KN must be appended to claims for replacement of facial prostheses provided by a nonphysician reported with codes L8040 through L8047. These codes include prosthetic procedures over various regions of the face like nasal prosthesis, midfacial prosthesis, orbital prosthesis, and others.
KO	**Single drug unit dose formulation** **Definition:** Append modifier KO to the code for a single drug supplied in a unit dose container, which the provider administers to a patient. **Explanation:** Append this modifier to a drug code to show that the provider administers a single drug that was supplied as a unit dose to the patient. **Tips:** Do not append this modifier to drug codes that are not supplied in a unit dose vial or container. Drugs supplied in unit dose form consist of inhalation drugs administered via a device classified as durable medical equipment, or DME. However, do not append modifier KO to J2545, Pentamidine isethionate, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, per 300 mg or Q4074, Iloprost, inhalation solution, FDA approved final product, noncompounded, administered through DME, unit dose form, up to 20 mcg. Do not append the modifier to codes for the concentrated form of a drug. If the provider dispenses the first drug of the multiple drug in unit dose, append modifier KP, First drug of a multiple drug unit dose formulation. If the provider dispenses second or subsequent dose of a multiple drug in unit dose, append modifier KQ, Second or subsequent drug of a multiple drug unit dose formulation. If you do not append modifier KO, KP, or KQ to a code for a unit dose of a drug, Medicare will deny the claim.

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Mod	Modifier Description, Definition, Explanation, and Tips
KP	**First drug of a multiple drug unit dose formulation** **Definition:** Append modifier KP to the drug code for the first drug that the provider includes in a multiple drug formulation compounded from drugs supplied in a unit dose form or for the first dose of a single drug supplied in a unit dose form when the total dose is greater than the amount supplied in a single vial or container. **Explanation:** Append this modifier to a code for the first drug that that the provider uses to compound a multiple drug unit dose formulation composed of more than one drug dispensed in a unit dose form. Also, append this modifier to the code for the first dose of a drug when the provider administers a single drug in a dose greater than the amount supplied in the unit dose form. **Tips:** Do not append this modifier to drug codes that are not supplied in a unit dose vial or container. Do not append the modifier to drug codes for a concentrated form of the drug. For the first dose, when the provider compounds a multiple drug formulation from two or more drugs dispensed in single drug unit form or when the provider administers a larger dose of a drug than that supplied in single unit dose form, append modifier KQ, Second or subsequent drug of a multiple drug unit dose formulation. If more than two drugs are compounded from drugs dispensed in unit dose form, no modifier is appended to the codes for the additional drugs. If the provider dispenses a unit dose of a single drug, append modifier KO, Single drug unit dose formulation. Use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded in order to receive payment for the amount of discarded drug or biological. If you do not append modifier KO, KP, or KQ to a code for a unit dose of a drug, Medicare will deny the claim.
KQ	**Second or subsequent drug of a multiple drug unit dose formulation** **Definition:** Append modifier KQ to the drug code for the second drug that the provider includes in a multiple drug formulation compounded from drugs supplied in a unit dose form or for the second dose of a single drug supplied in a unit dose form when the total dose is greater than the amount supplied in a single vial or container. **Explanation:** Append this modifier to a code for the second drug that that the provider uses to compound a multiple drug unit dose formulation composed of more than one drug dispensed in a unit dose form. Also, append this modifier to the code for the second dose of a drug when the provider administers a single drug in a dose greater than the amount supplied in the unit dose form. **Tips:** Do not append this modifier to drug codes that are not supplied in a unit dose vial or container. Do not append the modifier to drug codes for a concentrated form of the drug. For the first dose, when the provider compounds a multiple drug formulation from two or more drugs dispensed in single drug unit form or when the provider administers a larger dose of a drug than that supplied in single unit dose form, append modifier KP, First drug of a multiple drug unit dose formulation. If more than two drugs are compounded from drugs dispensed in unit dose form, no modifier is appended to the codes for the additional drugs. If the provider dispenses a unit dose of a single drug, append modifier KO, Single drug unit dose formulation. Use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded in order to receive payment for the amount of discarded drug or biological. If you do not append modifier KO, KP, or KQ to a code for a unit dose of a drug, Medicare will deny the claim.
KR	**Rental item, billing for partial month** **Definition:** Append modifier KR to the code for a claim for a partial month rental for durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS. **Explanation:** Append this modifier to DMEPOS claims for a partial month of the capped rental period. The supplier submits the code for a month's rental of the DMEPOS and appends this modifier when the rental period was less than the month claimed. Capped rental involves the payment of rent for 13 consecutive months to the supplier of the item, while the beneficiary uses the equipment. It covers all the costs including reasonable repairs, maintenance, replacement, or other costs. **Tips:** You should append the modifier KR with modifier RR, Rental; use the RR modifier when DME is to be rented. For the first month rental period, use modifier KH, DMEPOS item, initial claim, purchase or first month rental. If the rental period continues to a second or third rental month, append modifier KI, DMEPOS item, second or third month rental. If the rental period continues for a fourth to 15th month, append modifier KJ, DMEPOS item, parenteral enteral nutrition, pen, pump or capped rental, months four to 15.

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Mod	Modifier Description, Definition, Explanation, and Tips
KS	**Glucose monitor supply for diabetic beneficiary not treated with insulin** **Definition:** Append modifier KS when the provider supplies a glucose monitor to a patient who is not being treated with insulin injections. **Explanation:** The provider appends modifier KS when he dispenses all diabetic supplies to a patient per his order. The documentation must include the diagnosis of diabetes in order for the supplies to be covered. Append modifier KS on every claim for a glucose monitor and related supplies for patients not receiving insulin injections. **Tips:** The provider must have a record for the supplies that exceed the utilization guideline. New documentation should be presented at least every six months if the patient regularly uses the supplies.
KT	**Beneficiary resides in a competitive bidding area and travels outside that competitive bidding area and receives a competitive bid item** **Definition:** Append modifier KT when a beneficiary residing in a competitive bidding area, or CBA, receives a competitive bid item while traveling outside that competitive bidding area. **Explanation:** The supplier appends modifier KT for competitive bidding items, such as durable medical equipment, prosthetics, orthotics, and similar supplies, or DMEPOS, which he supplies to beneficiaries traveling outside the CBA in which they reside. Append the KT modifier to claims for nonmail order durable medical equipment, prosthetics, orthotics, and supplies when supplying these items to beneficiaries who require these items when traveling outside their resident CBA. If a CBA resident obtains a CBA item in a nonCBA area while traveling, the noncontract supplier must append modifier KT to the claim. Similarly, if a CBA resident obtains a CBA item from a contract supplier in a different CBA, the contract CBA supplier must append modifier KT to the claim. **Tips:** Important questions that need to be answered when a beneficiary needs a competitively bid item while traveling include the following: Is the beneficiary's permanent residence inside or outside a CBA? To verify a beneficiary's permanent CBA address, enter the beneficiary's permanent residence ZIP code into the CBA finder tool on the home page of the competitive bidding implementation contractor, or CBIC. Is the item being obtained inside or outside a CBA? If the beneficiary whose permanent address is inside a CBA travels to another CBA and the required item is a competitively bid item, the beneficiary must obtain the item from a CBA contractor who must append modifier KT to the claim. If the beneficiary needs a noncompetitive bid item, any Medicare enrolled supplier can provide the item. If the beneficiary whose permanent address is inside a CBA travels to nonCBA and needs a competitive bid item, the beneficiary may obtain the item from any Medicare enrolled supplier, and the supplier must affix the KT modifier to the claim If the beneficiary's permanent residence is not in a CBA and the beneficiary travels to a CBA and requires a competitive bid item, the beneficiary must obtain the item from a contract supplier for the area where he or she is visiting. If the beneficiary needs a nonbid item, he or she may obtain the item from any Medicare enrolled supplier. In both cases, the supplier will be paid the fee schedule amount for the area where the patient permanently resides. If the beneficiary's permanent residence is not in a CBA and the beneficiary travels to an area that is not in a CBA and requires a competitive bid item, the beneficiary may obtain the item from any Medicare enrolled supplier. The supplier will be paid the fee schedule amount for the state where the beneficiary permanently resides. Claims submitted without the KT modifier by skilled nursing facilities, or SNFs, and other nursing facilities that are not located in a CBA and are not contract suppliers will be denied for residents who receive enteral nutrition items while in the facility if their permanent home address is in a CBA. Mail order CBA diabetic supplies claims with the KT modifier will be denied for traveling beneficiaries unless the supplies are shipped to the beneficiary's permanent CBA home address.

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Mod	Modifier Description, Definition, Explanation, and Tips
KU	**DMEPOS item subject to DMEPOS competitive bidding program number 3** **Definition:** Append this modifier to indicate a durable medical equipment item depending upon the DMEPOS competitive bidding program number three, i.e., reserved for future program use. **Explanation:** Append modifier KU when the supplier supplies the same durable medical equipment, prosthetics, orthotics, and similar supplies, or DMEPOS, in multiple competitive bidding product categories or when the same code can be used to describe both competitively and noncompetitively bid items. The KU modifier is reserved for future use. **Tips:** The KG, KK, KU and KW modifiers are pricing modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and noncompetitively bid items. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The competitive bid modifiers KG, KK, KU, and KW are only used on claims for beneficiaries that live in a Competitive Bidding Area, or CBA. Competitive Bidding Program pricing modifiers KE, KG, KK, KU, KW, or KY, NU, RR or UE modifier should be placed in the first position following the HCPCS code and the KE modifier should be placed in the second position.
KV	**DMEPOS item subject to DMEPOS competitive bidding program that is furnished as part of a professional service** **Definition:** Append modifier KV, when professional providers, who are not contract suppliers, supply walkers and related accessories to beneficiaries in a competitive bidding area or CBA. **Explanation:** The noncontract professional provider appends modifier KV when he or she supplies walkers and other accessories to beneficiaries in a competitive bidding area or CBA. Contract suppliers should not append modifier KV. **Tips:** Walkers that are appropriately supplied in accordance with this exception will be paid at the single payment amount. The provider, as a noncontract supplier, should append modifier KV in combination with the following HCPCS codes: A4636, Replacement, handgrip, cane, crutch, or walker, each; A4637, Replacement, tip, cane, crutch, walker, each; and E0130 to E0159 for walkers and replacement parts. On the claim billed to the Durable Medical Equipment Medicare Administrative Contractor or DME MAC, the walker line item must have the same date of service as the professional service office visit billed to the Part A or Part B MAC. The provider and treating practitioners should submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.
KW	**DMEPOS item subject to DMEPOS competitive bidding program number 4** **Definition:** Append this modifier to indicate a durable medical equipment item depending upon the DMEPOS competitive bidding program number four, i.e., reserved for future program use. **Explanation:** Append modifier KW when the supplier supplies the same DMEPOS item in multiple competitive bidding product categories. This modifier is reserved for future use. **Tips:** The KG, KK, KU and KW modifiers are pricing modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and noncompetitively bid items. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The competitive bid modifiers, KG, KK, KU, and KW, are only used on claims for beneficiaries that live in a Competitive Bidding Area, or CBA. Competitive Bidding Program pricing modifiers KE, KG, KK, KU, KW, or KY, the NU, RR or UE modifier should be placed in the first position following the HCPCS code and the KE modifier should be placed in the second position.

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Mod	Modifier Description, Definition, Explanation, and Tips
KX	**Requirements specified in the medical policy have been met** **Definition:** The provider should append modifier KX when exceptions are in effect and the beneficiary qualifies for an exception. **Explanation:** Modifier KX is a multipurpose modifier for part B professional services claims to over-ride therapy caps for physical therapy, occupational therapy or speech language pathology services, for certain DMEPOS services, and to bypass gender-specific (services identified as male or female) edits for patients with ambiguous genitalia and transgender patients. Appending modifier KX affirms that the documentation supports the requirements stated in the medical policy have been met and that the service was medically necessary. For example, you may append modifier KX on claims for physical therapy, occupational therapy or speech language pathology services when therapy exceeds the caps listed in the medical policy. When you append modifier KX, it means that the provider attests that the requirements in the medical policy that relate to therapy cap exceptions have been met. In addition, it means the medical record documents that the additional therapy was medically necessary. The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception require that the KX modifier be added to the claim. DME example: Append KX to codes for the supply of glucose monitors and testing supplies when the patient is receiving insulin injections. By appending the KX modifier, the provider attests that the services billed are reasonable and necessary services, that they meet the policy requirements, that the medical record justifies the services, and that they qualify for an exception using the automatic process exception. **Tips:** The following CPT® codes for evaluation procedures may qualify for requests for an exception with the addition of modifier KX: 97161-97172. If physical therapy, occupational therapy, or speech language pathology services would be payable before the cap is reached and can be justified as still medically necessary after the cap is reached, that service should be covered. Contact your contractor for interpretation if you are not sure that a service qualifies for an exception. It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. Use the KX modifier only when therapy that exceeds the cap can be justified and documented. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Ensure that the medical record includes sufficient detail to support the use of the modifier. Documentation does not have to provided unless requested, however. In addition to its other existing uses, modifier KX should also be used to identify services that are gender-specific, i.e., services that are considered female or male only, which includes transgender patients or patients with ambiguous genitalia; that the physician or practitioner is performing a service on a patient for whom gender-specific editing may apply; and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service. Justification for exceptions to therapy caps includes medical diagnoses and complications that might directly and significantly influence the amount of treatment required. Other variables, such as the availability of a caregiver at home, that affect appropriate treatment may also justify an exception. Published research, clinical guidelines from professional sources, and or clinical or common sense should support the request for an exception to therapy caps. The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not constitute justification for exceptions to therapy caps. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. Note: Append KX to bypass gender-specific code requirements on Part B claims. For Part A claims, append condition code 45 (Ambiguous Gender Category) on any outpatient claim related to transgender or hermaphrodite issues.

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Mod	Modifier Description, Definition, Explanation, and Tips
KY	**DMEPOS item subject to DMEPOS competitive bidding program number 5** **Definition:** Append modifier KY to codes for a claim for competitive bid, or CB, wheelchair accessories in the durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, competitive bidding program number five. **Explanation:** Append this modifier when the supplier delivers the same DMEPOS item in multiple competitive bidding product categories for complex product category. The KY modifier should only be appended to competitive bid, or CB, wheelchair accessories. The competitive bidding program sets payment amounts for certain durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS to reduce beneficiary copays and save Medicare money while ensuring beneficiary access to quality items and services. **Tips:** Failure to report this modifier may result in claim denial, Medicare overpayments, and other penalties that may lead to termination of the contract. The KG and KK modifiers are used in the round one rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use. The modifier KY indicates a claim for a beneficiary who resides in a competitive bidding area and purchases accessories and supplies for use with durable medical equipment. The competitive bidding program includes nine DMEPOS product categories; the number in the descriptor is the round number and indicates an expansion of the program to designated geographical boundaries. These modifiers are described as follows: KG: DMEPOS item subject to DMEPOS competitive bidding program number one. KK: DMEPOS item subject to DMEPOS competitive bidding program number two. KU: DMEPOS item subject to DMEPOS competitive bidding program number three. KW: DMEPOS item subject to DMEPOS competitive bidding program number four. KY: DMEPOS item subject to DMEPOS competitive bidding program number five.
KZ	**New coverage not implemented by managed care** **Definition:** Append modifier KZ when the provider implants a defibrillator in a patient for a new indication not previously included in managed care or Medicare Advantage plan guidelines for implantation of a defibrillator. **Explanation:** Append modifier KZ to the claim when the provider implants a cardioverter defibrillator, or ICD, based on an indication or condition not previously included in managed care guidelines. Append modifier KZ to codes for ICDs placed on Medicare Managed Care claims for the new coverage guidelines. However, make sure you report implants performed under the older guidelines without this modifier. Medicare does not require an advanced beneficiary notice or ABN to reimburse the services given by the provider. **Tips:** CPT® codes to which HCPCS modifier KZ may be appended include 33240 through 33241; 33243 and 33244; 33249 and 33979.
LC	**Left circumflex coronary artery** **Definition:** Append modifier LC to a code for procedures on the left circumflex coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the left circumflex coronary artery. The left circumflex coronary artery supplies blood to the left atrium and left ventricle of the heart, i.e., the upper and the lower chambers of the heart respectively. **Tips:** The various types of procedures on the left circumflex coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the right coronary artery, append modifier RC, right coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider targets the left main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.

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Mod	Modifier Description, Definition, Explanation, and Tips
LD	**Left anterior descending coronary artery** **Definition:** Append modifier LD to a code for procedures on the left anterior descending coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the left anterior descending coronary artery, also known as the anterior interventricular artery. The left anterior descending coronary artery supplies blood to the left ventricle, the left lower chamber of the heart that pumps blood out of the heart to the rest of the body. **Tips:** The various types of procedures on the left anterior descending coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the right coronary artery, append modifier RC, right coronary artery. If the provider performs a procedure on the left circumflex coronary artery, append modifier LC, left circumflex coronary artery. If the provider targets the left main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.
LL	**Lease/rental (use the 'll' modifier when DME equipment rental is to be applied against the purchase price)** **Definition:** A provider appends modifier LL to durable medical equipment, or DME, rental items that he applies the rental payments against the purchase price. DME is medical equipment that helps a patient to manage his activities of daily living, or ADL, in an easier way or that provides therapeutic benefits to a patient. **Explanation:** A provider appends modifier LL to codes for DME rental that he applies the rental payments against the purchase price for the item. DME helps the patient to manage his activities of daily living in an easier way. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** A provider uses modifier RR, Rented item, if the DME item is being rented by the patient, modifier NU, New purchased item, if the DME item is purchased new by the patient, and modifier NR, New when rented, when the DME, which was new at the time of rental is subsequently purchased.
LM	**Left main coronary artery** **Definition:** Append modifier LM to a code for procedures on the left main coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the left main coronary artery. The left main coronary artery supplies blood to a large portion of the heart and the arteries branching off the heart. **Tips:** The various types of procedures on the left main coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the right coronary artery, append modifier RC, right coronary artery. If the provider performs a procedure on the left circumflex coronary artery, append modifier LC, left circumflex coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.
LR	**Laboratory round trip** **Definition:** Append modifier LR to a code for travel costs involved with obtaining a diagnostic laboratory service from either a nursing home patient or homebound patient. **Explanation:** Modifier LR identifies a code for a diagnostic or a laboratory procedure that requires round trip travel to acquire the specimen. The provider identifies the round trip travel by use of the LR modifier. Independent clinical laboratories may append this modifier to a HCPCS code such as P9604, Travel allowance one way in connection with a medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge. **Tips:** Not using modifier LR should have no effect on payment.
LS	**FDA-monitored intraocular lens implant** **Definition:** Append modifier LS to a code for a patient undergoing surgery and fitted with an intraocular lens implant, or IOL. **Explanation:** Modifier LS illustrates a code for a patient undergoing surgery and fitting with an intraocular lens implant, or IOL. The provider surgically places an intraocular lens in the eye of a patient with eye disorders such as cataracts or myopia. A cataract is an eye condition in which the lens of the eye becomes opaque gradually, leading to blurred vision. Myopia causes the patient to lose focus of distant objects, and he is only able to see nearby objects clearly. Modifier LS provides additional information to the payer when billing eye procedures that the provider places an IOL that is being monitored by the Food and Drug Administration, or FDA. **Tips:** Append this modifier on provider claims for eye surgery in patients with IOL implants.

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Mod	Modifier Description, Definition, Explanation, and Tips
LT	**Left side (used to identify procedures performed on the left side of the body)** **Definition:** Append modifier LT to specify the procedure that the provider performs is on the left side of the body. **Explanation:** Modifier LT illustrates that a provider performs a procedure on the left side of a patient's body. LT represents the left anatomical side of the body, when the body contains the same anatomical part on both the right and left side of the body. The provider applies LT in the case of procedures he performs on the left side of a paired organ such as the kidneys, lungs, legs, or ears. A provider does not append this modifier when a procedure code specifies bilateral, or modifier 50, Bilateral Procedure, as they are not compatible or if the code specifies a particular side of the body. **Tips:** Modifier LT does not affect the allowed amount on a claim; however, lack of the modifier can lead to denials. Some private payers do not recognize the LT and RT, Right side modifiers. For these procedures, a provider may use a single code with modifier 50, Bilateral Procedure, to denote a bilateral procedure. When using more than one modifier, place a pricing modifier, or a modifier that affects reimbursement, in the first modifier position. Then place the informational modifier in the second modifier position. For example if a provider uses a procedure code with modifier 22, Increased Procedural Services and modifier LT, then place modifier 22 first and modifier LT second.
LU	**Fractionated payment** **Definition:** Append modifier LU to a code to alert the payer that you are reporting fractional units for a single procedure or service to allow accurate payment. **Explanation:** Append this modifier to a code to indicate to the payer that you are reporting a single procedure or service using fractionated units, as defined by the payer. For instance, the code descriptor may state "per therapeutic dose, " but a contractor may have a rule to divide the allowed total payment by 10, requiring the provider to bill in 0.1 unit fractions. The provider would then bill a total of 10 fractional units to reach the total allowed payment amount of 1 unit. Note that this is only an example of a possible rule. Instructions may vary based on the individual payer. This modifier may be appropriate when a claim system's field length is not long enough for the price for a service. Providers can use modifier LU to bill fractional units of a single service so the claim reflects the total dollar amount. **Tips:** Check individual payer and contractor reporting rules regarding proper use of this modifier, as rules may vary.
M2	**Medicare secondary payer (MSP)** **Definition:** Append modifier M2 to specify that Medicare is the secondary payer for a drug procured outside of the Competitive Acquisition Program, or CAP, for drugs and biological. **Explanation:** The M2 modifier is only for the submission of claims by providers, enrolled in the Competitive Acquisition Program, or CAP, for drugs and biological, an alternative reimbursement methodology to the Average Sales Price, or ASP payment method. The provider appends this modifier when he incorrectly identifies the patient's main insurer and procures a CAP drug for a Medicare patient from a source other than the CAP vendor. The CAP provider later determines that Medicare is primary and that the drug should have been ordered through the approved CAP vendor. The provider appends the M2 modifier to the drug, which allows the local carrier's claims processing system to make a payment under ASP. The participating CAP provider maintains documentation in the beneficiary's medical record to provide further information if necessary as to why they made the initial determination that Medicare is secondary to another payer. The local carrier may request this documentation for review purposes. **Tips:** Modifier M2 is no longer effective for services after December 31, 2008.
MA	**Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition** **Definition:** Append modifier MA to a code for services when the provider did not consult a clinical decision support mechanism because the patient had a suspected or confirmed emergency medical condition. **Explanation:** Modifier MA indicates that a provider did not access or receive support from a qualified clinical decision support mechanism for a service he provided due to the patient having or suspected to have an emergency medical condition. Qualified clinical decision support mechanisms (CDSM) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements, but this is an exception to the rule. **Tips:** For other instances when the ordering professional is not required to consult a clinical decision support mechanism, see modifiers MB through MD.

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Mod	Modifier Description, Definition, Explanation, and Tips
MB	**Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access** **Definition:** Append modifier MB to a code for services when the provider did not consult a clinical decision support mechanism because he had insufficient Internet access. **Explanation:** Modifier MB indicates that a provider did not access or receive support from a qualified clinical decision support mechanism for a service he provided due to not having sufficient access to the Internet. Qualified clinical decision support mechanisms (CDSM) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements, but this is an exception to the rule. **Tips:** For other instances when the ordering professional is not required to consult a clinical decision support mechanism, see modifiers MA through MD.
MC	**Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues** **Definition:** Append modifier MC to a code for services when the provider did not consult a clinical decision support mechanism (CDSM) because of EHR or CDSM issues. **Explanation:** Modifier MC indicates that a provider did not access or receive support from a qualified clinical decision support mechanism for a service he provided due to issues with the electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues. Qualified clinical decision support mechanisms (CDSM) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements, but this is an exception to the rule. **Tips:** For other instances when the ordering professional is not required to consult a clinical decision support mechanism, see modifiers MA through MD.
MD	**Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances** **Definition:** Append modifier MD to a code for services when the provider did not consult a clinical decision support mechanism because of uncontrollable circumstances or because doing so would represent a significant hardship. **Explanation:** Modifier MD indicates that a provider did not access or receive support from a qualified clinical decision support mechanism (CDSM) for a service he provided due to circumstances beyond his control or because accessing or receiving support from a CDSM would represent a significant hardship. Qualified clinical decision support mechanisms (CDSM) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements, but this is an exception to the rule. **Tips:** For other instances when the ordering professional is not required to consult a clinical decision support mechanism, see modifiers MA through MC.
ME	**The order for this service adheres to appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional** **Definition:** Append modifier ME to a code for services that meet appropriate use criteria according to the clinical decision support mechanism consulted. **Explanation:** Modifier ME indicates that the ordering professional consulted a qualified clinical decision support mechanism (CDSM) prior to ordering advanced diagnostic imaging services and that said services meet the appropriate use criteria (AUC). Qualified clinical decision support mechanisms (CDSMs) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements. **Tips:** When the advanced diagnostic imaging service requested by an ordering professional does not meet AUC, append modifier MF.

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Mod	Modifier Description, Definition, Explanation, and Tips
MF	**The order for this service does not adhere to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional** **Definition:** Append modifier MF to a code for services that DO NOT meet appropriate use criteria according to the clinical decision support mechanism consulted. **Explanation:** Modifier MF indicates that the ordering professional consulted a qualified clinical decision support mechanism (CDSM) prior to ordering advanced diagnostic imaging services but said services DO NOT meet the appropriate use criteria (AUC). Qualified clinical decision support mechanisms (CDSMs) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements. **Tips:** When an ordering professional consults a CDSM and the advanced diagnostic imaging services DO meet AUC, append modifier ME.
MG	**The order for this service does not have applicable appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional** **Definition:** Append modifier MG to a code for services when the ordering professional consults the clinical decision support mechanism (CDSM), but the CDSM does not have applicable appropriate use criteria. **Explanation:** Modifier MG indicates that the ordering professional consulted a qualified clinical decision support mechanism (CDSM) prior to ordering advanced diagnostic imaging services but the CDSM did have appropriate use criteria (AUC) that applied to the situation. Qualified clinical decision support mechanisms (CDSMs) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements.
MH	**Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider** **Definition:** Append modifier MH to a code for services when it is not known whether the ordering professional consulted the clinical decision support mechanism (CDSM) or whether related information was not provided to the professional or provider who furnishes the services. **Explanation:** Modifier MH applies to advanced diagnostic imaging services for which it is unknown if the ordering professional consulted a qualified clinical decision support mechanism (CDSM) prior to ordering the services or if the furnishing provider was not provided the related information. Qualified clinical decision support mechanisms (CDSMs) factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Ordinarily, registered qualified clinical decision support mechanism providers must meet certain requirements.
MS	**Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty** **Definition:** Append modifier MS to a code to identify the service is for a six month periodic, in home visit by the provider for inspection and servicing of equipment. The service the provider performs includes the general maintenance and servicing to the item as well as costs not covered by a manufacturer or supplier warranty for reasonable and necessary parts to service the equipment. **Explanation:** Modifier MS illustrates a code for the routine maintenance and performance checks a provider performs every six months on DME, or durable medical equipment such as oxygen equipment. This maintenance and servicing typically includes the labor time spent and any reasonable and necessary parts he uses to keep the equipment in good working order, and which are not covered under any manufacturer or supplier warranty. The provider appends this modifier to Healthcare Common Procedure Coding System, or HCPCS, codes such as oxygen concentrator codes E1390 to E1392, and K0738, Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing. **Tips:** Medicare no longer pays for maintenance and servicing of capped rental items every six months with the exception of oxygen equipment. For other capped rental items, Medicare typically covers reasonable and necessary repairs and servicing once the beneficiary owns the capped rental item.
N1	**Group 1 oxygen coverage criteria met** **Definition:** Append modifier N1 to indicate the service meets group 1 oxygen coverage criteria for the payer. **Explanation:** Append modifier N1 to indicate the service meets group 1 oxygen therapy coverage criteria as defined by the payer for the relevant date of service. Factors may include the patient's PO2 (partial pressure of oxygen, which is the amount of oxygen gas dissolved in the blood) and specific diagnoses.

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Mod	Modifier Description, Definition, Explanation, and Tips
N2	**Group 2 oxygen coverage criteria met** **Definition:** Append modifier N2 to indicate the service meets group 2 oxygen coverage criteria for the payer. **Explanation:** Append modifier N2 to indicate the service meets group 2 oxygen therapy coverage criteria as defined by the payer for the relevant date of service. Factors may include the patient's PO2 (partial pressure of oxygen, which is the amount of oxygen gas dissolved in the blood) and specific diagnoses.
N3	**Group 3 oxygen coverage criteria met** **Definition:** Append modifier N3 to indicate the service meets group 3oxygen coverage criteria for the payer. **Explanation:** Append modifier N3 to indicate the service meets group 3 oxygen therapy coverage criteria as defined by the payer for the relevant date of service. Factors may include the patient's PO2 (partial pressure of oxygen, which is the amount of oxygen gas dissolved in the blood) and specific diagnoses.
NB	**Nebulizer system, any type, FDA-cleared for use with specific drug** **Definition:** Append modifier NB to a code for any type of nebulizer system that is cleared by the Food and Drug Administration, or FDA, for use with specific drugs. **Explanation:** Modifier NB illustrates the use of a nebulizer system of any type. The nebulizer system that the provider appends the modifier to is a system cleared by the Food and Drug Administration, or FDA, for use with specific drugs. This modifier may be applicable to Healthcare Common Procedure Coding System, or HCPCS, codes E0550 through E0585, which identify different types of nebulizer systems. **Tips:** Append this modifier for Medicare services that the facility submits to a durable medical equipment, or DME Medicare Administrative Contractor, a DME MAC.
NR	**New when rented (use the 'NR' modifier when DME which was new at the time of rental is subsequently purchased)** **Definition:** A provider appends modifier NR to identify durable medical equipment, or DME, that was new at the time of rental, and a patient subsequently purchases it. DME is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. **Explanation:** A provider appends modifier NR to a code to indicate that a DME item that the patient purchases was new DME when the patient first received the item at the time of rental. DME helps the patient to manage his activities of daily living in an easier way. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** A provider uses the modifier RR, Rented item, if the item is being rented by the patient and modifier NU, New purchased item, if the item is purchased new by the patient.
NU	**New equipment** **Definition:** Append modifier NU to a code for new durable medical equipment item. **Explanation:** Modifier NU identifies that the beneficiary has received new or fresh durable medical equipment, or DME, that is equipment which has never been used before. The DME codes the provider may most often append this modifier to, are items that are inexpensive or routinely purchased items, capped rental items, items requiring frequent and substantial servicing, or oxygen equipment. The codes that may apply include HCPCS E codes and K codes items including complex rehabilitative power wheelchairs, K0835 through K0891. **Tips:** Append this modifier to identify new durable medical equipment, or DME, items.
P1	**A normal healthy patient** **Definition:** The provider administers anesthesia to a normal healthy individual. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to a normal healthy individual during any procedure. A normal healthy individual includes patients with no physiologic or psychiatric disorder and patients with a good level of exercise tolerance. It does not include very young and very old individuals. The medical record should justify the diagnosis that corresponds to the individual being normal and healthy. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.

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Mod	Modifier Description, Definition, Explanation, and Tips
P2	**A patient with mild systemic disease** **Definition:** The provider administers anesthesia to an individual with mild systemic disease. Patients with mild systemic disease have a well controlled disease of one body system. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to an individual with mild systemic disease during any procedure. Patients with mild systemic disease have a well controlled disease of one body system, for example, controlled hypertension, controlled diabetes mellitus, mild obesity, or a smoking history with no symptoms of chronic obstructive pulmonary disease. Mild systemic disease does not affect the activities of daily living. The medical record should justify the diagnosis that corresponds to mild systemic disease. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P3	**A patient with severe systemic disease** **Definition:** The provider administers anesthesia to an individual with severe systemic disease. Patients with severe systemic disease have some limitation in activities and well controlled disease of more than one body system or one major body system. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to an individual with severe systemic disease. Patients with severe systemic disease have some limitation in activities and well controlled disease of more than one body system or one major body system. For example, the category includes patients with stable angina, controlled congestive heart failure, poorly controlled hypertension, type 1 diabetes that has affected the vascular system, and moderate obesity. In severe systemic disease, there is no immediate danger of death. The medical record should justify the diagnosis that corresponds to severe systemic disease. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P4	**A patient with severe systemic disease that is a constant threat to life** **Definition:** The provider administers anesthesia in an individual with severe systemic disease that is a constant threat to the life of the patient. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to an individual with severe systemic disease that is a constant threat to life. Patients with severe systemic disease have a poorly controlled disease of more than one body system or one major body system. For example, the category includes patients with unstable angina, chronic renal failure, or symptomatic congestive heart failure. There is a possible risk and danger of death. The medical record should justify the diagnosis that corresponds to severe systemic disease that has a possible risk of death. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.

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Mod	Modifier Description, Definition, Explanation, and Tips
P5	**A moribund patient who is not expected to survive without the operation** **Definition:** The provider administers anesthesia to a terminally ill individual who will not survive without the operative procedure. **Explanation:** The provider administers anesthesia in a critically ill patient who will not survive without the operation. The medical record should justify the diagnosis that corresponds to a critically ill or injured patient who requires a life saving surgery. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
P6	**A declared brain-dead patient whose organs are being removed for donor purposes** **Definition:** The provider administers anesthesia in a brain dead individual undergoing organ removal for donor purposes. **Explanation:** The anesthesia provider appends this modifier to an anesthesia code to show that the provider administers anesthesia to a brain dead individual undergoing organ removal for donor purposes. Brain death is the complete and irreversible cessation of brain function as determined by two doctors not associated with the transplant team. The medical record should justify the diagnosis that corresponds to a brain dead individual for organ donor purposes. **Tips:** The anesthesia modifiers P1 to P6 identify the health condition of the patient in whom the provider is going to administer the anesthesia. The identification of the health condition helps the payer to determine the complexity of the anesthesia case. Many payers will reimburse more for anesthesia identified with modifiers P2 to P5 because the patient's case is likely more complex. Payers will not reimburse more for modifier P1 because the patient is normal and healthy or for P6 because the patient is brain dead. The provider uses this modifier only with anesthesia codes that range from 00100 to 01999. Coders will not append this modifier; only the anesthesia provider will append it.
PA	**Surgical or other invasive procedure on wrong body part** **Definition:** Append this modifier to indicate an adverse event when the provider performs a surgical or other invasive procedure on the wrong body part. **Explanation:** The provider appends modifier PA to surgical codes when he performs a surgical or other invasive procedure on the wrong body part due to an error. He appends this modifier so that the insurer including Medicare knows not to provide reimbursement. Not adhering to the Centers for Medicare and Medicaid Services, or CMS, guidelines of appending this modifier in situations where a provider performs a surgical or other invasive procedure on a body part that is not consistent with the correct documentation on the patient consent form may result in payment by the insurer and recoupment of the payment later on. Typically, the insurer considers all services the provider delivers in the operating room when an error occurs as related and considers them non covered as well. All other providers in the operating room when the error occurs, who bill individually for their services, are also not eligible for payment. Finally, all related services the patient receives during the same hospitalization in which the error occurs are usually not covered. **Tips:** Modifier PA notifies the insurer of the situation and ensures that the provider will not receive payment for the procedure done in error. Medicare also will not cover services related to the error. Using this modifier may increase malpractice risk. Use this modifier only with surgical codes.

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Mod	Modifier Description, Definition, Explanation, and Tips
PB	**Surgical or other invasive procedure on wrong patient** **Definition:** Append the PB modifier to indicate an adverse event when the provider performs a surgical or other invasive procedure on the wrong patient. **Explanation:** The provider appends modifier PB to codes when he performs a surgical or other invasive procedure on the wrong patient. He appends this modifier so that the insurer including Medicare knows not to provide reimbursement. Not adhering to the Centers for Medicare and Medicaid Services, or CMS, guidelines of appending this modifier in situations where a provider performs a surgical or other invasive procedure on the wrong patient may result in payment by the insurer and recoupment of the payment later on. Typically, the insurer considers all services the provider delivers in the operating room when an error occurs as related and considers them non covered as well. All other providers in the operating room when the error occurs, who bill individually for their services, are also not eligible for payment. Finally, all related services the patient receives during the same hospitalization in which the error occurs are usually not covered. **Tips:** Modifier PB notifies the insurer of the situation and ensures that the provider will not receive payment for the procedure done in error. Medicare also will not cover services related to the error. Using this modifier may increase malpractice risk.
PC	**Wrong surgery or other invasive procedure on patient** **Definition:** Append the PC modifier to indicate an adverse event when the provider performs the wrong surgery or other invasive procedure on a patient. **Explanation:** The provider appends modifier PC to codes when he performs the wrong surgery or other invasive procedure on a patient. He appends this modifier so that the insurer including Medicare knows not to provide reimbursement. Not adhering to the Centers for Medicare and Medicaid Services, or CMS, guidelines of appending this modifier in situations where a provider performs wrong surgery or other invasive procedure on patient may result in wrong payment by insurer and recoupment of the payment later on. Typically, the insurer considers all services the provider delivers in the operating room when an error occurs as related and considers them non covered as well. All other providers in the operating room when the error occurs, who bill individually for their services, are also not eligible for payment. Finally, all related services the patient receives during the same hospitalization in which the error occurs are usually not covered. **Tips:** Modifier PC will ensure that you will not receive reimbursement for the procedure done in error and Medicare also will not cover services related to the error. Using this modifier may increase malpractice risk.
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** **Definition:** Modifier PD is a payment modifier that a provider uses with diagnostic or related non diagnostic items or services that a provider delivers in a wholly owned or operated entity to a patient who becomes an inpatient within three days. **Explanation:** Append this modifier with Healthcare Common Procedure Code System, or HCPCS codes that the provider and supplier use to report preadmission diagnostic and non diagnostic services that relate to the admission. Use this modifier to identify that the entity providing the service is wholly owned or operated by the hospital and the patient who receives the services becomes an inpatient within three days. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. And, an entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. **Tips:** If the entity is not wholly owned or operated by a hospital, do not append modifier PD. Medicare will pay for the professional component of codes with a technical professional split that a provider delivers within three calendar days. When practices append PD to a code that doesn't have both professional and technical components, Medicare will pay for the service based on the facility rate.

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Mod	Modifier Description, Definition, Explanation, and Tips
PI	**Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing** **Definition:** Append modifier PI to a code for positron emission tomography, PET or PET computed tomography, CT imaging studies that a provider performs to help plan the initial treatment strategy in patients with tumors, suspected to be cancerous by other diagnostic testing or proven to be cancerous through a biopsy. The provider uses the study to determine the location or extent of the tumor. **Explanation:** Modifier PI illustrates the use of imaging studies such as positron emission tomography, PET, or PET computed tomography, CT, in patients known or strongly suspected of having a cancerous tumor, an abnormal growth of tissue that rapidly multiples and spreads throughout the body destroying normal cells. Computed tomography is when the provider rotates an X-ray tube and detectors around a patient, which produces a tomogram, a computer generated cross sectional image, which providers use to diagnose, manage, and treat the disease. These studies enable the provider to plan an initial treatment strategy for patients with tumors that are proven on biopsy or suspected of being cancerous by other diagnostic tests. **Tips:** Append modifier PI when services are related to F 18 fluoro D glucose or FDG PET imaging study. Append modifier PI for procedure codes, such as 78608, Brain imaging, positron emission tomography or PET; metabolic evaluation, and the PET range of codes 78811 through 78816.
PL	**Progressive addition lenses** **Definition:** Append modifier PL to a code for a patient undergoing eye procedures for progressive additional lenses. **Explanation:** Modifier PL illustrates an eye procedure in a patient for the fitting of progressive additional lenses. **Tips:** HCPCS Level II codes represent implantable materials used in the treatment of eye and ear disorders. These codes also report the supplies of visual aids such as contact lenses and glasses.
PM	**Post mortem** **Definition:** Append modifier PM to a code to identify post mortem visits to a patient. **Explanation:** Modifier PM identifies visits that occur after the death of a patient and on the same day as the patient's death, from visits occurring before death. Providers append the PM modifier for post mortem visits, on the date of death, regardless of the patient's level of care or site of service. The date of death is the date of death reported on the death certificate. Hospice providers are to report hospice visits that occur before death separately from those which occur after death. **Tips:** Do not report post mortem visits occurring on a date subsequent to the date of death, due to system limitations with reporting services after the date of the death. Report modifier PM when billing post mortem visits provided on the date of death beginning with services on or after April 1, 2014.
PN	**Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital** **Definition:** Modifier PN represents the technical component of non-excepted items and services. **Explanation:** With this modifier, hospitals are paid under the MPFS for non-excepted items and services, which are billed on the institutional claim and must be billed with a new claim line modifier PN to indicate that an item or service is a non-excepted item or service. The payment rate for these services will generally be 50 percent of the OPPS rate with some exceptions. Packaging, and certain other OPPS policies, will continue to apply to such services. Check the CMS website for specific reimbursement information related to services with modifier PN appended, as certain non-excepted services may be paid under MPFS. Do not append modifier PN to excepted items and services – Certain off-campus provider-based departments (PBDs) are permitted to continue to bill Medicare for excepted items and services under the OPPS. Excepted items and services are: All items and services furnished in a dedicated emergency department. Items and services that were furnished and billed by an off-campus PBD prior to November 2, 2015. Items and services furnished in a hospital department within 250 yards of a remote location of the hospital.
PO	**Excepted service provided at an off-campus, outpatient, provider-based department of a hospital** **Definition:** Append the PO modifier to indicate a service, procedure, or surgery that takes place at a provider based hospital outpatient department, off campus. **Explanation:** A hospital facility appends modifier PO to a code for each service, procedure, or surgery that takes place at an off campus location in a provider based outpatient department. Off campus means a location physically separate from the immediate area of the hospital facility and or in a building located more than 250 yards away from the main hospital buildings. This is an informational modifier for data collection purposes. **Tips:** Individual providers should not append modifier PO and instead should use the appropriate place of service code to indicate outpatient services furnished in an on campus, remote, or satellite location of a hospital or in an off campus, provider based hospital setting.

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Mod	Modifier Description, Definition, Explanation, and Tips
PS	**Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the pet study is needed to inform subsequent anti-tumor strategy** **Definition:** A provider appends modifier PS to a positron emission tomography, or PET, or computed tomography, or CT scan to determine a subsequent treatment strategy of cancerous tumors when the provider determines he needs the PET study to determine a subsequent antitumor strategy for the patient. **Explanation:** Modifier PS illustrates the use of imaging studies such as positron emission tomography, PET, or computed tomography, CT, in patients having a cancerous tumor, or an abnormal growth of tissue that rapidly multiplies and spreads throughout the body destroying normal cells. A positron emission tomography, or PET scan is a nuclear medicine imaging technique, which produces a three dimensional image of functional processes in the body; the system detects pairs of gamma rays emitted indirectly by a positron emitting radionuclide, or tracer, which is introduced into the body on a biologically active molecule, or glucose. A computed tomography, or CT scan is when the provider rotates an X-ray tube and detectors around a patient, which produces a tomogram, a computer generated cross sectional image, which providers use to diagnose, manage, and treat the disease. These studies enable the provider to determine a subsequent treatment strategy for patients with cancerous tumors. **Tips:** Append modifier PS to all procedure codes that the provider bills with a cancer diagnosis codes such as, 78608, Brain imaging, positron emission tomography or PET; metabolic evaluation, and code range 78811 to 78816. While submitting claim for the professional component only, append modifier 26 first, and then append modifier PS. While submitting claim for the technical component only, append modifier TC first, and then append modifier PS.
PT	**Colorectal cancer screening test; converted to diagnostic test or other procedure** **Definition:** Append this modifier when a colorectal cancer screening test converts to a diagnostic or therapeutic procedure. **Explanation:** Append modifier PT when the provider performs screening colonoscopy, flexible sigmoidoscopy, or barium enema and finds and or removes a lesion or performs a biopsy during the same encounter. **Tips:** Modifier PT waives the deductible for services furnished in connection with or in relation to a colorectal cancer screening test furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services and that became diagnostic or therapeutic. Codes associated with this modifier fall in the range of 10021-69990, Surgery.
Q0	**Investigational clinical service provided in a clinical research study that is in an approved clinical research study** **Definition:** Append modifier Q0 for a service which the provider performs for an approved investigative clinical research study. **Explanation:** Approved investigational clinical services consist of services that the provider investigates as an objective within the study. Not all investigational clinical services are approved. Investigational clinical services may include services that are approved, unapproved, or otherwise covered or not covered under Medicare. **Tips:** Append modifiers Q0 and Q1 on outpatient provider claims for services provided in Medicare qualified clinical trials studies. These include trials that fall under the 2007 Medicare Clinical Trial Policy, trials that a specific National Coverage Determination or NCD, and investigational device exemption or IDE trials required.
Q1	**Routine clinical service provided in a clinical research study that is in an approved clinical research study** **Definition:** Append modifier Q1 for a routine clinical service that the provider performs for a patient enrolled in an approved clinical research study. **Explanation:** The CMS defines routine clinical services as those items and services that Medicare typically covers for beneficiaries outside of the clinical research study that the provider uses for direct patient management within the study and that do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services, e.g., administration of a chemotherapeutic agent; clinically appropriate monitoring, whether or not required by the investigational clinical service, e.g., blood tests to measure tumor markers; and items or services required for the prevention, diagnosis, or treatment of research related adverse events, e.g., blood levels of various parameters to measure kidney function. **Tips:** Append modifiers Q0 and Q1 on outpatient provider claims for services provided in Medicare qualified clinical trials studies. These include trials that fall under the 2007 Medicare Clinical Trial Policy, trials that a specific National Coverage Determination or NCD, and investigational device exemption or IDE trials requires.

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Mod	Modifier Description, Definition, Explanation, and Tips
Q2	**Demonstration procedure/service** **Definition:** Append modifier Q2 to services billed in conjunction with a demonstration procedure or service. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append modifier Q2 when the services involve demonstration of a procedure/service to allow accurate identification and documentation of payment for Medicare beneficiaries enrolled in the demonstration.
Q3	**Live kidney donor surgery and related services** **Definition:** Append modifier Q3 when the provider performs services related to care for a live kidney donor. **Explanation:** The provider appends modifier Q3 for care for a live kidney donor to receive 100 percent reimbursement of the allowed charge. Live kidney donor services include those services which the provider performs during the preoperative, intraoperative, and postoperative periods. The provider bills these services to the carrier under the name and health insurance claim number of the kidney recipient. **Tips:** Medicare part B reimburses for services reported with modifier Q3 if the provider bills the transplant surgery codes 50320, Donor nephrectomy including cold preservation; open, from living donor or 50547, Laparoscopy, surgical; donor nephrectomy including cold preservation, from living donor.
Q4	**Service for ordering/referring physician qualifies as a service exemption** **Definition:** Append this modifier when a provider orders a service from or refers a Medicare beneficiary to another service provider with whom the original provider has a financial relationship if the service provided qualifies as a service related exemption. **Explanation:** Service related exemptions permit a provider to refer a Medicare beneficiary to a service entity with whom the referring provider has a financial relationship. Append modifier Q4 to the code for the service when an exemption applies. This modifier is for informational purposes only and does not affect the reimbursement. **Tips:** Unless an exception applies, if a physician or a member of a physician's immediate family has a financial relationship with a healthcare entity, the physician may not make referrals to that entity for the furnishing of designated health services, or DHS under the Medicare program. The following services are DHS: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. Individual payers may have policies that specify which nonphysicians you may use this modifier for. Check the payer's individual policy to be sure.

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Mod	Modifier Description, Definition, Explanation, and Tips
Q5	**Service furnished under a reciprocal billing arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area** **Definition:** Append modifier Q5 when a substitute provider (physician or physical therapist) evaluates a patient under a reciprocal billing arrangement in a rural area or an area with a shortage of healthcare professionals or medical services. **Explanation:** Modifier Q5 denotes when another provider examines or treats a patient due to absence of the regular provider and based on a prior agreement to cover for one another, when the care takes place in a rural or underserved area. The alternate provider should sign any reports documenting the care he provided. **Tips:** The patient's regular physician may submit the claim, and, if assignment is accepted, receive the Part B payment, for covered visit services, including emergency visits and related services, which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis under the following conditions: The regular physician must not be available to provide the visit services; and The Medicare patient needs to arrange or seek to receive the visit services from the regular physician; and This modifier is to be used by providers who render services to patients in a rural area, an area where there is a shortage of healthcare professionals, or an otherwise underserved area. The substitute physician may not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject with an exception for the provider being on active military duty; and The regular physician must identify the services as substitute physician services by entering HCPCS code Q5 modifier, service furnished by a substitute physician under a reciprocal billing arrangement, after the procedure code. The regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request. If the only substitution services a physician performs in connection with an operation are postoperative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services. A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing. The regular physician is not entitled to bill and receive direct payment for substitute provider services furnished after the expiration of 60 days of the period. The substitute physician must bill for these services in his or her own name. The regular physician may, however, bill and receive payment for the services that the substitute physician provides on his or her behalf during the 60 day the period. The provider should append modifier Q5 with the supporting documentation providing the reason for the service.
Q6	**Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area** **Definition:** Append this modifier when a locum tenens, or substitute, provider (physician or physical therapist) performs the services under a fee-for-time compensation agreement, in a rural area or an area with a shortage of healthcare professionals or medical services. **Explanation:** Append modifier Q6 when a locum tenens, or substitute, provider performs healthcare services in the absence of the original provider. Criteria for this modifier include that the regular physician is unavailable to provide the visit services; the Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician; the regular physician pays the locum tenens for his or her services on a per diem or similar fee for time basis; the substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject to some exceptions; the provider renders services to patients in a rural area, an area where there is a shortage of healthcare professionals, or an otherwise underserved area.; and the regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6. **Tips:** The locum tenens provider provides a service when the original provider is not present to provide due to any illness, pregnancy, vacation or continuation of medical education. If a provider leaves a medical group and the group hires a locum tenens physician, the medical group must keep on file a record of each service which the substitute provider assumes and also takes a note of the substitute provider's PIN or NPI. Also, the provider identification number PIN or NPI of the provider who has left the medical group is written on the claim to indicate who the locum tenens provider is substituting for. This modifier is to be used by providers who render services to patients in a rural area, an area where there is a shortage of healthcare professionals, or an otherwise underserved area. This modifier has no effect on payment.

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Mod	Modifier Description, Definition, Explanation, and Tips
Q7	**One class A finding** **Definition:** Append this modifier for foot care that involves at least one class A findings. The provider uses class findings to determine the level of foot care. Medicare does not cover routine foot care unless the patient is suffering from systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. **Explanation:** Append modifier Q7 when the provider identifies one class A finding. The provider uses class findings to determine the level of foot care. Class A findings include nontraumatic amputation of foot or integral skeletal portion thereof. Medicare covers the service when the provider renders foot care and identifies one class A finding. Medicare does not cover routine foot care unless the patient is suffering from systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections or if the patient has peripheral neuropathy, i.e., decreased sensation in the extremities that might result in injury if the patient tries to take care of his or her nails. Routine foot care involves excision of corns or calluses, maintenance of cleanliness of foot in bedridden patient, and trimming or debridement of nails. **Tips:** Append modifier Q9, One class B and two class C findings, when the provider identifies one class B and two class C findings. Append modifier Q8, Two class B findings, when the provider identifies two class B findings. Modifiers Q7, Q8, and Q9 should usually be used with HCPCS code G0127, Trimming of dystrophic nails, any number, or CPT® codes 11055 to 11057, Paring or cutting of benign hyperkeratotic lesion, e.g., corn or callus, depending on number of lesions; 11719, Trimming of nondystrophic nails, any number; and when appropriate, 11720, Debridement of nails by any methods; 1 to 5; or 11721, Debridement of nails by any methods; 6 or more.
Q8	**Two class B findings** **Definition:** Append this modifier for foot care required because of two class B findings. The provider uses class findings to determine the level of foot care. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. **Explanation:** Append modifier Q8 when the provider identifies two class B findings. The provider uses class findings to determine the level of foot care. Class B findings include absent posterior tibial pulse, absent dorsalis pedis pulse, advanced trophic changes which include any three of the following conditions, such as increased or decreased hair growth; nail thickening; or changes in color, texture, or reddening of the skin. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections or if the patient has peripheral neuropathy, i.e., decreased sensation in the extremities that might result in injury if the patient tries to take care of his or her nails. Routine foot care involves excision of corns or calluses, maintenance of cleanliness of foot in bedridden patient, and trimming or debridement of nails. **Tips:** Append modifier Q9, One class B and two class C findings, when the provider identifies one class B and two class C findings. Append modifier Q7, One class A finding, when the provider identifies one class A finding. Modifiers Q7, Q8, and Q9 should usually be used with HCPCS code G0127, Trimming of dystrophic nails, any number, or CPT® codes 11055 to 11057, Paring or cutting of benign hyperkeratotic lesion, e.g., corn or callus, depending on number of lesions; 11719, Trimming of nondystrophic nails, any number; and when appropriate, 11720, Debridement of nails by any methods; 1 to 5; or 11721, Debridement of nails by any methods; 6 or more.

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Mod	Modifier Description, Definition, Explanation, and Tips
Q9	**One class B and two class C findings** **Definition:** Append this modifier for routine foot care services for one class B finding and two class C findings. The provider uses class findings to determine the level of foot care. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. **Explanation:** Append modifier Q9 when the provider identifies one class B and two class C findings. The provider uses class findings to determine the level of foot care. Class B findings include absent posterior tibial pulse, absent dorsalis pedis pulse, advanced trophic changes which include any three of the following conditions, such as increased or decreased hair growth; nail thickening; or changes in color, texture, or reddening of the skin. Class C findings include claudication, burning, coldness of the feet, edema, tingling or abnormal spontaneous sensations in the feet. Medicare does not cover routine foot care unless the patient has systemic conditions which lead to decreased sensation over the area of foot and leg or when the foot care is essential. Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections or if the patient has peripheral neuropathy, i.e., decreased sensation in the extremities that might result in injury if the patient tries to take care of his or her nails. Routine foot care involves excision of corns or calluses, maintenance of cleanliness of foot in bedridden patient, and trimming or debridement of nails. **Tips:** Append modifier Q8, Two class B findings, when the provider identifies two class B findings. Append modifier Q7, One class A finding, when the provider identifies one class A finding. Modifiers Q7, Q8, and Q9 should usually be used with HCPCS code G0127, Trimming of dystrophic nails, any number, or CPT® codes 11055 to 11057, Paring or cutting of benign hyperkeratotic lesion, e.g., corn or callus, depending on number of lesions; 11719, Trimming of nondystrophic nails, any number; and when appropriate, 11720, Debridement of nails by any methods; 1 to 5; or 11721, Debridement of nails by any methods; 6 or more.
QA	**Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than 1 liter per minute (LPM)** **Definition:** Add modifier QA to a code when a patient at rest requires different amounts of stationary oxygen during the daytime and nighttime but the average of the two amounts is less than 1 L per minute (LPM). **Explanation:** Use this modifier when the provider prescribes two different amounts of stationary oxygen for daytime and nighttime use for a patient at rest but the averaged amounts equal less than 1 L per minute. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** See QB, QE, QF, QG, QH and QR for other oxygen-related modifiers.
QB	**Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds 4 liters per minute (LPM) and portable oxygen is prescribed** **Definition:** Append modifier QB when a provider prescribes different amounts of stationary oxygen for daytime and nighttime use for a patient at rest and the average of the two amounts is greater than 4 L per minute (LPM), when the patient also has portable oxygen prescribed. **Explanation:** Use this modifier when a patient at rest receives different amounts of provider-prescribed stationary oxygen for daytime and nighttime use and the two amounts average out to greater than 4 L per minute, and the patient also has portable oxygen. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** Proper use of QB is important because Medicare increases monthly payment for oxygen when the patient has a prescription for portable oxygen in addition to stationary oxygen. See QA, QE, QF, QG, QH and QR for other oxygen-related modifiers.
QC	**Single channel monitoring** **Definition:** Append this modifier for single channel monitoring. Report this modifier for informational purposes only; it does not affect payment. **Explanation:** Append modifier QC when the provider performs single channel monitoring. Report this modifier for informational purposes only; it does not affect payment. Providers routinely monitor patients in the ICU using single-channel electrocardiogram, or ECG, monitoring. **Tips:** Individual payers may have policies that specify which nonphysicians you may use this modifier for. Check the payer's individual policy to be sure.

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Mod	Modifier Description, Definition, Explanation, and Tips
QD	**Recording and storage in solid state memory by a digital recorder** **Definition:** Append this modifier for recording and storage by a digital recorder in solid state memory. Report this modifier for informational purposes only; it does not affect payment. **Explanation:** Append modifier QD when the provider records and stores the voice data by a digital recorder in a solid state memory. Report this modifier for informational purposes only; it does not affect payment. **Tips:** Individual payers may have policies that specify which nonphysicians you may use this modifier for. Check the payer's individual policy to be sure.
QE	**Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)** **Definition:** Append this modifier when a provider prescribes oxygen at less than 1 L per minute (LPM) to a patient. This modifier may be appended only to HCPCS codes for stationary oxygen systems. **Explanation:** Append modifier QE when the supplier prescribes oxygen at less than 1 LPM using a stationary oxygen system for a patient. You should not append this modifier with codes for portable systems or oxygen contents. **Tips:** Append modifier QE with stationary gaseous E0424, Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask, and tubing or liquid E0439, Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing systems or with an oxygen concentrator E1390, Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate and E1391, Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each. Fee schedule payments for stationary oxygen system rentals are all inclusive and represent a monthly allowance per beneficiary. Accordingly, a supplier must bill on a monthly basis for stationary oxygen equipment and contents furnished during a rental month. The monthly payment of stationary oxygen decreases by 50 percent if the home health agency supplies stationary oxygen. The suppliers bill this service by appending modifier QE. See QA, QB, QF, QG, QH and QR for other oxygen-related modifiers.
QF	**Prescribed amount of stationary oxygen while at rest exceeds 4 liters per minute (LPM) and portable oxygen is prescribed** **Definition:** Append modifier QF to a code for a patient who is oxygen dependent at rest and receiving more than 4 L of oxygen per minute via a stationary oxygen supply, and who has a provider-prescribed portable oxygen device. **Explanation:** Modifier QF illustrates the quantity of oxygen prescribed, more than 4 L per minute (LPM) to the lungs via a stationary oxygen supply for a patient at rest, as well as prescription of a portable oxygen device. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** When the oxygen supply is greater than 4 LPM without use of portable oxygen, use modifier QG (Prescribed Amount Of Stationary Oxygen While At Rest Is Greater Than 4 Liters Per Minute [LPM]). Proper use of QF is important because Medicare increases monthly payment for oxygen when the patient has a prescription for portable oxygen in addition to stationary oxygen. See QA, QB, QE, QG, QH and QR for other oxygen-related modifiers.
QG	**Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (LPM)** **Definition:** Append modifier QG to a code for a patient who is oxygen dependent at rest, and the provider prescribes oxygen via stationary supply at more than 4 L per minute. **Explanation:** Modifier QG illustrates the quantity of oxygen prescribed via a stationary supply at more than 4 L per minute (LPM) for a patient at rest. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF), the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** When the oxygen supply is greater than 4 LPM using a stationary supply, and the patient also has use of a portable oxygen supply, use modifier QG. Proper use of QG is important because Medicare increases monthly payment for oxygen when the patient has a prescription for portable oxygen in addition to stationary oxygen at greater than 4 LPM. See QA, QB, QE, QF, QH and QR for other oxygen-related modifiers.

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Mod	Modifier Description, Definition, Explanation, and Tips
QH	**Oxygen conserving device is being used with an oxygen delivery system** **Definition:** Append modifier QH to indicate the patient uses a device that controls oxygen flow from an oxygen cylinder based on the rate of inhalation or by delivering pulses of oxygen at fixed volumes per breath. **Explanation:** Modifier QH represents use of an oxygen conserving device with an oxygen delivery system. Patients who are unable to breathe properly due to severe lung disease need supplemental oxygen. The oxygen conserving device, OCD, on a tank or portable oxygen concentrator makes the oxygen supply last longer. It makes oxygen therapy more efficient, more portable. and more cost effective. **Tips:** Medicare requires home health agencies and other suppliers to use modifier QH to indicate the use of an oxygen conserving device. See QE to QH for the range of oxygen related modifiers.
QJ	**Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 CFR 411.4 (b)** **Definition:** Append modifier QJ to a code when the provider supplies the service or item to a patient in jail or custody, subject to the regulations at 42 CFR 411.4 (b). The regulations state Medicare may provide payment if the patient in custody has to repay the cost of the service or item provided to him. **Explanation:** Append modifier QJ only if a medical service or item goes to a prisoner or patient in custody whose state or local law requires him to pay for his own medical care, meeting the conditions of 42 CFR411.4b. Typically the state or local government is responsible for covering the costs of patients in custody, but those regulations say that Medicare may pay for services provided to a person in custody if the situation meets two conditions. The first condition is that state or local law requires the person to repay the cost of medical service she received while in custody. The second condition is that the state or local government bills individuals who received medical care, whether under Medicare or not, and then the government follows the same debt collection practices it uses for other debts. **Tips:** You cannot use modifier QJ with service codes when the patient is not in jail or custody. It is incorrect to use modifier QJ if the patient is in jail but state or local government pays the medical bills. If Medicare denies a modifier QJ claim, you may appeal either by showing that the claim meets the conditions of 42 CFR 411.4b or by showing that the patient was not in custody under authority of penal statute.
QK	**Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals** **Definition:** An anesthesiologist provides medical direction for two to four procedures that overlap each other. **Explanation:** When a physician performs medical direction of two to four concurrent procedures with anesthesia services by qualified individuals, the physician appends modifier QK. Examples of qualified individuals include certified registered nurse anesthetists (CRNAs), anesthesiologist assistants (AAs), interns, and residents. Concurrent means that there is some degree of overlap in the procedures. Depending on payer rules, one minute of overlap may be enough for procedures to be considered concurrent. **Tips:** Check payer rules regarding what qualifies as medical direction.
QL	**Patient pronounced dead after ambulance called** **Definition:** Append modifier QL to an ambulance code when an ambulance arrives and the patient has died on scene. **Explanation:** Modifier QL applies to those ambulance services in which the ambulance reaches the site where the patient is, such as the accident site or home, and a qualified provider declares the patient legally dead before transport in the ambulance. **Tips:** If a provider declares a patient is dead after ambulance dispatch but before ambulance transport, use modifier QL to ensure proper payment. Medicare payment will reflect the basic life support base rate but not mileage or the adjustment for rural services. For payers other than Medicare, check their specific policies.
QM	**Ambulance service provided under arrangement by a provider of services** **Definition:** Append QM modifier to ambulance codes for ambulance services provided under arrangement between the provider and an ambulance company. **Explanation:** When the provider has an arrangement with an ambulance company for ambulance services, then provider appends modifier QM with such ambulance services. **Tips:** If the requesting provider and ambulance service provider are one and the same, append modifier QN, Ambulance service furnished directly by a provider of services. All HCPCS ambulance codes must have a QM or QN modifier.

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Mod	Modifier Description, Definition, Explanation, and Tips
QN	**Ambulance service furnished directly by a provider of services** **Definition:** Append modifier QN to codes for ambulance services supplied directly by the provider. **Explanation:** Use modifier QN to identify ambulance services the provider supplies directly rather than under financial arrangement with outside ambulance service providers. **Tips:** When the provider has an arrangement with an ambulance company for ambulance services, then provider appends modifier QM, Ambulance service provided under arrangement by a provider of services. When ambulance services are provided by another service provider, it may affect reimbursement for these services from outside vendor. All HCPCS ambulance codes must have a QN or QM modifier.
QP	**Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT®-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060.** **Definition:** Append modifier QP to laboratory service codes when the clinician orders the test as a single test, whether as an individual test or as a panel. **Explanation:** Laboratory providers append modifier QP to those single laboratory CPT® codes for individual tests or panel tests. For example, if the lab performs many tests like total serum cholesterol, triglycerides, and high density lipid profile, the lab may report them with the single laboratory code 80061, Lipid panel, with modifier QP. When you append this modifier, you're letting the payer know that you have documentation available that the clinician ordered an individual test or a panel represented by a single CPT® code. **Tips:** Modifier QP is an informational modifier that does not affect payment. Note: Codes 80002-80019, G0058, G0059, and G0060 are deleted CPT® and HCPCS codes, but are still included in this official descriptor from CMS.
QQ	**Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional** **Definition:** Append modifier QQ to a code for services for which the provider consulted and received qualified decision support in determining appropriate use criteria (AUC) before ordering an advanced imaging procedure. **Explanation:** Modifier QQ indicates that a provider accessed and received support from a qualified clinical decision support mechanism for a service he provided. Qualified clinical decision support mechanisms factor into appropriate use criteria (AUC) and quality measures required by certain Medicare/CMS participation programs. Qualified clinical decision support mechanism providers must meet certain requirements and be registered by CMS. **Tips:** A list of qualified clinical decision support mechanisms can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM.html. Beginning in January 2019, physicians must use AUC when ordering advanced imaging procedures such as CT, MRI, and PET for certain specific conditions. Providers can earn points for quality by employing AUC earlier than this deadline.
QR	**Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than 4 liters per minute (LPM)** **Definition:** Add modifier QR to a code when a patient at rest requires different amounts of stationary oxygen during the daytime and nighttime and the average of the two amounts is greater than 4 L per minute (LPM). **Explanation:** Use this modifier when the provider prescribes two different amounts of stationary oxygen for daytime and nighttime use for a patient at rest and the two amounts average greater than 4 L per minute. The prescribed oxygen amount depends upon the severity of disease. In severe conditions like chronic obstructive pulmonary disease (COPD) or chronic respiratory failure (CRF) the lungs fail to provide sufficient oxygen to the body tissues. Sufficient oxygen is essential for all normal physiological functions. **Tips:** When the daytime and nighttime oxygen supply averages greater than 4 LPM and the patient also has a prescribed portable oxygen supply, use modifier QB. See QA, QB, QE, QF, QG, and QH for other oxygen-related modifiers.

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Mod	Modifier Description, Definition, Explanation, and Tips
QS	**Monitored anesthesia care service** **Definition:** Append modifier QS to an anesthesia code when the anesthesia provider's services meet the definition of monitored anesthesia care, or MAC. MAC refers a combination of a local anesthetic with sedation generally administered by a provider who is qualified to provide general anesthesia. **Explanation:** Modifier QS indicates that the anesthesia provider, who may be an anesthesiologist or other qualified individual such as a Certified Registered Nurse Anesthetist, CRNA, or Anesthesiologist Assistant, AA, performs monitored anesthesia care. MAC involves monitoring the patient's vital signs while in the operating room, examination prior to anesthesia, the prescription for anesthesia care, and postoperative care. **Tips:** This modifier does not impact reimbursement; it is informational only. Use this modifier in addition to P modifiers for anesthesia codes. If anesthesia provider provides monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure, use modifier G8. If anesthesia provider provides monitored anesthesia care for a patient who has history of severe cardiopulmonary condition, use modifier G9. Some payers may pay more for this modifier as long as reasons for providing MAC are medically necessary and documented in the record.
QT	**Recording and storage on tape by an analog tape recorder** **Definition:** Append modifier QT to any CPT® or HCPCS code when a recording is made on analog tape while performing any procedure. **Explanation:** Append this modifier when the provider records any procedure or part of a procedure on analog tape. This modifier does not impact reimbursement, it is purely informational only. **Tips:** You can use this modifier at the last modifier position after all other important modifiers.
QW	**CLIA waived test** **Definition:** Append modifier QW to a laboratory test which has been waived from Clinical Laboratory Improvement Amendments requirements. It is compulsory to have CLIA number for such Centers. **Explanation:** Append this modifier to codes for individual laboratory tests that have been waived by the FDA from CLIA requirements. All medical laboratories, including physician office laboratories, must have CLIA certification in order to receive payments from Medicare and Medicaid. The FDA waives some individual tests from CLIA requirements, and CMS publishes a list of these CLIA waived tests quarterly. Lists of waived tests may be obtained from the CMS CLIA web page and clicking on Categorization of Tests in the menu and downloading Tests Granted Waived Status Under CLIA. Providers may use this list to determine if a particular test product can be appropriately performed by a laboratory with a CLIA waiver and is eligible to be billed using the QW modifier.
QX	**CRNA service: with medical direction by a physician** **Definition:** A certified registered nurse anesthetist (CRNA) performs a service under the medical direction of a physician. **Explanation:** When a certified registered nurse anesthetist (CRNA) performs an anesthesia service under the medical direction of a physician, the CRNA appends modifier QX on the claim. **Tips:** The anesthesiologist providing medical direction should use a different modifier, such as modifier QY. If a CRNA performs anesthesia services without medical direction, the CRNA should use modifier QZ. Check payer rules regarding what qualifies as medical direction.
QY	**Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist** **Definition:** An anesthesiologist provides medical direction of one certified registered nurse anesthetist (CRNA). **Explanation:** When an anesthesiologist provides medical direction of one certified registered nurse anesthetist (CRNA) performing an anesthesia service, the anesthesiologist appends modifier QY on the claim. **Tips:** The CRNA performing the procedure should use modifier QX. See modifier QK for medical direction of two to four concurrent anesthesia procedures. Check payer rules regarding what qualifies as medical direction.
QZ	**CRNA service: without medical direction by a physician** **Definition:** A certified registered nurse anesthetist (CRNA) performs a service that a physician does not provide medical direction for. **Explanation:** When a certified registered nurse anesthetist (CRNA) performs an anesthesia service without the medical direction of a physician, the CRNA appends modifier QZ on the claim. **Tips:** If a CRNA performs anesthesia services with medical direction, use modifier QX. Check payer policy for rules regarding what qualifies as medical direction.

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Mod	Modifier Description, Definition, Explanation, and Tips
RA	**Replacement of a DME, orthotic or prosthetic item** **Definition:** Append the modifier RA when the provider replaces the durable medical equipment, prosthetics, or orthotics, and supplies, or DMEPOS, when the beneficiary loses the item or damages it in such a way that it can't be repaired. **Explanation:** Append this modifier to the claim for the replacement of DMEPOS when the supplier furnishes the beneficiary with a new item, identical to the original item, to replace a lost, stolen, or irreparably damaged item. Irreparable damage refers to the wear and tear of the equipment due to an accident, disaster, day to day use, or other event. The medical documentation must include the details related to the replacement of the item. Append the RA modifier on all DMEPOS claims where an item replaces the same item which has been lost, stolen, or irreparably damaged prior to the equipment's reasonable useful lifetime and also for billing replacement claims when the DMEPOS item has met its reasonable useful lifetime. CMS encourages suppliers to enter the abbreviation RUL which indicates reasonable useful lifetime and the date the beneficiary received the original equipment that is being replaced when billing for an item that has met its reasonable useful lifetime use. **Tips:** If the supplier replaces only a part of the item to repair it, use modifier RB, Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair.
RB	**Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair** **Definition:** Append the modifier RB when the provider replaces a part of the durable medical equipment, prosthetics, orthotics, and supplies, or DMEPOS, to repair the item. **Explanation:** Append this modifier to the claim for the replacement of a part of the DMEPOS, so as to repair the damage. The supplier furnishes the beneficiary with a new replacement part for a damaged or worn out part of the item. The medical documentation must include the details related to the replacement of the part of the item, including the amount of time the repair takes, the HCPCS code for the base equipment, that the patient owns the equipment, and the date the patient acquired the equipment. This modifier applies only to items that the beneficiary owns. If the beneficiary rents the DMEPOS item, the rental amount includes the cost of repair and maintenance. **Tips:** If the provider replaces the item completely, use modifier RA, Replacement of a DME, orthotic or prosthetic item.
RC	**Right coronary artery** **Definition:** Append modifier RC to a code for procedures on the right coronary artery. **Explanation:** Append this modifier to codes when the provider performs a procedure on the right coronary artery. The right coronary artery supplies blood to the right atrium and ventricle of the heart, i.e., the upper and the lower chamber of the heart respectively. **Tips:** The various types of procedures on the right coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the left circumflex, append modifier LC, Left circumflex coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider targets the main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on ramus intermedius coronary artery, use modifier RI, Ramus intermedius coronary artery.
RD	**Drug provided to beneficiary, but not administered "incident-to"** **Definition:** Append modifier RD to a claim for a drug that the provider supplies to the beneficiary and the beneficiary may administer the drug on his own. **Explanation:** Report this modifier when the provider supplies a drug to the beneficiary which he may administer on his own. The phrase incident to refers to when the provider administers or supplies a drug as part of his services, such as those necessary to accomplish a primary procedure.
RE	**Furnished in full compliance with FDA-mandated risk evaluation and mitigation strategy (REMS)** **Definition:** Append modifier RE to report extended release or long acting opioid drugs that the provider supplies in compliance with the Food and Drug Administration, or FDA, risk evaluation and mitigation strategy, or REMS. **Explanation:** Append this modifier to the code for an extended release, ER, or long acting, LA, opioid drug, which the provider supplies in compliance with the FDA's risk evaluation and mitigation strategy. ER, LA opioids are highly potent FDA approved drugs, such as morphine sulfate, fentanyl, oxycodone, and hydrocodone, used to treat moderate to severe persistent pain for serious and chronic conditions. The misuse and abuse of these drugs have resulted in a serious public health crisis of addiction, overdose, and death. The REMS is part of a multiagency federal effort to address the growing problem of prescription drug abuse and misuse. The REMS introduces new safety measures to reduce risks and improve safe use of ER, LA opioids while continuing to provide access to these medications for patients in pain.

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Mod	Modifier Description, Definition, Explanation, and Tips
RI	**Ramus intermedius coronary artery** **Definition:** Append modifier RI to the codes for a procedure on the ramus intermedius coronary artery. **Explanation:** Append this modifier to the code when the provider performs a procedure on the ramus intermedius coronary artery. The ramus intermedius coronary artery branches off the left coronary artery, one of the major arteries that supplies blood to the left atrium and ventricle of the heart, i.e., the upper and the lower chambers of the heart respectively. **Tips:** The various types of procedures on the coronary artery include angioplasty, atherectomy, stent placement, or grafting. If the provider performs a procedure on the left circumflex, append modifier LC, Left circumflex coronary artery. If the provider performs a procedure on the left anterior descending artery, use modifier LD, Left anterior descending coronary artery. If the provider targets the main coronary artery, use modifier LM, Left main coronary artery. If the provider performs a procedure on right coronary artery, use modifier RC, Right coronary artery.
RR	**Rental (use the 'RR' modifier when DME is to be rented)** **Definition:** A provider appends modifier RR to identify the use of rented durable medical equipment, or DME, items. **Explanation:** Append modifier RR for rented DME's. Durable medical equipments is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. The equipment this modifier is typically applicable to may be inexpensive or other routinely purchased DME, frequent or substantial servicing, certain customized items, or oxygen equipment. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** Append modifier RR for certain services that the provider submits to durable medical equipment Medicare Administrative Contractors.
RT	**Right side (used to identify procedures performed on the right side of the body)** **Definition:** Append this modifier to the code for a procedure that a provider performs on the patient's right side. **Explanation:** Use this modifier to identify a procedure on the right side of the body. This modifier usually applies to procedures on paired organs, such as eyes, nostrils, ears, ovaries, lungs, and kidneys. **Tips:** If the provider performs the procedure on the left side of the body, append modifier LT, Left side, to identify procedures performed on the left side of the body. If the provider carries out a procedure on both sides, i.e., on each organ of an organ pair, append modifier 50, Bilateral procedure. If the provider performs the service on an organ which is not paired, such as the right side of the back, do not append modifier RT, since there is only one back.
SA	**Nurse practitioner rendering service in collaboration with a physician** **Definition:** Append modifier SA when a nurse practitioner assists the provider in a procedure, other than a surgery. **Explanation:** Use this modifier to show that a nurse practitioner assists the provider in performing a procedure. This modifier should not be used with a surgery code. Nurse practitioner may refer to a certified registered nurse or an assistant. Nurse practitioners are graduates of a nursing program. **Tips:** Use this modifier when the provider bills a service on behalf of the nurse practitioner, who assists the provider during nonsurgical services. If a nurse midwife assists the provider, append modifier SB, Nurse midwife.
SB	**Nurse midwife** **Definition:** Append modifier SB when a nurse midwife performs a service, other than a surgery. **Explanation:** Use this modifier to show that a nurse midwife assists the provider in performing a nonsurgical procedure. This modifier should not be appended to a surgery code. Nurse midwives are certified graduates of a nursing program, who specialize in midwifery i.e., those who provide patient care during pregnancy and childbirth. **Tips:** Use this modifier when the provider bills a service on behalf of the nurse midwife, who assists the provider during nonsurgical services. If a nurse practitioner assists the provider, append modifier SA, Nurse practitioner rendering service in collaboration with a physician.

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Mod	Modifier Description, Definition, Explanation, and Tips
SC	**Medically necessary service or supply** **Definition:** Append modifier SC to codes for services or supplies deemed medically necessary under Medicare's coverage requirements. **Explanation:** The provider appends this modifier for the supply of medically necessary services. Medically necessary services and supplies are those that help to diagnose and treat a medical condition and meet the standard care of medical practice.
SD	**Services provided by registered nurse with specialized, highly technical home infusion training** **Definition:** Append modifier SD to infusion codes when a registered nurse or RN provides infusion services to a patient with a chronic illness who continues to need intravenous infusions at home after discharge from a hospital or rehabilitation Centers. **Explanation:** Append this modifier to infusion codes when a patient, who has a chronic illness and requires intravenous therapy for long term care, receives the service from a trained infusion nurse. Services include administering intravenous therapies, monitoring the patient's condition at home, and training the patient or caregiver how to properly clean and adjust intravenous tubes. Registered nurses are graduates of a nursing program who have passed a national licensing exam. Infusion nurses obtain specialized training and credentials to administer intravenous medications. **Tips:** Do not use modifier SD with infusion codes when the infusion is administered in a hospital setting.
SE	**State and/or federally-funded programs/services** **Definition:** Append modifier SE to codes for services that are paid by state or federal government. **Explanation:** Use modifier SE for those CPT® and HCPCS codes where the state or federal government pays the bills for the services or programs.
SF	**Second opinion ordered by a professional review organization (PRO) per section 9401, p.l. 99-272 (100% reimbursement - no Medicare deductible or coinsurance)** **Definition:** Append modifier SF to such CPT® codes where a quality improvement organization or QIO, also known as peer review organization or PRO, asks a provider to give a second opinion to confirm the decision of another provider. Codes with the SF modifier are reimbursed at 100% with no Medicare deductible or coinsurance if approved. **Explanation:** Append this code when a QIO or PRO asks a provider to give a second opinion for a decision or diagnosis made by another provider. When this modifier is applied, the patient does not pay a deducible or have to use coinsurance, and Medicare pays the provider 100% per section 9401, p.l. 99-272. **Tips:** You can use modifier SF only with certain eye surgery codes.
SG	**Ambulatory surgical Centers (ASC) facility service** **Definition:** Modifier SG appended to CPT® codes identified services provided by an ambulatory surgical Centers, which means facility fee only. Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC providers should discontinue applying the SG modifier on ASC facility claims. **Explanation:** Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC providers should discontinue applying the SG modifier on ASC facility claims.
SH	**Second concurrently administered infusion therapy** **Definition:** Append modifier SH to infusion codes for the second drug when a provider administers more than one drug at the same time by intravenous infusion. Use this code for intravenous infusion therapy codes administered in the patient's home. **Explanation:** When the provider administers two drugs at the same time by intravenous infusion in the patient's home, append this code. This modifier applies only to home infusion therapy. **Tips:** If provider administers three or more drugs by infusion therapy at the same time, use modifier SJ, Third or more concurrently administered infusion therapy.
SJ	**Third or more concurrently administered infusion therapy** **Definition:** Append modifier SJ to home infusion codes for each additional drug after the second when the provider administers multiple drugs at the same time by intravenous infusion. Use this code for intravenous infusion therapy codes administered in the patient's home. **Explanation:** When the provider administers three or more drugs at the same time by intravenous drug infusion in the patient's home, append modifier SH. This modifier applies only to home infusion therapy. **Tips:** If provider administers two drugs at the same time by intravenous infusion, use modifier SH, Second concurrently administered infusion therapy.

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Mod	Modifier Description, Definition, Explanation, and Tips
SK	**Member of high risk population (use only with codes for immunization)** **Definition:** Append modifier SK to immunization codes that are identified for those people who are at high risk for getting a disease, e.g., underlying medical conditions, weakened immune systems, work related, or other special circumstances that increase risk of illness. **Explanation:** When the provider provides immunization to people that he identifies as high risk, he appends modifier SK to such codes. High risk includes those with underlying medical conditions, weakened immune systems, work related, or other special circumstances that increase risk of illness. Identification of high risk individuals is determined by clinical expertise. Decisions regarding whether an individual is part of a high risk population and should receive a specific preventive item or service identified for those at high risk should be made by the attending provider. **Tips:** Do not use modifier SK for immunization codes that are given to patients who are not at high risk.
SL	**State supplied vaccine** **Definition:** Append modifier SL to vaccine codes that a state supplies and a provider administers at no cost to eligible individuals. **Explanation:** Each state provides some vaccines free of cost. Use modifier SL with immunization procedure codes to identify those immunization materials obtained from the state Department of Health to identify that the vaccine itself was obtained at no cost to the provider or patient. **Tips:** You may use this modifier with CPT® codes in the range of 90460 to 90474, Immunization administration for vaccines and toxoids that accurately reflects the administration of the vaccines. Do not append modifier SL to the administration procedure codes. Both the procedure code for the vaccine itself and the code for administration must be submitted, and all vaccines administered on a single date of service must be reported on the same claim.
SM	**Second surgical opinion** **Definition:** Append modifier SM to evaluation and management codes for claims by a consulting provider, when another provider has requested a second opinion. **Explanation:** Use this modifier when you submit an evaluation and management code for a second opinion. The provider performing the second opinion submits the code with the modifier. **Tips:** This modifier may be used with CPT® and HCPCS level II codes. Patient initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures, e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy, are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery, or other major procedure, a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.
SN	**Third surgical opinion** **Definition:** Use this modifier when you submit an evaluation and management code for a third opinion. The provider performing the third opinion submits the code with the modifier. **Explanation:** Use this modifier when you submit an evaluation and management code for a third opinion. The provider performing the third opinion submits the code with the modifier. A third opinion might be requested when the original provider and the consultant come to different conclusions. **Tips:** Patient initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures, e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy, are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery, or other major procedure, a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.

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Mod	Modifier Description, Definition, Explanation, and Tips
SQ	**Item ordered by home health** **Definition:** Append this modifier to indicate that the item the provider orders is for home health service in a patient's home. **Explanation:** Append modifier SQ for an item ordered for a patient receiving home health services such as home infusion therapy, catheter care or maintenance, and respiratory therapy equipment and services. A provider may need to use the SQ modifier for medical and dressing supplies, or durable medical equipment, DME to indicate that the item is for home health use. For coverage of an item, medical documentation for the item and a dated order is generally necessary, with some items requiring preauthorization. **Tips:** This modifier is not covered by Medicare. However, some other payers may allow the claim to process under their home care benefit without a copayment when the provider appends this modifier. For rented durable medical equipment, or DME, use modifier RR, Rented equipment.
SS	**Home infusion services provided in the infusion suite of the IV therapy provider** **Definition:** Append modifier SS when the therapy provider introduces a requisite drug at a specific dosage and at a specific rate into the patient's blood vessels at the infusion therapy providers outpatient infusion suite, a medical office that provides outpatient infusion services. **Explanation:** Append modifier SS when the provider prepares the infusion equipment or provides administration and supplies using the provider's own infusion suite. For example, a typical infusion may involve the provider using an intravenous line connected to a small mechanical pump to administer the drug at the prescribed rate for the prescribed length of time. The time recorded is for the duration of the patient service in the suite. Providers append the modifier to applicable HCPCS codes, which may include: S5522, PICC line insertion, supplies catheter excluded; S5520, PICC line kit; S5523, Midline insertion, supplies catheter excluded and S5521, Midline kit. **Tips:** This modifier is not covered by Medicare. However, some other payers may allow the claim to process under the home care benefit without a copayment. If a nurse does the infusion, use modifier SD, Services provided by registered nurse with specialized, highly technical home infusion training.
ST	**Related to trauma or injury** **Definition:** Append modifier ST to services the provider performs in the case of trauma or injury. **Explanation:** Append modifier ST to report procedures or services which the provider performs on a patient who has undergone a trauma or injury. **Tips:** This modifier is not covered by Medicare but other payers may allow the addition of the ST modifier to codes associated with a trauma patient's care, as long as the care is related to the trauma. The ST modifier may permit a supplemental payment for designated trauma Centers and enhanced rates to providers for trauma cases that meet specific criteria. If a trauma response team associated with hospital provides intensive level of examination and care that a Medicare patient requires, use code G0390, Trauma services associated with critical care services. Medicare policies provide coverage for critical care services of less than 30 minutes provided to the beneficiaries.
SU	**Procedure performed in physician's office (to denote use of facility and equipment)** **Definition:** A provider appends modifier SU to indicate where the provider performs the service in order to show that the provider uses his own facility and equipment while performing a procedure on the patient. **Explanation:** A provider appends modifier SU as an informational modifier to show the location of the service relative to the costs associated with the procedure that the provider performs for the patient. This may include the costs of running an office such as rent, equipment, supplies, and nonphysician staff costs, which may be referred to as the practice expense. **Tips:** Modifier SU is not payable by Medicare.
SV	**Pharmaceuticals delivered to patient's home but not utilized** **Definition:** A provider appends modifier SV to the pharmaceuticals or drugs that a patient receives in the home but the patient never uses them. **Explanation:** A provider appends modifier SV as an informational modifier to indicate drugs that a patient receives in his home setting but never uses them. There are various reasons for the patient not using the drugs, such as a change in the patient's condition, the patient dies, or the patient is admitted to a hospital or skilled nursing facility, or other facility. **Tips:** Modifier SV is not payable by Medicare.

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Mod	Modifier Description, Definition, Explanation, and Tips
SW	**Services provided by a certified diabetic educator** **Definition:** Append modifier SW to identify services that a certified diabetic educator provides to a diabetic patient. **Explanation:** Append modifier SW to denote services that a certified diabetic educator provides to a diabetic patient about lifestyle modification and self management. He may give training to the patient on how to monitor blood glucose levels, educate the patient about diet and exercise, and provide awareness about insulin treatment plans. The educator provides these services according to the instruction of the provider, who is managing the patient's diabetes condition. Certification from the provider, who is managing the patient's condition, is necessary regarding the patient's needs and implementation for the coverage of the service. **Tips:** Medicare provides coverage for diabetes self management education and training, which is provided by a certified provider in accordance with Medicare policies. Reimbursement is based on carrier judgment.
SY	**Persons who are in close contact with member of high-risk population (use only with codes for immunization)** **Definition:** Append this modifier to codes for immunizations a patient receives who either cares for or works closely with patient who are highly prone to infection or a disease. **Explanation:** Append this informational modifier with codes for immunization of persons in close contact with patients who come under the category of high risk population, meaning patients who may have a preexisting risk factor, pathology, or decreased immunity and are more likely to be affected with an infection or disease. Append this modifier with codes for immunizations such as G0008, Administration of influenza virus vaccine, or CPT® 90371, Hepatitis B immune globulin (HBIg), human, for intramuscular use. This code includes the provider counseling the patient or family. **Tips:** Medicare does not pay for this modifier. For immunizations of a member of a high risk population, use modifier SK, Member of high risk population, use only with codes for immunization.
T1	**Left foot, second digit** **Definition:** Append modifier T1 to identify that the provider performs the procedure on the second digit, or toe, of the left foot. **Explanation:** This modifier identifies services that the provider performs on the second digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis, or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T2	**Left foot, third digit** **Definition:** Append modifier T2 to identify that the provider performs a procedure on the third digit, or toe, of the left foot. **Explanation:** This modifier identifies services that a provider performs on the third digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

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Mod	Modifier Description, Definition, Explanation, and Tips
T3	**Left foot, fourth digit** **Definition:** Append modifier T3 to identify that the provider performs a procedure on the fourth digit, or toe, of the left foot. **Explanation:** This modifier identifies services that the provider performs on the fourth digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T4	**Left foot, fifth digit** **Definition:** Append modifier T4 to identify that the provider performs a procedure on the fifth digit, or toe, of the left foot. **Explanation:** This modifier identifies services that a provider performs on the fifth digit, or toe, of a patient's left foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T5	**Right foot, great toe** **Definition:** Append modifier T5 to identify that the provider performs a procedure on the great toe of the right foot. **Explanation:** This modifier identifies services that a provider performs on the great toe of a patient's right foot. Use this modifier for services such as amputation, arthrodesis (fusion) of joints, repair, revision, reconstruction, removal of a foreign body, and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the second through fifth digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the second through fifth digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T6	**Right foot, second digit** **Definition:** Append modifier T6 to identify that the provider performs a procedure on the second digit, or toe, of the right foot. **Explanation:** This modifier identifies services that a provider performs on the second digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

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Mod	Modifier Description, Definition, Explanation, and Tips
T7	**Right foot, third digit** **Definition:** Append modifier T7 to identify that the provider performs a procedure on the third digit, or toe, of the right foot. **Explanation:** This modifier identifies that the provider performs the procedure on the third digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T8	**Right foot, fourth digit** **Definition:** Append modifier T8 to identify that the provider performs a procedure on the fourth digit, or toe, of the right foot. **Explanation:** This modifier identifies services that the provider performs on the fourth digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. These modifiers help to prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
T9	**Right foot, fifth digit** **Definition:** Append modifier T9 to identify that the provider performs a procedure on the fifth digit, or toe, of the right foot. **Explanation:** This modifier identifies services that the provider performs on the fifth digit, or toe, of a patient's right foot. Use this modifier for services such as amputation, arthrodesis or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.
TA	**Left foot, great toe** **Definition:** Append modifier TA to identify that the provider performs a procedure on the great toe of the left foot. **Explanation:** This modifier identifies services that the provider performs on the great toe of a patient's left foot. Add this modifier to codes for services such as amputation, arthrodesis, or fusion of joints of the toe, a repair, revision or reconstruction procedure, removal of foreign body from within the toe and nail bed procedures. **Tips:** Modifier TA represents the great toe of the left foot, and modifiers T1 through T4 represent the 2nd through 5th digits (toes) of the left foot respectively. Modifier T5 represents the great toe of the right foot, and modifiers T6 through T9 represent the 2nd through 5th digits (toes) of the right foot, respectively. These modifiers help prevent denials when the provider submits duplicate codes to report separate procedures on different sites or different sides of the body.

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Mod	Modifier Description, Definition, Explanation, and Tips
TB	**Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes** **Definition:** Entities append informational modifier TB to a code for a drug or biological (a drug derived from a living organism using biotechnology) purchased at a discount under the 340B Drug Pricing Program. **Explanation:** Modifier TB indicates that a drug was purchased at a discount determined under the 340B Drug Pricing Program. Entities use this modifier for informational purposes in line with 340B program reporting rules. Biological refers to a drug or agent derived from human, animal, or microorganism components using biotechnology; examples include cells, genes, tissues, recombinant proteins, vaccines, allergens, and blood and blood components.
TC	**Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable X-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable X-ray suppliers will then be used to build customary and prevailing profiles** **Definition:** A provider appends modifier TC to bill for the technical component of a test only. **Explanation:** Append modifier TC to report the technical component of a procedure that has both a technical and professional component, the payment for which consists of the practice and the malpractice expenses. The provider commonly appends this modifier to procedures such as injection administration, laboratory, radiology, surgery, and radiation therapy. **Tips:** Append modifier TC if the procedure reads as 1, in the PC or TC indicator on the Medicare physician fee schedule database, or MPFSDB. As modifier TC is a payment modifier, report this modifier as the first modifier.
TD	**RN** **Definition:** A provider appends this license level modifier TD when a registered nurse, or RN, provides services to a patient. A license level modifier such as TD represents the treating provider's license level that some payers base reimbursement upon. **Explanation:** A provider may use this modifier to show that a registered nurse helps the provider perform a service. This modifier should not be used with a surgery code. The modifier may also be applicable for behavioral health use, or for home health billing. The nurses may only provide services and bill for codes that fall within the scope of practice allowed by their professional training and state licensure. Check state specific requirements and payer's guidelines for all applicable uses for this code. **Tips:** If a nurse midwife assists the provider, append modifier SB, Nurse midwife. If a nurse practitioner assists the provider with a service, append modifier SA, Nurse practitioner rendering service in collaboration with a physician.
TE	**LPN/LVN** **Definition:** Append this license level modifier TE when a licensed practical nurse, LPN, or a licensed vocational nurse, LVN, provides services to a patient. A license level modifier represents the treating provider's license level that some payers base reimbursement upon. **Explanation:** A provider may use this modifier to show that a licensed practical nurse or a licensed vocational nurse helps the provider perform a service. This modifier stands for a licensed practical nurse, or LPN, in most of the United States. In other areas such as California and Texas, they are also known as a licensed vocational nurse, or LVN. An LPN or LVN takes care of patients who are ill, disabled, or injured. They work under the direction of a supervising physician. This modifier should not be used with a surgery code. The modifier may also be applicable for behavioral health use, or for home health billing. The nurses may only provide services and bill for codes that fall within the scope of practice allowed by their professional training and state licensure. Check state specific requirements and payer's guidelines for all applicable uses for this code. **Tips:** Medicare does not pay for this modifier. If a nurse midwife assists the provider, append modifier SB, Nurse midwife. If a nurse practitioner assists the provider with a service, append modifier SA, Nurse practitioner rendering service in collaboration with a physician. If a registered nurse assists the provider, append the modifier TD, RN.

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Mod	Modifier Description, Definition, Explanation, and Tips
TF	**Intermediate level of care** **Definition:** A provider may append this tier level modifier of TF when the patient receives services at an intermediate level of care. **Explanation:** This modifier indicates that the patient receives an intermediate level of care. A provider determines a patient's level of care by the type and amount of assistance or care the patient requires. An intermediate level is physician supervised service of a patient that typically does not need continuous care or daily therapeutic treatment. Some payers also require this modifier for physical, and or occupational therapy services, home management activities assistance, and even when reporting some tiered office level services. Medicare may even require this modifier at times such as on provider claims for demonstration services to indicate a level of complexity. **Tips:** Medicare does not pay for this modifier. If the patient receives a complex or high level of care, append modifier TG, Complex high level of care.
TG	**Complex/high tech level of care** **Definition:** A provider appends modifier TG when a patient receives a complex or high level of care. **Explanation:** This modifier indicates that the patient receives a complex or high level of care. A provider determines a patient's level of care by the type and amount of assistance or care the patient requires. The patient with a complex or high level of care may have multiple conditions simultaneously, or a critical condition that necessitates a highly skilled and complex level of care, which one or more multispecialty providers may render in a well equipped facility. This may be combined with behavioral health problems, limited functional capabilities, and other patient needs. A provider uses this code to indicate a more intense level of service and a higher complexity of treatment. **Tips:** Medicare does not pay for this modifier. If the patient receives an intermediate level of care, append modifier TF, Intermediate level of care.
TH	**Obstetrical treatment/services, prenatal or postpartum** **Definition:** A provider appends modifier TH when a female patient receives medical care for problems related to her pregnancy and following the birth of the child. **Explanation:** This modifier indicates that a female patient receives medical care for problems related to her pregnancy and following the birth of the child. The provider may render requisite treatment for the various aspects of pregnancy, including monitoring the health of the mother and providing medical support for the recovery of the mother following a cesarean or normal delivery. **Tips:** Medicare does not pay for this modifier.
TJ	**Program group, child and/or adolescent** **Definition:** Append modifier TJ when a group of children or adolescents receive a treatment or therapy program together as a group. **Explanation:** This modifier indicates that the provider renders a service or provides therapy to a group of children or adolescent patients together at the same session. Some states may use to flag service for children's screening exams or mental health services, too. **Tips:** Medicare does not pay for this modifier.
TK	**Extra patient or passenger, non-ambulance** **Definition:** A provider appends modifier TK for a nonambulance vehicle transport of a patient with the patient's caregiver or parent, or an extra patient or passenger. **Explanation:** Use this modifier when a non ambulance vehicle such as a wheel chair van, mini bus or mobility van carries a patient and their caregiver or parent, or an extra patient or passenger. A multiple carry trip for example typically consists of two or more patients who a provider transports on the same trip. **Tips:** Medicare does not pay for this modifier.
TL	**Early intervention/individualized family service plan (IFSP)** **Definition:** A provider appends modifier TL when the provider charts out an early intervention or an individualized service plan for a patient. **Explanation:** Use modifier TL if the provider suggests an early intervention plan for a patient with a condition such as developmental delay, one of a group of disorders a patient can develop in childhood, affecting behavioral growth and development skills. The provider may also offer a customized plan that he charts out according to the specific needs of the patient and family. This type of service is often known as an individualized family service plan, or IFSP. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies and durable medical equipment codes. Medicare does not pay for this modifier.

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Mod	Modifier Description, Definition, Explanation, and Tips
TM	**Individualized education program (IEP)** **Definition:** A provider appends modifier TM when the provider charts out an individualized service plan, or IEP for a patient. **Explanation:** Use modifier TM if the provider suggests a customized patient education plan that he charts out according to the specific needs of the patient and family. A comprehensive IEP treatment plan developed for a specific child may include behavior health, physical therapy, occupational therapy, speech therapy, and audiology services along with screening and assessment services and even IEP specialized transportation. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.
TN	**Rural/outside providers' customary service area** **Definition:** A provider appends this modifier to services he provides in a rural area or an area outside his normal service area. **Explanation:** A provider appends modifier TN as an informational modifier to identify services he provides in a rural area or area outside his normal service area such as outside the county in which the provider is located. This modifier may also identify such services as nonambulance transportation services, home health or hospice services, respite care services, and nursing care, or therapy services a provider renders outside their regular service area. **Tips:** This modifier may be applicable with certain transportation codes.
TP	**Medical transport, unloaded vehicle** **Definition:** A provider appends modifier TP to indicate mileage when a patient is not present in the vehicle. **Explanation:** Use this informational modifier to indicate unloaded mileage when submitting claims for nonemergency transport services such as a wheelchair van, mini bus, or mobility van. Transportation providers are normally paid for loaded mileage, or the time a patient is actually in the vehicle. An unloaded vehicle usually refers to when a patient is not present in the vehicle. Any unloaded mileage is usually inclusive in the base rate for these services. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier. Some payers may also require use of modifier TP with procedure codes A0021 to A0999, which identify all transportation services, including ambulance.
TQ	**Basic life support transport by a volunteer ambulance provider** **Definition:** A provider appends modifier TQ when a volunteer ambulance provider performs a basic life support transport. **Explanation:** Use this modifier when a volunteer ambulance provider performs a basic life support level of service patient transport to the requisite destination. Basic life support services, or BLS services, require the ambulance provider meet certain guidelines, which may include at least two attendants in the ambulance, one of which must be a certified emergency medical technician, or EMT, legally approved to operate all lifesaving and life-sustaining equipment. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier. Some payers may also require use of modifier TP with procedure codes A0021 to A0999, which identify all transportation services, including ambulance.
TR	**School-based individualized education program (IEP) services provided outside the public school district responsible for the student** **Definition:** A provider appends modifier TR when the provider performs school based customized education program services. He provides these services outside the public school district responsible for the student. **Explanation:** Use HCPCS modifier TR when the provider renders a personalized school based education program for a student. He provides this individualized education service, or IEP, outside the public school district responsible for the student. A comprehensive IEP treatment plan developed for a specific child may include behavior health, physical therapy, occupational therapy, speech therapy, and audiology services, along with screening and assessment services, and even IEP specialized transportation. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.

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Mod	Modifier Description, Definition, Explanation, and Tips
TS	**Follow-up service** **Definition:** A provider appends modifier TS for a follow up service for a patient after a first or initial service or procedure. **Explanation:** Use this HCPCS modifier when the provider renders follow up service subsequent to the initial service or procedure. In the follow up service, the provider monitors the recovery or prognosis of the patient's condition. He may also advise additional measures to manage new symptoms that may emerge since the patient's last visit. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare individuals with a diagnosis of prediabetes and certain risk factors may receive up to two screening tests per year and one screening test every six months. A provider reports these screening services with the appropriate Glucose code from the range 82947 to 82951 and modifier TS to indicate the service is a follow up service.
TT	**Individualized service provided to more than one patient in same setting** **Definition:** A provider appends modifier TT when the provider offers an individualized service to more than one patient in the same setting. **Explanation:** Use the HCPCS modifier TT when the provider renders personalized service to each of two or more patients in the same setting. This modifier may identify services provided to two patients who reside in the same residence. The provider generally delivers the service simultaneously. The services can range from nursing services, to multiple passenger transports, to behavior therapy services. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.
TU	**Special payment rate, overtime** **Definition:** A provider appends modifier TU for a special payment rate when the provider performs overtime work, or time worked before or after normally scheduled hours. **Explanation:** Use HCPCS modifier TU to denote the special payment rate that applies when the provider performs services overtime. For example some payers may reimburse for after hours care provided outside the normal business hours, including weekends or holidays and before 8 am and after 5 pm; Monday through Friday. In these situations the payer may require the provider to report the services with the TU modifier in order to receive the special rate. **Tips:** The T modifiers are the HCPCS modifiers for procedures, supplies, and durable medical equipment codes. Medicare does not pay for this modifier.
TV	**Special payment rates, holidays/weekends** **Definition:** A provider appends modifier TV to all services that a patient receives on holidays or weekends, to advise the payer that special payment rates may apply. **Explanation:** Append modifier TV for additional reimbursement for delivery of service at times other than regularly scheduled office hours. This may include, such situations as off hours care, or extended care on a weekend or holiday, when the office is normally closed. **Tips:** Modifier TV is not payable by Medicare. A provider may use modifier TV for a patient who requires seven day per week home care service. Medicaid and other insurers may pay a higher rate for home care visits made on recognized holidays if they are preauthorized.
TW	**Back-up equipment** **Definition:** A provider appends modifier TW to report all types of back up durable medical equipment, or DME. Back up DME, is a secondary piece of equipment that is identical or similar to DME that is already in use. It meets the same medical need for a patient but is provided as a precaution for an emergency situation in case the primary piece of equipment fails. **Explanation:** A provider appends modifier TW for back up durable medical equipment. DME is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. A few examples of back up DME's are wheelchairs, oxygen and other respiratory apparatus such as a backup ventilator, other patient monitoring devices, patient safety equipment, ambulatory infusion pumps, fracture and traction apparatus, and artificial kidney machines. **Tips:** Payers may require providers to append modifier TW to identify back up DME when requesting prior authorization for the item, as well as when submitting claims. Some payers may also request the TW modifier for Orthotic and Prosthetic Devices. Modifier TW is not payable by Medicare.

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Mod	Modifier Description, Definition, Explanation, and Tips
U1	**Medicaid level of care 1, as defined by each state** **Definition:** A provider appends modifier U1 to report the services related to a Medicaid level of care 1, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U1 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or skilled nursing services A or B level of care. A provider may also use this code when he does not identify any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** The definition of modifier U1 may depend upon the procedure code the provider appends the modifier to. For example, in Minnesota the U1 modifier may define Care coordination, basic complexity level when a provider reports with Medical home program, comprehensive care coordination and planning codes S0280 or S0281, but it may mean substance abuse treatment for a special population or clients with children when the provider reports the modifier with H2035, Alcohol And/Or Other Drug Treatment Program, Per Hour. In compliance with Texas, or TX Medicaid, a provider appends modifier U1 to U3, with all delivery claims with codes, 59409, Vaginal delivery only, with or without episiotomy and or forceps, 59612, Vaginal delivery only, after previous cesarean delivery with or without episiotomy and or forceps, 59514, Cesarean delivery only, and 59620, Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery. Providers in Minnesota follow healthcare homes payment methodology to determine whether a patient's condition meets the requirement for a major chronic condition. At this time, the tier reflects the number of major chronic condition groups the patient has and a provider uses a modifier to reflect the projected intensity of care coordination services the patient will require. A provider uses modifier U1 for patients who have one to three major chronic condition groups, to indicate the patient is in Tier one.
U2	**Medicaid level of care 2, as defined by each state** **Definition:** A provider appends modifier U2 to report the services related to a Medicaid level of care 2, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U2 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or skilled nursing services A or B level of care. A provider may also use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** In compliance with Texas, or TX Medicaid, a provider appends modifier U1 to U3, with all delivery claims with codes, 59409, Vaginal delivery only, with or without episiotomy and or forceps, 59612, Vaginal delivery only, after previous cesarean delivery with or without episiotomy and or forceps, 59514, Cesarean delivery only, and 59620, Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery. Providers in Minnesota follow healthcare homes payment methodology to determine whether a patient's condition meets the requirement for a major chronic condition. At this time, the tier reflects the number of major chronic condition groups the patient has and a provider uses a modifier to reflect the projected intensity of care coordination services the patient will require. A provider uses modifier U2 for patients who have seven to nine major chronic condition groups, to indicate the patient is in Tier three.

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Mod	Modifier Description, Definition, Explanation, and Tips
U3	**Medicaid level of care 3, as defined by each state** **Definition:** A provider appends modifier U3 to report the services related to a Medicaid level of care 3, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U3 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or skilled nursing services A or B level of care. A provider may use this code for a mental health services encounter when he performs a behavioral health screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** Professional claims for Medicare demonstration services may include optional supplemental factor modifier U3. Supplemental complexity modifiers means that the provider will be eligible to receive a 15 percent or 30 percent increase in his healthcare homes care coordination payment for certain more complex patients. To indicate complexity, providers in Minnesota may use modifier U3, Primary language non English. This means that the English language skills are not sufficient to discuss and create complicated care plans, complex care choices, and options. This may apply to the patient or to a caregiver of a dependent patient. This also includes those patients or caregivers who are hearing impaired and require a sign language interpreter or use an augmentative communication device. Providers must consider whether the language barrier is significant enough to prevent a discussion with a patient's care team for care coordination services and report this modifier.
U4	**Medicaid level of care 4, as defined by each state** **Definition:** A provider appends modifier U4 to report the services related to a Medicaid level of care 4, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U4 according to their states specific requirements. A provider may use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is a child with a significant or potential behavioral health services need. **Tips:** Professional claims for Medicare demonstration services may include optional supplemental factor modifier U4. Supplemental complexity modifiers mean that the provider will be eligible to receive a 15 percent or 30 percent increase in his healthcare homes care coordination payment for certain more complex patients. To indicate complexity, providers in Minnesota may use modifier U4 for severe and persistent mental illness. This means the patient has an active diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder as per Minnesota statute. This may apply to the patient or to a caregiver of a dependent patient. If a patient has either one of the supplemental complexity modifiers, the allowable charge for the tier payment at this time increases by 15 percent. If both complexity modifiers are present, the allowable charge for the tier payment increases by 30 percent. Providers follow the guidelines provided by the Minnesota healthcare homes payment methodology to determine whether a patient's situation meets the level of warranting a supplemental complexity factor.
U5	**Medicaid level of care 5, as defined by each state** **Definition:** A provider appends modifier U5 to report the services related to a Medicaid level of care 5, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U5 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan, or an increased substance abuse treatment with medical services. A provider may use this code for a mental health services encounter when he performs a behavioral health screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** A provider uses U5 as a local modifier with codes for obstetrical and gynecological services in Illinois. The modifier flags the services as Direct Access services, or service available without a referral. For the Kansas Medical Assistance Program, or KMAP, a provider can append the U5 modifier to identify a Targeted Case Management service when appropriate, typically in the case of the frail and elderly who require a higher level of service. Modifier U5 is not payable by Medicare.

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Mod	Modifier Description, Definition, Explanation, and Tips
U6	**Medicaid level of care 6, as defined by each state** **Definition:** A provider appends modifier U6 to report the services related to a Medicaid level of care 6, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U6 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or for increased service such as an authorized podiatry encounter. A provider may use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is a child with a significant or potential behavioral health services need. **Tips:** An Illinois provider may use U6 as a local modifier with codes for service provided within 60 days of hospital discharge such as a therapy visit within 60 days of hospital discharge. One use of the modifier for California Medicaid is to indicate EC pills, or emergency contraceptive pills. When filing Arkansas Medicaid family planning claims for provider services in an outpatient clinic, the modifier U6, identifies a basic family planning visit, Modifier U6 is not payable by Medicare.
U7	**Medicaid level of care 7, as defined by each state** **Definition:** A provider appends modifier U7 to report the services related to a Medicaid level of care 7, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U7 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or an increased service such as an All-inclusive Clinic Visit. A provider may use this code for a mental health services encounter when he performs a behavioral health screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is typically a child with a significant or potential behavioral health services need. **Tips:** Illinois uses U7 as a local modifier to flag the services for pregnancy resulting from incest. California Medicaid, applies the U7 modifier to denote services rendered by a Physician Assistant, PA. A provider appends the U7 modifier in Indiana for all waiver services. Modifier U7 is not payable by Medicare.
U8	**Medicaid level of care 8, as defined by each state** **Definition:** A provider appends modifier U8 to report the services related to a Medicaid level of care 8, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U8 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or an all inclusive service. A provider may use this code when he identifies any behavioral health need during screening or evaluation of a patient. Identification of behavioral health need means that the provider, who is evaluating the patient, identifies a patient who is a child with a significant or potential behavioral health services need. **Tips:** Illinois uses U8 as a local modifier with codes for pregnancy threatening the mother's life; where New York uses the modifier to flag a delivery prior to 39 weeks of gestation. Modifier U8 is not payable by Medicare.

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Mod	Modifier Description, Definition, Explanation, and Tips
U9	**Medicaid level of care 9, as defined by each state** **Definition:** A provider appends modifier U9 to report the services related to a Medicaid level of care 9, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier U9 according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as a healthcare home programs, comprehensive care, coordination and planning, and initial plan; or for such services as when he evaluates, diagnoses, and treats patients with vision problems, for example. **Tips:** Although Medicaid pays for routine vision care services, such as eyeglasses and routine eye care exams, Medicare generally does not. Therefore, Medicaid requires providers to apply the Medicaid standard fee schedule amounts when submitting claims for routine vision care services to recipients who are enrolled in both Medicaid and Medicare.
UA	**Medicaid level of care 10, as defined by each state** **Definition:** A provider appends modifier UA to report the services related to a Medicaid level of care 10, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UA according to their states specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such to designate that the patient was admitted to the hospital or transferred to another hospital from the ED. **Tips:** Modifier UA is a Medicaid only modifier. Claims using this modifier submitted for members of plans other than Medicaid will be denied. Some providers use the UA modifier for surgical or nongeneral anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. However, when a provider reports this modifier with heroin detoxification code, H0014, Alcohol and/or drug services; ambulatory detoxification, the UA modifier indicates the outpatient heroin detoxification services per visit, days 1 – 7; something completely different.
UB	**Medicaid level of care 11, as defined by each state** **Definition:** A provider appends modifier UB to report the services related to a Medicaid level of care 11, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UB according to their state specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as identifying that a transport is of a critically ill or injured patient over 24 months of age. The UB modifier can also indicate that the age of the patient is less than 21 or greater than 59, as for some Vision care services. **Tips:** Ohio for example uses the UB modifier to describe a Comprehensive ophthalmologic service for an individual younger than 21 or older than 59. In this situation the modifier is applicable only to CPT® procedure codes 92004, Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits, and 92014, Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits. In California, a provider uses this code to identify surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code. However, when a provider reports this modifier with heroin detoxification code, H0014, Alcohol and/or drug services; ambulatory detoxification, the UB modifier indicates outpatient heroin detoxification services per visit, days 8 – 21. In Georgia, modifier UB indicates a delivery is a medically necessary delivery prior to 39 weeks of gestation. Wisconsin providers append the UB modifier to some Mental Health, Telemedical and Health and Behavior procedure codes to indicate an Advanced Practice Nurse provides the service.

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Mod	Modifier Description, Definition, Explanation, and Tips
UC	**Medicaid level of care 12, as defined by each state** **Definition:** A provider appends modifier UC to report the services related to the Medicaid level of care 12, as defined by each state. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. A state may also use this code to have the provider identify a type of service or patient situation. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UC according to their state specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as identifying a Clinical Nurse Specialist performs the service or to ensure payment goes to a Community Mental Health Services Program Provider, or CMHSP, and not to the rendering provider as this modifier indicates the CMHSP is billing Medicaid fee for service for a Community Based Services Waiver Program, or CWP beneficiary. **Tips:** Medicaid rules governing professional services within the Ohio Administrative Code, or OAC, indicate that one may report modifier UC along with 26 if the professional component for radiology procedure codes is provided by an advanced practice nurse, or APN, operating within the APN's scope of practice.
UD	**Medicaid level of care 13, as defined by each state** **Definition:** A provider appends modifier UD to report the services related to a Medicaid level of care 13, as defined by each state. A state may also use this code to have the provider identify a type of service or patient situation. The level of care may relate to the amount of assistance a patient requires, or the complexity of care. See state specific requirements for use of this code. **Explanation:** A provider appends modifier UD according to their state specific requirements. The code often defines a tiered service based upon complexity of care but a provider may need to apply the modifier to identify a type of service or situation such as to denote services provided or drugs purchased under a particular program or when billing for an attending ED provider evaluation and management, or E and M service, to designate that the patient was discharged from the hospital and not admitted. **Tips:** Modifier UD is a Medicaid only modifier. Claims using this modifier submitted for members of plans other than Medicaid will be denied.
UE	**Used durable medical equipment** **Definition:** A provider appends modifier UE to identify an item as used durable medical equipment, or DME, that a patient purchases. DME is medical equipment that helps a patient to manage his activities of daily living in an easier way or that provides therapeutic benefits to a patient. **Explanation:** A provider appends modifier UE to codes for used DME. DME helps the patient to manage his activities of daily living in an easier way. The codes this modifier is typically applicable to are defined as Inexpensive or Routinely Purchased Items, or IRP Items, Capped Rental Items, Items Requiring Frequent and Substantial Servicing, or Oxygen Equipment. A few examples of DME's are crutches, wheelchairs, commodes, canes, walkers, hospital beds, patient safety equipment, and fracture and traction apparatus. **Tips:** Using modifier UE indicates that the provider is furnishing the patient with purchased used durable medical equipment. A provider uses modifier RR, Rented item, if the item is being rented by the patient and modifier NU, New purchased item, if the item is purchased new by the patient.
UF	**Services provided in the morning** **Definition:** A provider appends modifier UF to report that the services that the patient receives from the provider are occurring the morning. **Explanation:** Append modifier UF to identify that the provider sees the patient in the morning. This modifier typically defines services the patient receives between 6 a.m. to 11:59 a.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UF is not payable by Medicare.
UG	**Services provided in the afternoon** **Definition:** A provider appends modifier UG to report that the services that the patient receives from the provider occur in the afternoon. **Explanation:** Append modifier UG to cover services that the patient receives by the provider in the afternoon. This modifier typically defines services the patient receives between 12 p.m. to 5:59 p.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UG is not payable by Medicare.

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Mod	Modifier Description, Definition, Explanation, and Tips
UH	**Services provided in the evening** **Definition:** A provider appends modifier UH to report that the services that the patient receives from the provider occur in the evening. **Explanation:** Append modifier UH to identify that the provider sees the patient in the evening. This modifier typically defines services the patient receives between 6 p.m. to 11:59 p.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UH is not payable by Medicare.
UJ	**Services provided at night** **Definition:** A provider appends modifier UJ to report that the services that the patient receives from the provider occur at night. **Explanation:** Append modifier UJ to cover services that the patient receives by the provider at night. This modifier typically defines services the patient receives between 12 a.m. to 5:59 a.m. and can include such services as provider professional services as well as home visits for mechanical ventilation care; nursing care, assessment or evaluation. **Tips:** Modifier UJ is not payable by Medicare.
UK	**Services provided on behalf of the client to someone other than the client (collateral relationship)** **Definition:** A provider appends modifier UK to report services that the provider performs for someone other than the client, on behalf of the client. **Explanation:** Append modifier UK to cover the services that the provider renders to someone other than the client, on behalf of the client. A provider may need to report this modifier for mental health services such as, a family or couple visit without the client present; or when using H0046, Mental health services, not otherwise specified. This code may also be necessary if submitting newborn care services under the mother's ID information. **Tips:** Modifier UK is not payable by Medicare.
UN	**Two patients served** **Definition:** A provider appends modifier UN when two patients receive services at the same location such as portable X-ray services for two Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. When you report this code combination, R0075 with modifier UN, the total Medicare payment for a single patient service covers both patients. **Tips:** If the provider serves only one patient in the example given, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
UP	**Three patients served** **Definition:** A provider appends modifier UP when three patients receive services at the same location such as for portable X-ray services for three Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to three patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.

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Mod	Modifier Description, Definition, Explanation, and Tips
UQ	**Four patients served** **Definition:** A provider appends modifier UQ when four patients receive services at the same location such as for portable X-ray services for four Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to four patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
UR	**Five patients served** **Definition:** A provider appends modifier UR when five patients receive services at the same location such as for portable X-ray services for five Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to five patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
US	**Six or more patients served** **Definition:** A provider appends modifier US when six patients receive services at the same location such as for portable X-ray services for six Medicare patients at the same location. The provider serves the patients during a single trip that the portable X-ray supplier makes to a particular location. **Explanation:** A provider reports this modifier when he provides services to six patients at the same location. A provider may for example append the modifier with HCPCS code R0075, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, when submitting Medicare portable X-rays. **Tips:** If the provider serves only one patient, he reports a different HCPCS code R0070, Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, and no modifier, since the descriptor for this code states that the service is for one patient seen. Medicare allows a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
V1	**Demonstration modifier 1** **Definition:** Append modifier V1 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.
V2	**Demonstration modifier 2** **Definition:** Append modifier V2 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.

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Mod	Modifier Description, Definition, Explanation, and Tips
V3	**Demonstration modifier 3** **Definition:** Append modifier V3 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.
V4	**Demonstration modifier 4** **Definition:** Append modifier V4 to indicate that the service/procedure is part of a demonstration. **Explanation:** CMS conducts and sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations study the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds. Append the appropriate modifier when the services involve demonstration of a procedure/service to allow accurate identification and documentation for Medicare beneficiaries enrolled in the demonstration. **Tips:** This modifier is part of a series of similar modifiers that indicates demonstration services/procedures. It is advisable to check payer guidelines for use of any of these modifiers.
V5	**Vascular catheter (alone or with any other vascular access)** **Definition:** A provider appends modifier V5 to report a vascular catheter he uses to perform hemodialysis for a patient such as one with end stage renal disease, or ESRD. The provider may use the catheter alone or with another vascular access. **Explanation:** A provider appends this modifier to report the type of vascular access he uses for the delivery of hemodialysis to an ESRD patient. The provider uses the V5 modifier when he uses a vascular catheter for the ESRD patient's hemodialysis service and he uses this access with or without another vascular access to perform the service. ESRD defines the final stage of kidney failure where a patient is not able to live without dialysis or a transplant because of the complete or nearly complete irreversible loss of renal function. ESRD is also referred to as end stage kidney disease, end stage kidney failure, and end stage renal failure. Hemodialysis is a blood filtration procedure for a patient with this advanced, permanent kidney failure. During typical hemodialysis, a dialysis machine removes harmful wastes, salts, and fluid from the blood that would normally be eliminated in the urine. A provider uses a vascular catheter, or a flexible tube that he inserts into a blood vessel through which he can remove and return blood during hemodialysis, or perform other services such as pass instruments, draw blood, or instill fluids. **Tips:** ESRD claims for hemodialysis must indicate the type of vascular access the provider uses for the delivery of the hemodialysis at the last hemodialysis session of the month.
V6	**Arteriovenous graft (or other vascular access not including a vascular catheter)** **Definition:** A provider appends modifier V6 to report an arteriovenous graft, or other vascular access he uses to perform hemodialysis for a patient such as one with end stage renal disease, or ESRD. The provider may use the graft alone or with another vascular access but he does not use a vascular catheter for this service. **Explanation:** A provider appends this modifier to report the type of vascular access he uses for the delivery of hemodialysis to a patient such as an ESRD patient. The provider uses the V6 modifier when he uses an arteriovenous graft, or other vascular access but not a vascular catheter to perform an ESRD patient's hemodialysis service. The provider uses an arteriovenous graft, for the hemodialysis service by surgically connecting a vein to an artery using a soft plastic tube, or an organic material from a person or animal. The provider then uses this access to remove and return blood during the hemodialysis service. ESRD defines the final stage of kidney failure where a patient is not able to live without dialysis or a transplant because of the complete or nearly complete irreversible loss of renal function. ESRD is also referred to as end stage kidney disease, end stage kidney failure, and end stage renal failure. Hemodialysis is a blood filtration procedure for a patient with this advanced, permanent kidney failure. During typical hemodialysis, a dialysis machine removes harmful wastes, salts, and fluid from the blood that would normally be eliminated in the urine. **Tips:** ESRD claims for hemodialysis with must indicate the type of vascular access the provider uses for the delivery of the hemodialysis at the last hemodialysis session of the month.

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Mod	Modifier Description, Definition, Explanation, and Tips
V7	**Arteriovenous fistula only (in use with two needles)** **Definition:** A provider appends modifier V7 to represent an arteriovenous fistula, in use with two needles to perform hemodialysis for a patient such as one with end stage renal disease, or ESRD. The provider does not use a vascular catheter, arteriovenous graft, or other vascular access when he reports this service. **Explanation:** A provider appends this modifier to report the type of vascular access he uses for the delivery of hemodialysis to a patient such as an ESRD patient. A provider appends modifier V7 to represent an arteriovenous fistula, in use with two needles. The provider then uses this access to remove and return blood during the hemodialysis service. ESRD defines the final stage of kidney failure where a patient is not able to live without dialysis or a transplant because of the complete or nearly complete irreversible loss of renal function. ESRD is also referred to as end stage kidney disease, end stage kidney failure, and end stage renal failure. Hemodialysis is a blood filtration procedure for a patient with this advanced, permanent kidney failure. During typical hemodialysis, a dialysis machine removes harmful wastes, salts, and fluid from the blood that would normally be eliminated in the urine. An arteriovenous fistula is a tract or abnormal passageway that is not supposed to be there that connects a coronary artery to the pulmonary venous circulation. **Tips:** ESRD claims for hemodialysis must indicate the type of vascular access the provider uses for the delivery of the hemodialysis at the last hemodialysis session of the month.
VM	**Medicare diabetes prevention program (MDPP) virtual make-up session** **Definition:** Append modifier VM to a code when a provider delivers an in-person virtual make-up session to a beneficiary who missed a group-based, classroom-style, core Medicare diabetes prevention program (MDPP) session. **Explanation:** Modifier VM indicates that the provider electronically delivered a make-up session as part of an established MDPP curriculum to a patient who missed a face-to-face group class. **Tips:** The MDPP is a six-month CDC-approved curriculum consisting of a minimum of 16 intensive "core" educational sessions delivered to a group of patients with prediabetes in a classroom-style setting aimed at preventing progression to type 2 diabetes mellitus. The curriculum provides training in long-term dietary change, increased physical activity, and behavior modification strategies for weight control. Less intensive follow-up monthly sessions help ensure that the participants maintain healthy behaviors. The primary goal of the expanded model is at least 5 percent average weight loss by participants.
VP	**Aphakic patient** **Definition:** A provider appends modifier VP to represent an aphakic patient, or a patient without a lens in the eye. **Explanation:** A provider appends modifier VP to represent an aphakic patient. An aphakic patient is one who has lost the lens of his eye, due to reasons such as surgical removal, an intervening ulcer, or an anomaly from birth. This may lead to problems related to the eye, such as, far sightedness and a loss of accommodation, or adjustment of the eye to view different objects. There may be complications which arise due to aphakia. These may include detachment of the retina and glaucoma. **Tips:** Modifier VP is informational only and you may report it with different types of service such as medical care, surgery, consultation, diagnostic radiology, anesthesia, assistant at surgery, other medical items or services, ambulatory surgical Centers, or facility usage for surgical services. If you report modifier VP with codes for any other types of service, the payer may return the claim as unprocessable. The provider may need to resubmit as a new claim without the modifier.
X1	**Continuous/broad services** **Definition:** Append modifier X1 to a code for continuing, broad or comprehensive care services, typically for a patient with multiple chronic conditions, with no anticipated endpoint, provided by primary care and specialty providers. **Explanation:** Modifier X1 defines a patient relationship category in which either a primary care physician or specialist, either directly or coordinating care by others, provide continuous broad or comprehensive care, potentially dealing with multiple chronic health issues, and the patient's health problems are such that no endpoint (cure or other endpoint) is anticipated. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
X2	**Continuous/focused services** **Definition:** Append modifier X2 to a code for ongoing management of a chronic disease with no anticipated endpoint, typically provided by a specialist. **Explanation:** Modifier X2 defines a patient relationship category in which typically a specialist provides ongoing care and management for a specific chronic health issue, such as rheumatoid arthritis, heart disease, or diabetes, and no endpoint (cure or other endpoint) is anticipated. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.

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Mod	Modifier Description, Definition, Explanation, and Tips
X3	**Episodic/broad services** **Definition:** Append modifier X3 to a code for services rendered by a provider with broad responsibility (i.e., oversight/management) for comprehensive and general care limited to a specific period or circumstance, such as a hospital admission. **Explanation:** Modifier X3 defines a patient relationship category in which a provider, such as a hospitalist, renders general and comprehensive care and management to a patient for a limited period of time, such as a hospitalization. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
X4	**Episodic/focused services** **Definition:** Append modifier X4 to a code for focused care services, such as surgical intervention or radiotherapy, for acute or chronic conditions rendered by a provider for a limited or defined period of time. **Explanation:** Modifier X4 defines a patient relationship category in which a provider, such as a surgeon or radiation oncologist, renders care and management or intervention to a patient for a specific chronic or acute condition over a defined or limited period of time. **Tips:** Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
X5	**Diagnostic services requested by another clinician** **Definition:** Append modifier X5 to a code for primarily diagnostic services, such as interpreting an imaging study, rendered by a provider only as ordered by another clinician. **Explanation:** Modifier X5 indicates that a provider renders a service, primarily diagnostic, to a patient only at the request or order of another provider. The service could be something like interpretation of an imaging study, EKG, or laboratory test. The services may also be subsequent or related services as requested or ordered by another provider. **Tips:** This patient relationship category is reported for patient relationships that may not be adequately captured by modifiers X1-X4. Patient relationship categories facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care.
XE	**Separate encounter, a service that is distinct because it occurred during a separate encounter** **Definition:** Append modifier XE to services that the provider performs for a patient at separate encounters on the same date of service. **Explanation:** A provider appends this modifier when the provider performs services on a patient at separate patient encounters that occur on the same date of service. Modifier XE defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XE, for billing certain codes at high risk for incorrect billing. For example, a provider may identify a particular code pair as payable only with modifier XE but not modifier 59. Modifier XE is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XE is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of this selective modifier as an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XE as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and the XE modifier. However, the system aggregates lines with the XE modifier along with lines containing modifier 59, whenever it collects the modifier 59 lines.
XP	**Separate practitioner, a service that is distinct because it was performed by a different practitioner** **Definition:** Append modifier XP to identify a service that a different provider performs on the patient. **Explanation:** A provider appends this modifier to identify a distinct service that a patient receives from a different provider who performs the service on the patient. Modifier XP defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XP, for billing certain codes at high risk for incorrect billing. Modifier XP is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XP is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of these selective modifiers an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XP as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and XP modifier. However, the system aggregates lines with the XP modifier along with lines containing modifier 59 whenever it collects modifier 59 lines.

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Mod	Modifier Description, Definition, Explanation, and Tips
XS	**Separate structure, a service that is distinct because it was performed on a separate organ/structure** **Definition:** Append modifier XS to a service that the provider performs for a patient on a separate organ or structure. **Explanation:** A provider appends this modifier to identify a distinct service when the provider performs services on a patient on different organs or structures. Modifier XS defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XS, for billing certain codes at high risk for incorrect billing. Modifier XS is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XS is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of this selective modifier as an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XS as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and XS modifier. However, the system aggregates lines with the XS modifier along with lines containing modifier 59 whenever it collects the modifier 59 lines.
XU	**Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service** **Definition:** Append modifier XU to a service that is distinct because it does not overlap with the usual components of the main service. **Explanation:** A provider appends this modifier to identify the service as a distinct service, as the service the provider performs does not overlap with the unusual components of the main, or primary, service he renders to a patient. Modifier XU defines a subset of the modifier 59, Distinct Procedural Service. CPT® instructions state that a provider should not use modifier 59 when a more descriptive modifier is available, such as modifier XU, for billing certain codes at high risk for incorrect billing. Modifier XU is a more selective version of modifier 59 so it would be incorrect to include both modifiers on the same line. The combination of an alternative specific modifier with a general less specific modifier creates additional evaluation for both reporting and editing. Modifier XU is a valid modifier even before national edits are in place, so contractors are not prohibited from requiring the use of this selective modifier as an alternative to the general modifier 59 when necessary by local program integrity and compliance needs. **Tips:** Contractors recognize modifier XU as a separate modifier and the system allows a provider to report multiple lines with modifier 59 and XU modifier. However, the system aggregates lines with the XU modifier along with lines containing modifier 59 whenever it collects modifier 59 lines.

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Appendix C
List of Abbreviations

Abbreviation	Description
/	or
<	less than
<=	less than equal to
>	greater than
>=	greater than equal to
AAA	abdominal aortic aneurysm
AC	alternating current
ACE	Angiotensin converting enzyme
AFO	ankle-foot orthosis
AICC	anti-inhibitor coagulant complex
AK	above the knee
AKA	above knee amputation
ALS	advanced life support
AMP	ampule
ARB	Angiotensin receptor blocker
ART	arterial
ASC	ambulatory surgery center
ATT	attached
A-V	arteriovenous
AVF	arteriovenous fistula
BICROS	bilateral routing of signals
BK	below the knee
BKA	below knee amputation
BLS	basic life support
BMI	body mass index
BP	blood pressure
BTE	behind the ear (hearing aid)
CAD	coronary artery disease
CAPD	continuous ambulatory peritoneal dialysis
Carb	carbohydrate
CBC	complete blood count
cc	cubic centimeter
CCPD	continuous cycling peritoneal dialysis
CGH	comparative genomic hybridization
CHF	congestive heart failure
CIC	completely in the canal (hearing aid)
CIM	Coverage Issue Manual
CISD	critical incident stress debriefing
cm	centimeter
CMN	certificate of medical necessity
CMS	Centers for Medicare & Medicaid Services

Abbreviation	Description
CMV	Cytomegalovirus
Conc	concentrate(d)
Cont	continuous
CP	clinical psychologist
CPAP	continuous positive airway pressure
CPT®	Current Procedural Terminology
CRF	chronic renal failure
CRNA	certified registered nurse anesthetist
CROS	contralateral routing of signals
CSW	clinical social worker
CT	computed tomography
CTLSO	cervical-thoracic-lumbar-sacral orthosis
cu	cubic centimeter
DC	direct current
DI	diabetes insipidus
DLI	donor leukocyte infusion
DME	durable medical equipment
DME MAC	durable medical equipment Medicare administrative contractor
DMEPOS	durable medical equipment; prosthetic, orthotics, and other supplies
DMERC	durable medical equipment regional carrier
DR	diagnostic radiology
Dx	diagnosis
DXA	dual-energy X-ray absorptiometry
e.g.	for example
Ea	each
ECF	extended care facility
EEG	electroencephalogram
EKG	electrocardiogram
EMG	electromyography
EO	elbow orthosis
EP	electrophysiologic
EPO	epoetin alfa
EPSDT	early periodic screening, diagnosis and treatment
ESRD	end-stage renal disease
Ex	extended
EXPER	experimental
Ext	external
FDA	Food and Drug Administration

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Abbreviation	Description
FDG-PET	positron emission with tomography with 18 fluorodeoxyglucose
Fem	female
FO	finger orthosis
FPD	fixed partial denture
Fr	french
ft	foot
G-CSF	filgrastim (granulocyte colony-stimulating factor)
gm or g	gram
H2O	water
HCL	hydrochloric acid
HCPCS	Healthcare Common Procedural Coding System
HCT	hematocrit
HCV	Hepatitis C virus
HDL-C	high density lipoprotein- cholesterol
HF	heart failure
HFO	hand-finger orthosis
HHA	home health agency
HI	high
HI-LO	high-low
HIT	home infusion therapy
HKAFO	hip-knee-ankle foot orthosis
HLA	human leukocyte antigen
HMES	heat and moisture exchange system
HNPCC	hereditary non-polyposis colorectal cancer
HO	hip orthosis
HPSA	health professional shortage area
HST	home sleep test
I-131	Iodine 131
IA	intra- arterial administration
Ibs	pounds
ICF	intermediate care facility
ICU	intensive care unit
IM	intramuscular
in	inch
INF	infusion
INH	inhalation solution
INJ	injection
IOL	intraocular lens
ip	interphalangeal
IPD	intermittent peritoneal dialysis
IPPB	intermittent positive pressure breathing
IT	intrathecal administration
ITC	in the canal (hearing aid)

Abbreviation	Description
ITE	in the ear (hearing aid)
IU	international units
IV	intravenous
IVF	in vitro fertilization
IVP	Intrauterine pregnancy
KAFO	knee-ankle-foot orthosis
KO	knee orthosis
KOH	potassium hydroxide
L	left
LASIK	laser in situ keratomileusis
LAUP	laser assisted uvulopalatoplasty
lbs	pounds
LDL	low density lipoprotein
LDS	lipodystrophy syndrome
Lo	low
LOPS	loss of protective sensation
LPM	liters per minute
LPN/LVN	Licensed Practical Nurse/Licensed Vocational Nurse
LSO	lumbar-sacral orthosis
LTC	long term care facility
LVEF	left ventricular ejection fraction
MAC	Medicare Administrative Contractor
mcg	microgram
mCi	millicurie
MCM	Medicare Carriers Manual
MCP	metacarpophalangeal joint
mEq	milliequivalent
MESA	microsurgical epididymal sperm aspiration
mg	milligram
mgs	milligrams
MHT	megahertz
ml	milliliter
mm	millimeter
mmHg	millimeters of Mercury
mp	metacarpophalangeal
MRA	magnetic resonance angiography
MRI	magnetic resonance imaging
NA	sodium
NCI	National Cancer Institute
NEC	not elsewhere classified
NG	nasogastric
NH	nursing home
NMES	neuromuscular electrical stimulation
NOC	not otherwise classified
NOS	not otherwise specified

Abbreviation	Description
NSR	normal sinus rhythm
O2	oxygen
OBRA	Omnibus Budget Reconciliation Act
OMT	osteopathic manipulation therapy
OPPS	outpatient prospective payment system
ORAL	oral administration
OSA	obstructive sleep apnea
Ost	ostomy
OTH	other routes of administration
oz	ounce
PA	physician's assistant
PAR	parenteral
PCA	patient controlled analgesia
PCH	pouch
PEN	parenteral and enteral nutrition
PENS	percutaneous electrical nerve stimulation
PET	positron emission tomography
PHP	pre-paid health plan
PHP	physician hospital plan
PI	paramedic intercept
PICC	peripherally inserted central venous catheter
PKR	photorefractive keratotomy
PNB	peripheral nerve block
Pow	powder
PPPS	personalized prevention plan of service
PQRS	physician quality reporting system
PRK	photoreactive keratectomy
PRO	peer review organization
PSA	prostate specific antigen
PTB	patellar tendon bearing
PTK	phototherapeutic keratectomy
PVC	polyvinyl chloride
R	right
Repl	replace
RN	registered nurse
RP	retrograde pyelogram
Rx	prescription
SACH	solid ankle, cushion heel
SC	subcutaneous
SCT	specialty care transport
SEO	shoulder-elbow orthosis
SEWHO	shoulder-elbow-wrist-hand orthosis
SEXA	single energy X-ray absorptiometry
SGD	speech generating device
SM	samarium
SNCT	sensory nerve conduction test
SNF	skilled nursing facility
SO	sacroiliac orthosis
SO	shoulder orthosis
Sol	solution
SQ	square
SR	screen
SR	sustained release
ST	standard
Syr	syrup
TABS	tablets
Tc	Technetium
Tc 99m	Technetium isotope
TD	diphtheria toxoids vaccine
TDAP	diphtheria toxoids and acellular pertussis vaccine
TEE	transesophageal echocardiography
TENS	transcutaneous electrical nerve stimulator
THKAO	thoracic-hip-knee-ankle orthosis
TLSO	thoracic-lumbar-sacral-orthosis
TM	temporomandibular
TMJ	temporomandibular joint
TPN	total parenteral nutrition
U	unit
uCi	microcurie
VAR	various routes of administration
w	with
w/	with
w/o	without
WAK	wearable artificial kidney
wc	wheelchair
WHFO	wrist-hand-finger orthotic
wk	week
Xe	Xenon (isotope mass of xenon 133)

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Appendix D
Place of Service/Type of Service

Place of Service

Code	Place of Service	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/ Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

Code	Place of Service	Place of Service Description
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post- partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long- term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

Code	Place of Service	Place of Service Description
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66	Programs of All-Inclusive Care for the Elderly (PACE) Center	A facility or location providing comprehensive medical and social services as part of the Programs of All-Inclusive Care for the Elderly (PACE). This includes, but is not limited to, primary care; social work services; restorative therapies, including physical and occupational therapy; personal care and supportive services; nutritional counseling; recreational therapy; and meals when the individual is enrolled in PACE. (Effective August 1, 2024)
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Type of Service

Code	Type of Service Description
0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services
A	Used DME
B	High Risk Screening Mammography
C	Low Risk Screening Mammography
D	Ambulance
E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center (Facility Usage for Surgical Services)

Code	Type of Service Description
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Outpatient Mental Health Treatment Limitation
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy

Appendix E
APC Status Indicators

This status indicator list reflects proposed OPPS payment status indicators for CY 2025 available when this book was published.

Status Indicator	Definition
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS,* for example: • Ambulance Services • Separately Payable Clinical Diagnostic Laboratory Services • Separately Payable Non-Implantable Prosthetics and Orthotics • Physical, Occupational, and Speech Therapy • Diagnostic Mammography • Unclassified drugs and biologicals reportable under HCPCS code C9399
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).
C	Inpatient Procedures
D	Discontinued Codes
E1	Items, Codes, and Services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary
E2	Items, Codes, and Services: For which pricing information and claims data are not available
F	Corneal Tissue Acquisition; Certain CRNA Services
G	Pass-Through Drugs and Biologicals
H	Pass-Through Device Categories
J1	Hospital Part B Services Paid Through a Comprehensive APC
J2	Hospital Part B Services That May Be Paid Through a Comprehensive APC
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine; Covid-19 Vaccine; Monoclonal Antibody Therapy Product
M	Items and Services Not Billable to the MAC
N	Items and Services Packaged Into APC Rates
P	Partial Hospitalization or Intensive Outpatient Program
Q1	STV-Packaged Codes
Q2	T-Packaged Codes
Q3	Codes That May Be Paid Through a Composite APC
Q4	Conditionally Packaged Laboratory Tests
R	Blood and Blood Products
S	Procedure or Service, Not Discounted When Multiple
T	Procedure or Service, Multiple Procedure Reduction Applies
U	Brachytherapy Sources
V	Clinic or Emergency Department Visit
Y	Non-Implantable Durable Medical Equipment

* Note — Payments under a fee schedule or payment system other than OPPS may be contractor priced.

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Appendix F
ASC Payment Indicators

Proposed ASC Payment Indicators for CY 2025 Proposed ASC Payment (Addendum DD1)
This payment indicator list reflects proposed OPPS/ASC payment indicators for CY 2025 available when this book was published. Be sure to check the CMS website at www.cms.gov for final changes.

Indicator	Payment Indicator Definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
B5	Alternative code may be available; no payment made.
D1	Ancillary dental service/item; no separate payment made.
D2	Non office-based dental procedure added in CY 2024 or later.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K5	Items, codes, and services for which pricing information and claims data are not available. No payment made.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L1	Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

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Appendix G
Column 1 and Column 2 Correct Coding Edits

Key to Modifier Indicators

0= Modifier Not Allowed

You cannot override this procedure-to-procedure code pair edit using a modifier under any circumstances. If you report both codes for the same patient, on the same date of service, the payer will only reimburse you for the column 1 code.

1= Modifier Allowed

In certain clinical circumstances, you can override this procedure-to-procedure code pair edit using an appropriate modifier. Documentation must support separate reporting and reimbursement.

Column 1	Column 2	Modifier
A9500	A9512	1
A9501	A9512	0
A9502	A9512	0
A9503	A9512	0
A9504	A9512	0
A9510	A9512	0
A9521	A9512	0
A9536	A9512	0
A9537	A9512	0
A9538	A9512	0
A9539	A9512	0
A9540	A9512	1
A9541	A9512	1
A9550	A9512	0
A9551	A9512	0
A9557	A9512	0
A9560	A9512	0
A9561	A9512	0
A9562	A9512	0
A9566	A9512	0
A9567	A9512	0
A9568	A9512	0
A9569	A9512	0
C5271	G0168	1
C5271	G0471	1
C5271	J0670	1
C5272	G0168	1
C5272	G0471	1
C5272	J0670	1
C5273	G0168	1
C5273	G0471	1
C5273	J0670	1
C5274	G0168	1
C5274	G0471	1
C5274	J0670	1
C5275	G0168	1
C5275	G0471	1
C5275	J0670	1
C5276	G0168	1
C5276	G0471	1
C5276	J0670	1
C5277	G0168	1
C5277	G0471	1
C5277	J0670	1
C5278	G0168	1
C5278	G0471	1
C5278	J0670	1
C8906	C8903	1
C8906	C8905	1
C8908	C8903	1
C8908	C8905	1
C8921	C8922	1
C8923	C8924	1
C8923	C8929	0
C8928	C8923	1
C8928	C8924	1
C8928	C8925	1
C8928	C8927	0
C8928	C8929	1
C8928	C8930	0
C8929	C8924	1
C8930	C8929	1
C8931	C8932	0
C8931	J1642	1
C8932	J1642	1
C8933	C8931	0
C8933	C8932	0
C8933	J1642	1
C8934	C8935	0
C8934	J1642	1
C8935	J1642	1
C8936	C8934	0
C8936	C8935	0
C8936	J1642	1
C8957	G0463	1
C9600	G0269	1
C9600	G0471	1
C9601	G0269	1
C9601	G0471	1
C9602	G0269	1
C9602	G0471	1
C9603	G0269	1
C9603	G0471	1
C9604	G0269	1
C9604	G0471	1
C9605	G0269	1
C9605	G0471	1
C9606	G0269	1
C9606	G0471	1
C9607	G0269	1
C9607	G0471	1
C9608	G0269	1
C9608	G0471	1
C9738	G0463	1
C9738	G0471	0
C9738	P9612	0
C9739	G0463	1
C9739	G0471	0
C9739	P9612	0
C9740	C9739	0
C9740	G0463	1
C9740	G0471	0
C9740	P9612	0
C9751	G0463	1
C9751	G0471	1

Column 1	Column 2	Modifier
C9751	J0670	1
C9761	G0463	1
C9761	G0471	0
C9761	P9612	1
C9765	C9764	1
C9766	C9764	1
C9767	C9764	1
C9767	C9765	1
C9767	C9766	1
C9769	C9739	1
C9769	C9740	1
C9769	G0463	1
C9769	G0471	0
C9769	J0670	1
C9769	P9612	0
C9773	C9772	1
C9773	C9774	1
C9773	C9775	1
C9774	C9772	1
C9774	C9775	1
C9775	C9772	1
C9778	G0463	1
C9778	G0471	0
E0781	E0782	1
G0101	G0181	1
G0101	G0182	1
G0101	G0380	1
G0101	G0381	1
G0101	G0382	1
G0101	G0383	1
G0101	G0384	1
G0101	G0406	1
G0101	G0407	1
G0101	G0408	1
G0101	G0425	1
G0101	G0426	1
G0101	G0427	1
G0101	G0463	1
G0101	G0508	1
G0101	G0509	1
G0104	G0105	0
G0104	G0106	1
G0104	G0120	1
G0104	G0121	0
G0104	G0181	1
G0104	G0182	1
G0104	G0380	1
G0104	G0381	1
G0104	G0382	1
G0104	G0383	1
G0104	G0384	1
G0104	G0406	1
G0104	G0407	1
G0104	G0408	1
G0104	G0425	1
G0104	G0426	1
G0104	G0427	1
G0104	G0463	1
G0104	G0471	1
G0104	G0508	1
G0104	G0509	1
G0105	G0122	0
G0105	G0181	1
G0105	G0182	1
G0105	G0380	1
G0105	G0381	1
G0105	G0382	1
G0105	G0383	1
G0105	G0384	1
G0105	G0406	1
G0105	G0407	1
G0105	G0408	1
G0105	G0425	1
G0105	G0426	1
G0105	G0427	1
G0105	G0463	1
G0105	G0471	1
G0105	G0508	1
G0105	G0509	1
G0106	G0105	0
G0106	G0121	0
G0106	G0122	0
G0106	G0181	1
G0106	G0182	1
G0106	G0380	1
G0106	G0381	1
G0106	G0382	1
G0106	G0383	1
G0106	G0384	1
G0106	G0406	1
G0106	G0407	1
G0106	G0408	1
G0106	G0425	1
G0106	G0426	1
G0106	G0427	1
G0106	G0463	1
G0106	G0508	1
G0106	G0509	1
G0108	G0270	0
G0108	G0271	0
G0109	G0270	0
G0109	G0271	0
G0117	G0118	0
G0120	G0105	0
G0120	G0106	0
G0120	G0121	0
G0120	G0122	0
G0120	G0181	1
G0120	G0182	1
G0120	G0380	1
G0120	G0381	1
G0120	G0382	1
G0120	G0383	1
G0120	G0384	1
G0120	G0406	1
G0120	G0407	1
G0120	G0408	1
G0120	G0425	1
G0120	G0426	1
G0120	G0427	1
G0120	G0463	1
G0120	G0508	1
G0120	G0509	1
G0121	G0105	0
G0121	G0122	0
G0121	G0380	1
G0121	G0381	1
G0121	G0382	1
G0121	G0383	1
G0121	G0384	1
G0121	G0406	1
G0121	G0407	1
G0121	G0408	1
G0121	G0425	1
G0121	G0426	1
G0121	G0427	1
G0121	G0463	1
G0121	G0471	1

Column 1	Column 2	Modifier
G0121	G0508	1
G0121	G0509	1
G0123	P3000	0
G0124	G0141	0
G0124	G0147	0
G0124	G0148	0
G0124	P3000	0
G0124	P3001	0
G0127	G0380	1
G0127	G0381	1
G0127	G0382	1
G0127	G0383	1
G0127	G0384	1
G0127	G0406	1
G0127	G0407	1
G0127	G0408	1
G0127	G0425	1
G0127	G0426	1
G0127	G0427	1
G0127	G0463	1
G0127	G0471	1
G0127	G0508	1
G0127	G0509	1
G0141	G0123	0
G0141	G0143	0
G0141	G0144	0
G0141	P3000	0
G0145	G0147	0
G0145	G0148	0
G0148	G0147	0
G0151	G0281	1
G0151	G0283	1
G0151	G0329	1
G0157	G0281	1
G0157	G0283	1
G0157	G0329	1
G0159	G0281	1
G0159	G0283	1
G0159	G0329	1
G0162	G0008	1
G0162	G0009	1
G0162	G0010	1
G0162	G0128	1
G0162	P9612	1
G0162	P9615	1
G0168	G0463	1
G0168	G0471	1
G0168	J0670	1
G0179	G0180	0
G0181	G0102	1
G0181	G0182	1
G0181	G0506	0
G0181	G0511	0
G0182	G0102	1
G0182	G0506	0
G0182	G0511	0
G0239	G0237	1
G0239	G0238	1
G0245	G0127	0
G0245	G0246	0
G0246	G0127	0
G0247	G0127	0
G0257	G0491	1
G0257	G0492	1
G0259	G0471	1
G0260	G0259	0
G0260	G0471	1
G0268	G0463	1
G0268	G0471	1
G0270	G0271	0
G0276	G0453	0
G0281	G0283	1
G0281	G0329	0
G0302	G0303	0
G0302	G0304	0
G0302	G0380	1
G0302	G0381	1
G0302	G0382	1
G0302	G0383	1
G0302	G0384	1
G0302	G0406	1
G0302	G0407	1
G0302	G0408	1
G0302	G0425	1
G0302	G0426	1
G0302	G0427	1
G0302	G0463	1
G0302	G0508	1
G0302	G0509	1
G0303	G0304	0
G0303	G0380	1
G0303	G0381	1
G0303	G0382	1
G0303	G0383	1
G0303	G0384	1
G0303	G0406	1
G0303	G0407	1
G0303	G0408	1
G0303	G0425	1
G0303	G0426	1
G0303	G0427	1
G0303	G0463	1
G0303	G0508	1
G0303	G0509	1
G0304	G0380	1
G0304	G0381	1
G0304	G0382	1
G0304	G0383	1
G0304	G0384	1
G0304	G0406	1
G0304	G0407	1
G0304	G0408	1
G0304	G0425	1
G0304	G0426	1
G0304	G0427	1
G0304	G0463	1
G0304	G0508	1
G0304	G0509	1
G0305	G0380	1
G0305	G0381	1
G0305	G0382	1
G0305	G0383	1
G0305	G0384	1
G0305	G0406	1
G0305	G0407	1
G0305	G0408	1
G0305	G0425	1
G0305	G0426	1
G0305	G0427	1
G0305	G0463	1
G0305	G0508	1
G0305	G0509	1
G0306	G0307	0
G0327	G0104	0
G0327	G0105	0
G0327	G0106	0
G0327	G0120	0
G0327	G0121	0

Column 1	Column 2	Modifier
G0327	G0122	0
G0327	G0452	1
G0327	G0476	1
G0329	G0283	1
G0337	G0101	0
G0337	G0102	0
G0337	G0104	0
G0337	G0105	0
G0337	G0106	0
G0337	G0117	0
G0337	G0118	0
G0337	G0120	0
G0337	G0121	0
G0337	G0245	0
G0337	G0246	0
G0337	G0248	0
G0337	G0250	1
G0337	G0270	0
G0337	G0271	0
G0337	G0410	1
G0337	G0411	1
G0337	G0459	0
G0337	G0463	0
G0337	P3000	0
G0337	P3001	0
G0337	Q0091	0
G0339	G0340	1
G0339	G0459	0
G0339	G0463	0
G0339	G0471	0
G0339	G0500	0
G0339	G6002	0
G0339	G6003	1
G0339	G6004	1
G0339	G6005	1
G0339	G6006	1
G0339	G6007	1
G0339	G6008	1
G0339	G6009	1
G0339	G6010	1
G0339	G6011	1
G0339	G6012	1
G0339	G6013	1
G0339	G6014	1
G0340	G0459	0
G0340	G0463	0
G0340	G0471	0
G0340	G0500	0
G0340	G6002	0
G0340	G6003	1
G0340	G6004	1
G0340	G6005	1
G0340	G6006	1
G0340	G6007	1
G0340	G6008	1
G0340	G6009	1
G0340	G6010	1
G0340	G6011	1
G0340	G6012	1
G0340	G6013	1
G0340	G6014	1
G0341	G0463	1
G0341	G0471	1
G0341	J0670	1
G0341	J1642	1
G0341	J1644	1
G0342	G0341	0
G0342	G0463	1
G0342	G0471	1
G0343	G0341	0
G0343	G0342	0
G0343	G0463	1
G0343	G0471	1
G0380	G0102	1
G0380	G0245	1
G0380	G0246	1
G0380	G0270	1
G0380	G0271	1
G0380	G0459	1
G0380	G0498	1
G0381	G0102	1
G0381	G0245	1
G0381	G0246	1
G0381	G0270	1
G0381	G0271	1
G0381	G0380	1
G0381	G0459	1
G0381	G0498	1
G0382	G0102	1
G0382	G0245	1
G0382	G0246	1
G0382	G0270	1
G0382	G0271	1
G0382	G0380	1
G0382	G0381	1
G0382	G0459	1
G0382	G0498	1
G0383	G0102	1
G0383	G0245	1
G0383	G0246	1
G0383	G0270	1
G0383	G0271	1
G0383	G0380	1
G0383	G0381	1
G0383	G0382	1
G0383	G0459	1
G0383	G0498	1
G0384	G0102	1
G0384	G0245	1
G0384	G0246	1
G0384	G0270	1
G0384	G0271	1
G0384	G0380	1
G0384	G0381	1
G0384	G0382	1
G0384	G0383	1
G0384	G0459	1
G0384	G0498	1
G0396	G0442	0
G0396	G2011	0
G0397	G0396	0
G0397	G0442	0
G0397	G2011	0
G0398	G0399	0
G0398	G0400	0
G0399	G0400	0
G0402	G0250	1
G0402	G0270	0
G0402	G0271	0
G0402	G0380	1
G0402	G0381	1
G0402	G0382	1
G0402	G0383	1
G0402	G0384	1
G0402	G0438	0
G0402	G0439	0
G0402	G0444	0
G0402	G0459	1

Column 1	Column 2	Modifier
G0402	G0463	1
G0403	G0404	0
G0403	G0405	0
G0406	G0102	0
G0406	G0245	0
G0406	G0246	0
G0406	G0250	0
G0406	G0270	0
G0406	G0271	0
G0406	G0459	0
G0406	G0498	1
G0407	G0102	0
G0407	G0245	0
G0407	G0246	0
G0407	G0250	0
G0407	G0270	0
G0407	G0271	0
G0407	G0406	0
G0407	G0459	0
G0407	G0498	1
G0408	G0102	0
G0408	G0245	0
G0408	G0246	0
G0408	G0250	0
G0408	G0270	0
G0408	G0271	0
G0408	G0406	0
G0408	G0407	0
G0408	G0459	0
G0408	G0498	1
G0409	G0155	1
G0409	G0176	1
G0409	G0177	1
G0409	G0459	1
G0410	G0176	1
G0410	G0177	1
G0410	G0270	0
G0410	G0271	0
G0410	G0380	1
G0410	G0381	1
G0410	G0382	1
G0410	G0383	1
G0410	G0384	1
G0410	G0459	0
G0410	G0463	1
G0411	G0176	1
G0411	G0177	1
G0411	G0270	0
G0411	G0271	0
G0411	G0380	1
G0411	G0381	1
G0411	G0382	1
G0411	G0383	1
G0411	G0384	1
G0411	G0410	1
G0411	G0459	0
G0411	G0463	1
G0412	G0463	1
G0412	G0471	1
G0413	G0463	1
G0413	G0471	1
G0414	G0463	1
G0414	G0471	1
G0415	G0413	1
G0415	G0463	1
G0415	G0471	1
G0420	G0421	1
G0422	G0423	1
G0422	G0471	1
G0423	G0471	1
G0425	G0102	0
G0425	G0245	0
G0425	G0246	0
G0425	G0250	1
G0425	G0270	0
G0425	G0271	0
G0425	G0406	0
G0425	G0407	0
G0425	G0408	0
G0425	G0459	0
G0425	G0498	1
G0426	G0102	0
G0426	G0245	0
G0426	G0246	0
G0426	G0250	1
G0426	G0270	0
G0426	G0271	0
G0426	G0406	0
G0426	G0407	0
G0426	G0408	0
G0426	G0425	0
G0426	G0459	0
G0426	G0498	1
G0426	G0508	0
G0426	G0509	0
G0427	G0102	0
G0427	G0245	0
G0427	G0246	0
G0427	G0250	1
G0427	G0270	0
G0427	G0271	0
G0427	G0406	0
G0427	G0407	0
G0427	G0408	0
G0427	G0425	0
G0427	G0426	0
G0427	G0459	0
G0427	G0498	1
G0427	G0508	0
G0427	G0509	0
G0428	G0471	1
G0429	G0463	1
G0429	G0471	1
G0438	G0250	1
G0438	G0270	0
G0438	G0271	0
G0438	G0380	1
G0438	G0381	1
G0438	G0382	1
G0438	G0383	1
G0438	G0384	1
G0438	G0439	0
G0438	G0444	0
G0438	G0459	1
G0438	G0463	1
G0439	G0250	1
G0439	G0270	0
G0439	G0271	0
G0439	G0380	1
G0439	G0381	1
G0439	G0382	1
G0439	G0383	1
G0439	G0384	1
G0439	G0459	1
G0439	G0463	1
G0442	G0250	1
G0442	G0270	0
G0442	G0271	0

Column 1	Column 2	Modifier
G0442	G0380	1
G0442	G0381	1
G0442	G0382	1
G0442	G0383	1
G0442	G0384	1
G0442	G0459	1
G0443	G0250	1
G0443	G0270	0
G0443	G0271	0
G0443	G0380	1
G0443	G0381	1
G0443	G0382	1
G0443	G0383	1
G0443	G0384	1
G0443	G0396	0
G0443	G0397	0
G0443	G0459	1
G0443	G2011	0
G0444	G0250	1
G0444	G0270	0
G0444	G0271	0
G0444	G0380	1
G0444	G0381	1
G0444	G0382	1
G0444	G0383	1
G0444	G0384	1
G0445	G0250	1
G0445	G0270	0
G0445	G0271	0
G0445	G0380	1
G0445	G0381	1
G0445	G0382	1
G0445	G0383	1
G0445	G0384	1
G0445	G0444	0
G0447	G0473	1
G0448	G0471	1
G0455	G0463	1
G0458	G0471	0
G0458	G0500	0
G0458	P9612	0
G0459	G0250	1
G0459	G0270	0
G0459	G0271	0
G0459	G0444	1
G0459	G0445	1
G0459	G0446	1
G0459	G0447	1
G0459	G0473	1
G0460	P9020	1
G0463	G0102	0
G0463	G0117	0
G0463	G0118	0
G0463	G0245	0
G0463	G0246	0
G0463	G0248	1
G0463	G0250	1
G0463	G0270	0
G0463	G0271	0
G0463	G0396	1
G0463	G0397	1
G0463	G0442	1
G0463	G0443	1
G0463	G0444	1
G0463	G0445	1
G0463	G0446	1
G0463	G0447	1
G0463	G0459	0
G0463	G0473	1
G0463	G2011	1
G0471	G0463	1
G0471	J0670	1
G0471	P9612	0
G0471	P9615	0
G0475	G0432	0
G0475	G0433	0
G0480	G0659	0
G0481	G0480	0
G0481	G0659	0
G0482	G0480	0
G0482	G0481	0
G0482	G0659	0
G0483	G0480	0
G0483	G0481	0
G0483	G0482	0
G0483	G0659	0
G0491	G0270	0
G0491	G0271	0
G0491	G0380	1
G0491	G0381	1
G0491	G0382	1
G0491	G0383	1
G0491	G0384	1
G0491	G0406	1
G0491	G0407	1
G0491	G0408	1
G0491	G0425	1
G0491	G0426	1
G0491	G0427	1
G0491	G0463	1
G0491	G0471	1
G0491	G0508	1
G0491	G0509	1
G0492	G0270	0
G0492	G0271	0
G0492	G0380	1
G0492	G0381	1
G0492	G0382	1
G0492	G0383	1
G0492	G0384	1
G0492	G0406	1
G0492	G0407	1
G0492	G0408	1
G0492	G0425	1
G0492	G0426	1
G0492	G0427	1
G0492	G0463	1
G0492	G0471	1
G0492	G0508	1
G0492	G0509	1
G0498	G0463	1
G0498	J1644	1
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G0500	G0383	1
G0500	G0384	1
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G0508	G0246	0
G0508	G0250	1

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G0508	G0509	0
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G0509	G0245	0
G0509	G0246	0
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G0509	G0406	0
G0509	G0407	0
G0509	G0408	0
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G0512	G0182	0
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G0518	J0670	1
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G2013	G0079	0
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G2015	G0084	0
G2015	G0085	0
G2015	G0086	0
G2015	G0087	0
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G6002	G0463	1
G6002	G0471	0
G6002	G0500	0
G6002	G6001	0
G6002	G6017	1
G6003	G0459	0
G6003	G0463	1
G6003	G0471	0
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G6004	G0459	0
G6004	G0463	1
G6004	G0471	0
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G6004	G6003	1
G6005	G0459	0
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G6005	G6004	1
G6006	G0459	0
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G6006	G0471	0
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G6006	G6003	1
G6006	G6004	1
G6006	G6005	1
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G6007	G0471	0
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G6009	G6005	1
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G6010	G0471	0
G6010	G0500	0
G6010	G6003	1
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G6010	G6006	1
G6010	G6007	1
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G6010	G6009	1
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G6011	G0471	0
G6011	G0500	0
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G6011	G6004	1
G6011	G6005	1
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G6011	G6008	1
G6011	G6009	1
G6011	G6010	1
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G6012	G0463	1
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G6013	G6010	1
G6013	G6011	1
G6013	G6012	1
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G6014	G0463	1
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G6014	G6007	1
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G6014	G6010	1
G6014	G6011	1
G6014	G6012	1
G6014	G6013	1
G6015	G0339	0
G6015	G0340	0
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G6015	G0463	1
G6015	G0471	0
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G6017	G0500	1
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J2790	J2792	1
J7298	J7297	0
M0222	M0245	1
M0223	E0781	1
M0223	G0463	1
M0243	M0245	1
M0244	E0781	1
M0244	G0463	1
M0246	E0781	1
M0246	G0463	1
P3000	G0380	1
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P3000	G0384	1
P3000	G0406	1
P3000	G0407	1
P3000	G0408	1
P3000	G0425	1
P3000	G0426	1
P3000	G0427	1
P3000	G0463	1
P3000	G0508	1
P3000	G0509	1
P3001	G0123	0
P3001	G0141	0
P3001	G0143	0
P3001	G0144	0
P3001	G0145	0
P3001	G0147	0
P3001	G0148	0
P3001	G0380	1
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P3001	G0382	1
P3001	G0383	1
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P3001	G0407	1
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Column 1	Column 2	Modifier
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P3001	G0426	1
P3001	G0427	1
P3001	G0463	1
P3001	G0508	1
P3001	G0509	1
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P9011	P9021	0
P9011	P9022	0
P9011	P9039	0
P9022	P9010	1
P9022	P9016	1
P9022	P9021	1
P9022	P9039	1
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P9032	P9011	1
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P9032	P9039	1
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P9033	P9010	1
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P9033	P9016	1
P9033	P9019	1
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P9033	P9035	1
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P9033	P9073	1
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P9036	P9011	1
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P9036	P9020	1
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Column 1	Column 2	Modifier
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P9036	P9035	1
P9036	P9039	1
P9036	P9073	1
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P9040	P9035	1
P9040	P9039	1
P9040	P9073	1
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Q0091	G0382	1
Q0091	G0383	1
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Q0091	G0463	1
Q0091	G0508	1
Q0091	G0509	1
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Q1004	Q1005	1
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Q2035	Q2036	0
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Q2035	Q2038	0
Q2035	Q2039	0
Q2036	Q2034	0
Q2036	Q2037	0
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Q2043	G0383	1
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Q2043	G0471	1
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Q9958	Q9951	0
Q9958	Q9959	0
Q9958	Q9964	0
Q9958	Q9965	1
Q9958	Q9966	1
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Q9960	Q9959	0
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Q9960	Q9965	1
Q9960	Q9966	1
Q9960	Q9967	1
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Q9961	Q9959	0
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Q9961	Q9964	0
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Q9962	Q9958	1
Q9962	Q9959	0
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Q9962	Q9964	0
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Q9962	Q9966	1
Q9962	Q9967	1
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Q9963	Q9958	1
Q9963	Q9959	0
Q9963	Q9960	1
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Q9963	Q9962	1
Q9963	Q9964	0
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Q9963	Q9966	1
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Q9965	Q9959	0
Q9965	Q9964	0
Q9966	Q9951	0
Q9966	Q9959	0
Q9966	Q9964	0
Q9966	Q9965	1
Q9967	Q9951	0
Q9967	Q9959	0
Q9967	Q9964	0
Q9967	Q9965	1
Q9967	Q9966	1
R0075	R0070	1
U0001	U0002	0

Appendix H
General Correct Coding Policies

Disclaimer: The information contained in this appendix was the most current information from the CMS website at the time of printing. For the most up-to-date information, visit www.cms.gov.

CHAPTER XII
SUPPLEMENTAL SERVICES

HCPCS LEVEL II CODES A0000 – V9999 FOR MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

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CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

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Chapter XII

Supplemental Services

HCPCS Level II Codes A0000-V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to Healthcare Common Procedure Coding System (HCPCS) Level II codes. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians shall report the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT®) code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT® code shall be reported only if all services described by the code are performed. A physician shall not report multiple HCPCS/CPT® codes if a single HCPCS/CPT® code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT® codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician shall not separately report these services simply because HCPCS/CPT® codes exist for them.

Specific issues unique to HCPCS Level II codes are clarified in this chapter.

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare & Medicaid Services (CMS) as a complementary coding system to the *CPT® Professional*. These codes describe physician and non-physician services not included in the *CPT® Professional*, supplies, drugs, durable medical equipment, ambulance services, etc. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicare Administrative Contractors (MACs) for Part B services.

B. Evaluation & Management (E&M) Services

This section summarizes some of the Medicare Global Surgery Rules for reporting Evaluation & Management (E&M) services in the global period.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the MAC. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider/supplier to the same beneficiary, certain Global Surgery Rules are applicable to the NCCI program. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 days under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M service is performed on the same date of service as a major surgical procedure to decide whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. The NCCI program does not contain edits based on this rule because MACs have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider/supplier is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall **not** be reported as a separate E&M code. Other "XXX" procedures are **not** usually performed by a physician and have no physician work relative value units associated with them. A provider/supplier shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure.

C. NCCI Procedure-to-Procedure (PTP) Edit Specific Issues

1. HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an E&M service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E&M service is not separately reportable. However, if a significant, separately identifiable E&M service is performed to evaluate other medical problems, the screening pap smear and the E&M service may be

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reported separately. Modifier 25 should be appended to the E&M CPT® code indicating that a significant, separately identifiable E&M service was rendered.

2. HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with E&M services under certain circumstances. If a Medicare covered reasonable and medically necessary E&M service requires breast and/or pelvic examination, HCPCS code G0101 shall not be additionally reported. However, if the Medicare covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT® code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

3. HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an E&M code (e.g., CPT®/HCPCS codes 99202-99499, G0463, G0466-G0470, G0438, G0439). CMS published this policy in the Federal Register, November 2, 1999, Page 59414 as follows:

   "As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

4. Subsection deleted, January 1, 2024.

5. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic, per millicurie) describes a radiopharmaceutical used for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 shall not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if 2 separate nuclear medicine studies are performed on the same date of service, 1 with the radiopharmaceutical described by HCPCS code A9512 and 1 with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported using an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be used for separate nuclear medicine studies on the same date of service as a nuclear medicine study using the radiopharmaceutical described by HCPCS code A9512.

6. The NCCI program contains PTP edits that bundle some radiopharmaceutical codes into *nuclear medicine* procedure codes. In some situations where a patient has 2 nuclear medicine procedures performed on the same date of service, the radiopharmaceutical used for 1 nuclear medicine procedure may be incompatible with the second nuclear medicine procedure. In this circumstance, it may be appropriate to report the radiopharmaceutical with modifiers 59 or *XE or XS*.

7. HCPCS code A4220 describes a refill kit for an implantable pump. It shall not be reported separately with CPT® codes 95990 (Refilling and maintenance of implantable pump..., spinal... or brain...when performed) or 95991 (Refilling and maintenance of implantable pump, spinal... or brain... requiring skill of physician or other qualified health care professional) since Medicare payment for these 2 CPT® codes includes the refill kit.

   Similarly, HCPCS code A4220 shall not be reported separately with CPT® codes 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) or 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 skill of a physician or other qualified health care professional)) since Medicare payment for these 2 CPT® codes includes the refill kit.

8. HCPCS code E0781 describes an ambulatory infusion pump used by a patient for infusions outside the physician office or clinic. It is a misuse of this code to report the infusion pump typically used in the physician office or clinic.

9. HCPCS codes G0422 and G0423 (Intensive cardiac rehabilitation...per session) include the same services as the cardiac rehabilitation CPT® codes 93797 and 93798, but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as 6 hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT® codes 97802-97804) shall not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation service.

   Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation benefit and are not separately reportable. (CMS Final Rule (Federal Register, Vol. 74, No. 226, November 25, 2009, pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable, and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier.

10. Pulmonary rehabilitation (HCPCS/CPT® codes G0424, 94625, 94626) includes therapeutic services and all related monitoring services to improve respiratory function. It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT® code 94618), cardiopulmonary exercise testing (CPT® code 94621)). Pulmonary rehabilitation shall not be reported with HCPCS codes G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles... (includes monitoring)), G0238 (Therapeutic procedures to improve respiratory function... (includes monitoring)), or G0239 (Therapeutic procedures to improve respiratory

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function or increase strength... (includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT® code 94618), cardiopulmonary exercise testing (CPT® code 94621)). (HCPCS code G0424 was deleted January 1, 2022.)

Physical or occupational therapy services performed at the same patient encounter as pulmonary rehabilitation services are included in the pulmonary rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable, and necessary patient encounter on the same date of service as pulmonary rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier. Similarly, physical, and occupational therapy services are not separately reportable with therapeutic pulmonary procedures for the same patient encounter.

Medical nutrition therapy services (CPT® codes 97802-97804) performed at the same patient encounter as a pulmonary rehabilitation or pulmonary therapeutic service are included in the pulmonary rehabilitation or pulmonary therapeutic service and are not separately reportable. The Medicare program provides a medical nutrition therapy benefit to beneficiaries for medical nutrition therapy related to diabetes mellitus or renal disease. If a physician provides a Medicare-covered medical nutrition service to a beneficiary with diabetes mellitus or renal disease on the same date of service as a pulmonary rehabilitation or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition therapy service may be separately reportable with an NCCI-associated modifier. The Medicare-covered medical nutrition service cannot be provided at the same patient encounter as the pulmonary rehabilitation or pulmonary therapeutic service.

11. Presumptive drug testing may be reported with CPT® codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

    Definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. HCPCS code G0659 defining a different type of definitive drug testing was added. Only one *definitive drug testing HCPCS* code may be reported per date of service.

12. In accordance with code descriptor changes for HCPCS codes G0416 effective January 1, 2015, CMS requires that surgical pathology, including gross and microscopic examination, of any and all submitted prostate needle biopsy specimens from a single patient be reported with one unit of service of HCPCS code G0416 rather than CPT® code 88305.

13. Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT® code 86945 (Irradiation of blood product, each unit) shall not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT® codes 86644 and/or 86645 (CMV antibody) shall not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT® codes 86930 (Frozen blood, each unit; freezing (includes preparation)), 86931 (Frozen blood, each unit; thawing), and/or 86932 (Frozen blood, each unit; freezing (includes preparation) and thawing) shall not be reported separately since the P code includes the freezing and thawing processes. If a P code describes a pooled blood product, CPT® code 86965 (Pooling of platelets or other blood products) shall not be reported separately since the P code includes the pooling of the blood products. If the P code describes a "frozen" plasma product, CPT® code 86927 (Fresh frozen plasma, thawing, each unit) shall not be reported separately since the P code includes the thawing process.

14. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes shall not be reported separately with an E&M, psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 shall not be additionally reported. If a provider/supplier reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code using an NCCI PTP-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

    HCPCS codes G0396 and G0397 describe services that are similar to those described by *CPT® codes 99408 and 99409*. The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS Level II codes (e.g., G0442 (Annual alcohol misuse screening, 15 minutes), G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (Annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS Level II code, the HCPCS Level II code is not separately reportable. For example, if a patient presents with symptoms suggestive of depression, the provider/supplier shall not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS Level II code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

15. HCPCS code G0269 describes placement of an occlusive device into a venous or arterial access site after an open or percutaneous vascular procedure. Since this code is status "B" on the Medicare Physician

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Fee Schedule Database, payment for this service is included in the payment for the vascular procedure. Under the Outpatient Prospective Payment System (OPPS), HCPCS code G0269 has a payment status indicator of "N," indicating that payment is packaged into the payment for other services paid. Providers/suppliers reporting services under Medicare's hospital OPPS should report all services in accordance with appropriate Medicare *Internet-Only Manual* (IOM) instructions.

16. HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) shall not be reported separately with CPT® codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since Medicare payment for these 2 CPT® codes includes the amniotic membrane.

17. HCPCS code G0515 (Development of cognitive skills to improve...each 15 minutes) has the same code descriptor as CPT® code 97127, All NCCI PTP and MUE issues that were relevant to CPT® code 97127 are also similarly relevant to HCPCS code G0515. CPT® codes 97129 and 97130 have similar code descriptors as CPT® 97127. All NCCI PTP and MUE issues that were relevant to CPT® code 97127 are also similarly relevant to CPT® codes 97129 and 97130. (HCPCS code G0515 was deleted on January 1, 2020. CPT® code 97127 was deleted January 1, 2020.)

D. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT® code, the provider/supplier may be coding units of service (UOS) incorrectly. The provider/supplier may consider contacting their national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

3. The MUE values of HCPCS Level II codes for discontinued drugs are generally "0."

4. The MUE value of HCPCS Level II codes describing compounded inhalation drugs is "0," because compounded drugs are generally not FDA approved. The CMS IOM *Medicare Benefit Policy Manual* (MCPM), Chapter 15, Section 50.4.1 requires that claims processing contractors only pay for FDA-approved drugs unless CMS issues other instructions.

5. HCPCS code J0171 (Injection, adrenalin, epinephrine, 0.1 mg) may be reported incorrectly. A 1 ml ampule of adrenalin/epinephrine contains 1.0 mg of adrenalin/epinephrine in a 1:1,000 solution. However, a 10 ml prefilled syringe with a 1:10,000 solution of adrenalin/epinephrine also contains only 1.0 mg of adrenalin/epinephrine. Thus, a physician must recognize that 10 UOS for HCPCS code J0171 correspond to a 1 ml ampule or 10 ml of a prefilled syringe (1:10,000 (0.1 mg/ml) solution).

6. There may be multiple HCPCS Level II codes describing certain drugs. For example, HCPCS code J1094 (Injection, dexamethasone acetate, 1 mg) is no longer manufactured and has an MUE value of "0." HCPCS code J1100 (Injection, dexamethasone sodium phosphate, 1 mg) is available and has an MUE of 120. When billing for drugs, providers/suppliers should be careful to report the correct formulation with the correct HCPCS code.

7. If a physician uses more than 999 USP units of the product described by J3471 (Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)), the provider/supplier may report HCPCS code J3471 on more than 1 line of a claim appending modifier 59 or XU to additional claim lines.

8. The MUE values for practitioner services for oral immunosuppressive, oral anti-cancer, and oral anti-emetic drugs are set at "0." Practitioners providing these medications to patients must bill the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), rather than the Part A/Part B Medicare Administrative Contractors (A/B MACs), using the National Drug Codes (NDC). A/B MACs do not pay codes for these oral medications when submitted on practitioner claims.

   The MUE values for outpatient hospital services are generally based on the amount of drug that might be administered to a patient on a single date of service. Facilities may not report to the A/B MAC more than a one-day supply of any of these drugs for a single date of service. Outpatient hospital facilities may submit claims to DME MACs for a multiple-day supply of these drugs provided on a single date of service.

9. If a HCPCS Level II drug code descriptor defines the unit of service as "per dose," only one unit of service may be reported per drug administration procedure even if more than the usual amount of drug is administered. For example, HCPCS code J7321 (Hyaluronan or derivative Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose) describes a drug that may be injected into the knee joint. Only one unit of service may be reported for injection of the drug into each knee joint, even if the amount of injected drug exceeds the usual amount of drug injected.

10. Presumptive drug testing may be reported with CPT® codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

    Definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes are reported "per day" and shall not be reported with more than one unit of service per day. Definitive drug testing HCPCS code G0659 is reported "per day" and shall not be reported with more than one unit of service per day. Only one definitive drug testing HCPCS code may be reported per date of service.

11. HCPCS codes Q9951 and Q9965-Q9967 describe low osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered. The MUE value for HCPCS code Q9951 (Low osmolar contrast material, 400 or greater mg/ml

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iodine concentration, per ml) is "0." When this MUE value was established, no low osmolar contrast material products with iodine concentration of 400 mg iodine or greater per ml were identified. HCPCS code Q9951 is often incorrectly reported for low osmolar contrast material products with lower iodine concentrations. Similarly, HCPCS codes Q9958-Q9964 describe high osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered.

12. HCPCS code K0462 (Temporary replacement for patient owned equipment being repaired, any type) may be reported with one unit of service for each item of patient-owned equipment that is being repaired. Component parts of a patient-owned piece of equipment being repaired shall not be reported separately. For example, if a patient-owned CPAP (continuous positive airway pressure) blower requires repair, the provider/supplier may report one unit of service for K0462. The provider/supplier shall not report an additional unit of service for an integral humidifier even if it also requires repair. Additionally, the provider/supplier shall not report an additional unit of service for a detachable humidifier unless it also requires repair at the same time.

13. Generally, only one unit of service for an item of durable medical equipment (DME) (e.g., oxygen concentrator, wheelchair base) may be paid on a single date of service. Medicare does not allow payment for backup or duplicate durable medical equipment. More than one unit of service may be paid on a single date of service for accessories and supplies related to DME when appropriate. Prosthetics and orthotics may also be paid with more than one unit of service on a single date of service when appropriate.

14. HCPCS code P9604 describes a prorated, one-way travel allowance for collection of medically necessary laboratory specimen(s) drawn from a home bound or nursing home bound patient. A round trip should be reported with modifier LR and 2 unit of service rather than 2 UOS. The reported UOS shall be prorated for multiple patients drawn at the same address and for stops at the homes of Medicare and non-Medicare patients, as described in the Medicare IOM Publication 100-04 MCPM, Chapter 16 (Laboratory Services), Section 60.2.

15. The CMS IOM Publication 100-04 MCPM, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one unit of service on a single claim line unless the code descriptor defines the procedure as "bilateral." If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50. The MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on 2 claim lines, each with 1 unit of service using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

16. HCPCS codes G0406-G0408 describe follow-up inpatient consultation services via telehealth, and HCPCS codes G0425-G0427 describe emergency or initial inpatient telehealth consultation services via telehealth. These codes shall not be reported by a practitioner on the same date of service that the practitioner reports a face-to-face E&M code. These codes are used to report telehealth services that, if performed with the patient physically present, would be reported with corresponding CPT® codes.

    Since follow-up inpatient consultation services with a patient present are reported using per diem CPT® codes 99231-99233, HCPCS codes G0406-G0408 may only be reported with a single unit of service per day.

    Since initial inpatient consultation services with a patient present are reported using per diem CPT® codes 99231-99233, HCPCS codes G0425-G0427 may only be reported with a single unit of service per day when reporting inpatient telehealth consultation services. However, if HCPCS codes G0425-G0427 are used to report emergency department services, reporting rules are comparable to CPT® codes 99281-99285.

17. HCPCS code G9157 (Transesophageal doppler measurement of cardiac output (including probe placement, image acquisition, and interpretation per course of treatment) for monitoring purposes) describes a diagnostic procedure reportable only for ventilated patients in the Intensive Care Unit or operative patients with a need for intra-operative fluid optimization. Reporting this code is limited to an inpatient hospital place of service. HCPCS code G9157 shall be reported no more than once per course of treatment.

E. General Policy Statements

1. The MUE values and NCCI PTP edits are based on services provided by the same provider/supplier to the same beneficiary on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

2. In this manual, many policies are described using the term "physician." Unless indicated differently the use of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT® codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules, CMS IOM Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services) and Global Surgery Rules, CMS IOM Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery) do not apply to hospitals.

3. Providers/suppliers reporting services under Medicare's hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare IOM instructions.

4. In 2010, the "*CPT® Professional* modified the numbering of codes so that the sequence of codes as they appear in the *CPT® Professional* does not necessarily correspond

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to a sequential numbering of codes. In the *Medicare NCCI* Policy Manual, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT® Professional*.

5. With few exceptions, the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT® codes. Wound closures using adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances, wound closure using tissue adhesive may be reported separately. If a practitioner uses a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (Wound closure utilizing tissue adhesive(s) only). If a practitioner uses tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under the OPPS, HCPCS code G0168 is not recognized and paid. Facilities may report wound closure using sutures, staples, or tissue adhesives, singly or in combination with each other, with the appropriate CPT® code in the Repair (Closure) section of the *CPT® Professional*.

6. With limited exceptions, Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The provider/supplier shall not report CPT® codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the provider/supplier shall not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT® code 36000), venipuncture (CPT® code 36410), drug administration (e.g., CPT® codes 96360-96379) or cardiac assessment (e.g., CPT® codes 93000-93010, 93040-93042) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

   Medicare generally allows separate reporting for moderate conscious sedation services (CPT® codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

   Under Medicare Global Surgery Rules, drug administration services (e.g., CPT® codes 96360-96379) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

   Under the OPPS, drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT® codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers/suppliers shall not report CPT® codes 96360-96379 for these services.

   Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT® codes 36000, 36410, 62320-62327, 64400-64450 describe some services that may be used for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

   If a physician performing an operative procedure provides a drug administration service (CPT® codes 96360-96379) unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT® codes 96360-96379) may be reported with an NCCI PTP-associated modifier if performed in a non-facility site of service.

7. The Medicare global surgery package includes insertion of urinary catheters. CPT® codes 51701-51703 (Insertion of bladder catheters) shall not be reported with any procedure with a global period of 000, 010, or 090 days, nor with some procedures with a global period of MMM.

8. Closure/repair of a surgical incision is included in the global surgical package except as noted below. Wound repair CPT® codes 12001-13153 shall not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT® codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT® codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT® codes 11600-11646). Wound repair codes (CPT® codes 12001-13153) not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT® codes 11400, 11420, 11440).

9. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable using modifier 78.

10. For more information regarding biopsies, see Chapter I, Section A, Introduction.

11. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI PTP-associated modifiers (Correct Coding Modifier Indicator (CCMI) of "1") because the 2 codes of the code pair edit may be reported if the 2 procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the 2 codes generally should not be reported together unless the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI PTP-associated modifiers should generally not be used.

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12. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

13. If the code descriptor for a HCPCS/CPT® code, "*CPT® Professional*" instruction for a code, or the CMS instruction for a code indicates that the procedure includes radiologic guidance, a provider/supplier shall not separately report a HCPCS/CPT® code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI PTP-associated modifier if appropriate.

14. CPT® code 36591 describes "collection of blood specimen from a completely implantable venous access device." CPT® code 36592 describes "collection of blood specimen using an established central or peripheral catheter, venous, not otherwise specified." These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

15. CPT® code 96523 describes "irrigation of implanted venous access..." This code may be reported only if no other service is reported for the patient encounter.

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Appendix I
Publication 100 References

Disclaimer: This appendix includes relevant CMS Internet-Only Manual (IOM) references commonly referred to as Pub 100. It is not an all-inclusive document. CMS updates policies and procedures frequently. The information contained here was the most up-to-date information on the CMS website at the time of printing. For more recent updates, visit the CMS website.

100-1, Chapter-1, 10.1

Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers post hospital extended care in SNFs and post hospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider. In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of post hospital extended care services.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

The Part A benefit categories *of* inpatient hospital services *and* SNF services are *each* subject to separate and mutually exclusive day limits, so that the use of benefit days under one of these benefits does not affect the number of benefit days that remain available under the other. *Accordingly*, the 90 days of inpatient hospital benefits (plus 60 nonrenewable lifetime reserve days – see Pub. 100-02, Medicare Benefit Policy Manual, chapter 5) that are available to a beneficiary in a hospital *do not* count against the 100 days of post hospital extended care benefits that are available in a SNF, and vice-versa.

100-1, Chapter-3, 20.5

Blood Deductibles (Part A and Part B)

Program payment may not be made for the first 3 pints of whole blood or equivalent units of packed red cells received under Part A and Part B combined in a calendar year. However, blood processing (e.g., administration, storage) is not subject to the deductible.

The blood deductibles are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

The deductible applies only to the first 3 pints of blood furnished in a calendar year, even if more than one provider furnished blood.

100-1, Chapter-3, 20.5.2

Part B Blood Deductible

Blood is furnished on an outpatient basis or is subject to the Part B blood deductible and is counted toward the combined limit. It should be noted that payment for blood may be made to the hospital under Part B only for blood furnished in an outpatient setting. Blood is not covered for inpatient Part B services.

100-1, Chapter-3, 20.5.3

Items Subject to Blood Deductibles

The blood deductibles apply only to whole blood and packed red cells. The term whole blood means human blood from which none of the liquid or cellular components have been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biological.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §231 regarding billing for blood and blood products under the Hospital Outpatient Prospective Payment System (OPPS).

100-1, Chapter-3, 30

Outpatient Mental Health Treatment Limitation

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 –December 31, 2011, the limitation percentage is 68.75%.
  (Medicare pays 55% and the patient pays 45%).
- January 1, 2012 –December 31, 2012, the limitation percentage is 75%
  (Medicare pays 60% and the patient pays 40%).
- January 1, 2013 –December 31, 2013, the limitation percentage is 81.25%.
  (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 –onward, the limitation percentage is 100%
  (Medicare pays 80% and the patient pays 20%).

For additional details concerning the outpatient mental health treatment limitation, please see the Medicare Claims Processing Manual, Publication 100-04, chapter 9, section 60 and chapter 12, section 210.

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100-1, Chapter-5, 90.2

Laboratory Defined

Laboratory means a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

100-2, Chapter-1, 10

Covered Inpatient Hospital Services Covered Under Part A

Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. (Inpatient hospital services do not include extended care services provided by hospitals pursuant to swing bed approvals. See Pub. 100-02, Chapter 8, §10.3, "Hospital Providers of Extended Care Services."). However, both inpatient hospital and inpatient SNF benefits are provided under Part A - Hospital Insurance Benefits for the Aged and Disabled, of Title XVIII).

Additional information concerning the following topics can be found in the following chapters of this manual:

- Benefit Period is found in Chapter 3
- Counting Inpatient Days is found in Chapter 3
- Lifetime reserve days is found in Chapter 5
- Related payment information is housed in the Provider Reimbursement Manual

Blood must be furnished on a day which counts as a day of inpatient hospital services to be covered as a Part A service and to count toward the blood deductible. Thus, blood is not covered under Part A and does not count toward the Part A blood deductible when furnished to an inpatient after the inpatient has exhausted all benefit days in a benefit period, or where the individual has elected not to use lifetime reserve days. However, where the patient is discharged on their first day of entitlement or on the hospital's first day of participation, the hospital is permitted to submit a billing form with no accommodation charge, but with ancillary charges including blood.

The records for all Medicare hospital inpatient discharges are maintained in CMS for statistical analysis and use in determining future Prospective Payment System (PPS) Diagnosis Related Group (DRG) classifications and rates.

Non-PPS hospitals do not pay for noncovered services generally excluded from coverage in the Medicare Program. This may result in denial of a part of the billed charges or in denial of the entire admission, depending upon circumstance. In PPS hospitals, the following are also possible:

1. In appropriately admitted cases where a noncovered procedure was performed, denied services may result in payment of a different DRG (i.e., one which excludes payment for the noncovered procedure); or
2. In appropriately admitted cases that become cost outlier cases, denied services may lead to denial of some or all of an outlier payment.

The following examples illustrate this principle. If care is noncovered because a patient does not need to be hospitalized, the A/B MAC Part A denies the admission and makes no Part A (i.e., PPS) payment unless paid under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider **and** the beneficiary were **not** aware the services were not necessary and could not reasonably be expected to know that the services were not necessary. For detailed instructions, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 30,"Limitation on Liability" section 20. If a patient is appropriately hospitalized but receives (beyond routine services) only noncovered care, the admission is denied.

NOTE: The A/B MAC Part A does not deny an admission that includes covered care, even if noncovered care was also rendered. Under PPS, Medicare assumes that it is paying for **only** the covered care rendered whenever covered services needed to treat and/or diagnose the illness were in fact provided.

If a noncovered procedure is provided along with covered nonroutine care, a DRG change rather than an admission denial might occur. If noncovered procedures are elevating costs into the cost outlier category, outlier payment is denied in whole or in part.

When the hospital is included in PPS, most of the subsequent discussion regarding coverage of inpatient hospital services is relevant only in the context of determining the appropriateness of admissions, which DRG, if any, to pay, and the appropriateness of payment for any outlier cases.

If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or for only the appropriate prospective payment amount. This provision applies not only to inpatient services, but also to all hospital services under Parts A and B of the program. If the items or services were requested by the patient, the hospital may charge him or her the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services (see §10.2 below). Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

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- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Renal Dialysis - Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. Patients staying at home, who are ambulatory, whose conditions are stable and who come to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, are considered outpatients. On the other hand, patients undergoing short-term dialysis until their kidneys recover from an acute illness (acute dialysis), or persons with borderline renal failure who develop acute renal failure every time they have an illness and require dialysis (episodic dialysis) are usually inpatients. A patient may begin dialysis as an inpatient and then progress to an outpatient status.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

Refer to chapters 4 and 7 of Pub. 100-10, Quality Improvement Organization Manual with regard to initial determinations for these services. The QIO will review the swing bed services in these PPS hospitals as well.

NOTE: When patients requiring extended care services are admitted to beds in a hospital, they are considered inpatients of the hospital. In such cases, the services furnished in the hospital will not be considered extended care services, and payment may not be made under the program for such services unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of Health and Human Services.

100-2, Chapter-1, 10.1.4

Charges for Deluxe Private Room

Beneficiaries found to need a private room (either because they need isolation for medical reasons or because they need immediate admission when no other accommodations are available) may be assigned to any of the provider's private rooms. They do not have the right to insist on the private room of their choice, but their preferences should be given the same consideration as if they were paying all provider charges themselves. The program does not, under any circumstances, pay for personal comfort items. Thus, the program does not pay for deluxe accommodations and/or services. These would include a suite, or a room substantially more spacious than is required for treatment, or specially equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. If the beneficiary (or representative) requests such deluxe accommodations, the provider should advise that there will be a charge, not covered by Medicare, of a specified amount per day (not exceeding the differential defined in the next sentence); and may charge the beneficiary that amount for each day he/she occupies the deluxe accommodations. The maximum amount the provider may charge the beneficiary for such accommodations is the differential between the most prevalent private room rate at the time of admission and the customary charge for the room occupied. Beneficiaries may not be charged this differential if they (or their representative) do not request the deluxe accommodations.

The beneficiary may not be charged such a differential in private room rates if that differential is based on factors other than personal comfort items. Such factors might include differences between older and newer wings, proximity to lounge, elevators or nursing stations, desirable view, etc. Such rooms are standard 1-bed units and not deluxe rooms for purposes of these instructions, even though the provider may call them deluxe and have a higher customary charge for them. No additional charge may be imposed upon the beneficiary who is assigned to a room that may be somewhat more desirable because of these factors.

100-2, Chapter-1, 40

Supplies, Appliances, and Equipment

Supplies, appliances, and equipment, which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during the inpatient hospital stay, are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered under Part A even though the supplies, appliances and equipment leave the hospital with the patient upon discharge. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are:

- Items permanently installed in or attached to the patient's body while an inpatient, such as cardiac valves, cardiac pacemakers, and artificial limbs; and
- Items which are temporarily installed in or attached to the patient's body while an inpatient, and which are also necessary to permit or facilitate the patient's release from the hospital, such as tracheotomy or drainage tubes.

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Hospital "admission packs" containing primarily toilet articles, such as soap, toothbrushes, toothpaste, and combs, are covered under Part A if routinely furnished by the hospital to all its inpatients. If not routinely furnished to all patients, the packs are not covered. In that situation, the hospital may charge beneficiaries for the pack, but only if they request it with knowledge of what they are requesting and what the charge to them will be.

Supplies, appliances, and equipment furnished to an inpatient for use **only** outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item, which is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply, is covered as an inpatient hospital service.

Oxygen furnished to hospital inpatients is covered under Part A as an inpatient supply.

100-2, Chapter-1, 70

Inpatient Services in Connection With Dental Services

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the Dentist reduces a jaw fracture of an inpatient at a participating hospital. In addition, hospital inpatient services, which are necessary because of the patient's underlying medical condition and clinical status or the severity of a non covered dental procedure, are covered.

When the hospital services are covered, all ancillary services such as X-rays, administration of anaesthesia, use of the operating room, etc., are covered.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with non covered dental services are not covered. The services of an anaesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.

100-2, Chapter-6, 10

Medical and Other Health Services Furnished to Inpatients of Participating Hospitals

Payment may be made under Part B for physician services and for the nonphysician medical and other health services as provided in this section when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. This policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals. In this section, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

For services to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements (see chapter 16, §170 of this manual, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider"). A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 415.102. Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision.

100-2, Chapter-6, 20.6

Outpatient Observation Services

A. Outpatient Observation Services Defined

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Hospitals may bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department (ED) visit. Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.

See, Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 290, at http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf for billing and payment instructions for outpatient observation services.

Future updates will be issued in a Recurring Update Notification.

B. Coverage of Outpatient Observation Services

When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released, or be admitted as an inpatient (see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 10 "Covered Inpatient Hospital Services Covered Under Part A" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf). For more information on correct reporting of observation services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 290.2.2.)

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare. Observation services are reported using HCPCS code G0378 (Hospital observation

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service, per hour). As of January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378. In most circumstances, observation services are supportive and ancillary to the other separately payable services provided to a patient. Beginning January 1, 2016, in certain circumstances when observation care is billed in conjunction with a clinic visit, Type A emergency department visit (Level 1 through 5), Type B emergency department visit (Level 1 through 5), critical care services, or direct referral for observation services as an integral part of a patient's extended encounter of care, comprehensive payment may be made for all services on the claim including, the entire extended care encounter when certain criteria are met. For information about billing and payment methodology for observation services in years prior to CY 2008, see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §§290.3-290.4. For information about payment for extended assessment and management under composite APCs and comprehensive APCs, see §290.5.

Payment for all reasonable and necessary observation services is packaged into the payments for other separately payable services provided to the patient in the same encounter. Observation services packaged through assignment of status indicator N are covered OPPS services. Since the payment for these services is included in the APC payment for other separately payable services on the claim, hospitals must not bill Medicare beneficiaries directly for the packaged services.

C. Services Not Covered by Medicare and Notification to the Beneficiary

In making the determination whether an ABN can be used to shift liability to a beneficiary for the cost of non-covered items or services related to an encounter that includes observation care, the provider should follow a two-step process. First, the provider must decide whether the item or service meets either the definition of observation care or would be otherwise covered. If the item or service does not meet the definitional requirements of any Medicare-covered benefit under Part B, then the item or service is not covered by Medicare and an ABN is not required to shift the liability to the beneficiary. However, the provider may choose to provide voluntary notification for these items or services.

Second, if the item or service meets the definition of observation services or would be otherwise covered, then the provider must decide whether the item or service is "reasonable and necessary" for the beneficiary on the occasion in question, or if the item or service exceeds any frequency limitation for the particular benefit or falls outside of a timeframe for receipt of a particular benefit. In these cases, the ABN would be used to shift the liability to the beneficiary (see Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, "Financial Liability Protections," Section 20, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf for information regarding Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed).

If an ABN is not issued to the beneficiary, the provider may be held liable for the cost of the item or service unless the provider/supplier is able to demonstrate that they did not know and could not have reasonably been expected to know that Medicare would not pay for the item or service.

100-2, Chapter-10, 10.2.2

Reasonableness of the Ambulance Trip

Under the FS payment is made according to the level of medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the FS is made only for the level of service furnished, and then only when the service is medically necessary.

100-2, Chapter-10,10.3.3

Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service

Transportation of a beneficiary from his or her home, an accident scene, or any other point of origin is covered under Part B as an ambulance service only to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury and only if medical necessity and other program coverage criteria are met. An ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B provided that the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.

Medicare-covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills Part B of the program, or as a packaged service, in which case the entity furnishing the ambulance service must seek payment from the provider who is responsible for the beneficiary's care. If either the origin or the destination of the ambulance transport is the beneficiary's home, then the ambulance transport is paid separately by Medicare Part B, and the entity that furnishes the ambulance transport may bill its A/B MAC (A) or (B) directly. If both the origin and destination of the ambulance transport are providers, e.g., a hospital, critical access hospital (CAH), skilled nursing facility (SNF), then responsibility for payment for the ambulance transport is determined in accordance with the following sequential criteria.

NOTE: These criteria must be applied in sequence as a flow chart and not independently of one another.

1. Provider Numbers:

   If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2, "campus".

2. Campus:

   Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, then the transport is not separately billable to the program. In this case the provider is responsible for payment. If the campuses of the two providers are different, then consider criterion 3, "patient status." "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly

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contiguous to the main buildings, but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office to be part of the provider's campus.

3. Patient Status: Inpatient vs. Outpatient

   Following criteria 1 and 2, if the patient is an inpatient at both providers (i.e., inpatient status both at the origin and at the destination, providers sharing the same provider number but located on different campuses), then the transport is not separately billable. In this case the provider is responsible for payment. All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program.

In the case where the point of origin is not a provider, Part A coverage is not available because, at the time the beneficiary is being transported, the beneficiary is not an inpatient of any provider paid under Part A of the program and ambulance services are excluded from the 3-day preadmission payment window.

The transfer, i.e., the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also payable as a Part B ambulance transport, provided all program coverage criteria are met, because, at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes an outpatient transfer from a remote, off-campus emergency department (ER) to becoming an inpatient or outpatient at the main campus hospital, even if the ER is owned and operated by the hospital.

Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. (If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under Part B. Also, if the beneficiary is a SNF resident and not in a Part A covered stay and must be transported by ambulance to the nearest supplier of medically necessary services not available at the SNF, the ambulance transport, including the return trip, may be covered under Part B.) Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.

100-2, Chapter-10, 20

Coverage Guidelines for Ambulance Service Claims

Payment may be made for expenses incurred by a patient for ambulance service provided conditions I, 2, and 3 in the left-hand column have been met. The right-hand column indicates the documentation needed to establish that the condition has been met.

NOTE: A patient's residence is the place where he or she makes his/her home and dwells permanently, or for an extended period of time. A skilled nursing facility is one, which is listed in the Directory of Medical Facilities as a participating SNF or as an institution which meets §1861(j)(1) of the Act.

Conditions	Review Action
1. Patient was transported by an approved supplier of ambulance services.	1. Ambulance suppliers are explained in greater detail in §10.1.3
2. The patient was suffering from an illness or injury, which contraindicated transportation by other means. (§10.2)	2. (a) The A/B MAC (A) or (B) presumes the requirement was met if the submitted documentation indicates that the patient: • Was transported in an emergency situation, e.g., as a result of an accident, injury or acute illness, or • Needed to be restrained to prevent injury to the beneficiary or others; or • Was unconscious or in shock; or • Required oxygen or other emergency treatment during transport to the nearest appropriate facility; or • "Exhibits signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain; or" • Exhibits signs and symptoms that indicate the possibility of acute stroke; or • Had to remain immobile because of a fracture that had not been set or the possibility of a fracture; or • Was experiencing severe hemorrhage; or • Could be moved only by stretcher; or • Was bed-confined before and after the ambulance trip.

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Conditions	Review Action
	b. In the absence of any of the conditions listed in (a) above additional documentation should be obtained to establish medical need where the evidence indicates the existence of the circumstances listed below: i. Patient's condition would not ordinarily require movement by stretcher, or ii. The individual was not admitted as a hospital inpatient (except in accident cases), or iii. The ambulance was used solely because other means of transportation were unavailable, or iv. The individual merely needed assistance in getting from his room or home to a vehicle. c. Where the information indicates a situation not listed in 2(a) or 2(b) above, refer the case to your supervisor.
3. The patient was transported from and to points listed below. a. From patient's residence (or other place where need arose) to hospital or skilled nursing facility.	3. Claims should show the ZIP Code of the point of pickup. a. i. Condition met if trip began within the institution's service area as shown in the carrier's locality guide. ii. Condition met where the trip began outside the institution's service area if the institution was the nearest one with appropriate facilities.

NOTE: A claim for ambulance service to a participating hospital or skilled nursing facility should not be denied on the grounds that there is a nearer nonparticipation institution having appropriate facilities.

b. Skilled nursing facility to a hospital or hospital to a skilled nursing facility.	b. i. Condition met if the ZIP Code of the pickup point is within the service area of the destination as shown in the A/B MAC (B)'s locality guide. ii. Condition met where the ZIP Code of the pickup point is outside the service area of the destination if the destination institution was the nearest appropriate facility.
c. Hospital to hospital or skilled nursing facility to skilled nursing facility.	c. Condition met if the discharging institution was not an appropriate facility and the admitting institution was the nearest appropriate facility.
d. From a hospital or skilled nursing facility to patient's residence.	d. i. Condition met if patient's residence is within the institution's service area as shown in the A/B MAC (B)'s locality guide. ii. Condition met where the patient's residence is outside the institution's service area if the institution was the nearest appropriate facility.
e. Round trip for hospital or participating skilled nursing facility inpatients to the nearest hospital or nonhospital treatment facility.	e. Condition met if the reasonable and necessary diagnostic or therapeutic service required by patient's condition is not available at the institution where the beneficiary is an inpatient.

NOTE: Ambulance service to a physician's office or a physician- directed clinic is not covered. See §10.3.8 above, where a stop is made at a physician's office en route to a hospital and §10.3.3 for additional exceptions.)

4. Ambulance services involving hospital admissions in Canada or Mexico are covered (Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §10.1.3.) if the following conditions are met :	4. a. The foreign hospitalization has been determined to be covered; and b. The ambulance service meets the coverage requirements set forth in §§10-10.3. If the foreign hospitalization has been determined to be covered on the basis of emergency services (See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §10.1.3), the necessity requirement (§10.2) and the destination requirement (§10.3) are considered met.
5. The A/B MAC will make partial payment for otherwise covered ambulance service, which exceeded limits defined in item	5 & 6 (a) From the pickup point to the nearest appropriate facility, or
6. The A/B MAC will base the payment on the amount payable had the patient been transported:	5 & 6 (b) From the nearest appropriate facility to the beneficiary's residence where he or she is being returned home from a distant institution.

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100-2, Chapter-10, 30.1.1

Ground Ambulance Services

Basic Life Support (BLS)

Definition: BLS is transportation by ground ambulance vehicle (as defined in section 10.1, above) and the provision of medically necessary supplies and services (as defined in section 10.2, above), including BLS ambulance services as defined by the state.

The ambulance vehicle must be staffed by at least two people who meet the requirements of the state and local laws where the services are being furnished, and at least one of the staff members must be certified at a minimum as an emergency medical technician-basic (EMT-Basic) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from state to state or within a state.

Basic Life Support (BLS) – Emergency

Definition: When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response (as defined below).

Advanced Life Support, Level 1 (ALS1)

Definition: Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle (as defined in section 10.1, above) and the provision of medically necessary supplies and services (as defined in section 10.2, above) including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

Advanced Life Support Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response (as defined below) that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS Emergency service, as defined below, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier shall be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary, as defined in section 10.2, above and all other coverage requirements are met.

Advanced Life Support Intervention

Definition: An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT Intermediate) or EMT-Paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1 (ALS1) - Emergency

Definition: When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response, as defined below.

Advanced Life Support, Level 2 (ALS2)

Definition: Advanced life support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three **separate administrations** of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

a. Manual defibrillation/cardioversion;
b. Endotracheal intubation;
c. Central venous line;
d. Cardiac pacing;
e. Chest decompression;
f. Surgical airway; or
g. Intraosseous line.

Application: Crystalloid fluids include but are not necessarily limited to 5 percent Dextrose in water (often referred to as D5W), Saline and Lactated Ringer's. To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example: intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

The IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to meet the ALS2 level of payment. For example, if the local protocol for the treatment of supraventricular tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem, then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.

The fractional administration of a single dose (for this purpose, meaning a "standard" or "protocol" dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose 3 times does not equate to three qualifying doses to support claiming ALS2-level care. For example, administering one-third of a dose of X medication 3 times might = Y (where Y is a standard/protocol drug amount), but the same sequence does not equal 3 times Y. Thus, if 3 administrations of the same drug are required to claim ALS2 level care, each administration must be in accordance with local protocols; the run will not qualify at the ALS2 level on the basis of drug administration if that administration was not according to local protocol. The criterion of multiple administrations of the same drug requires that a suitable quantity of the drug be administered and that there be a suitable amount of time between administrations, and that both are in accordance with standard medical practice guidelines.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate is the administration of a single 1 mg dose of IV Epinephrine in partial increments to treat an adult pulseless Ventricular Tachycardia/Ventricular

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Fibrillation (VF/VT) patient. The American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, administering IV Epinephrine in separate increments of 0.25 mg, 0.25 mg, and 0.50 mg (for a total of 1 mg) over the course of a single 3 to 5 minute episode would not qualify for the ALS2 level of payment. Conversely, administering three separate 1 mg doses of IV Epinephrine over the requisite protocol-based time period to a patient with unresolved VF/VT would qualify for an ALS2 level of service.

NOTE: refer to and abide by your authorized protocols; AHA's ACLS protocols are referenced here only by way of widely recognized example.

Another example that **would not qualify** for the ALS2 payment level is administering Adenosine in three 2 mg increments (for a total of 6 mg) in treating an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). ACLS guidelines dictate treating PSVT with 6 mg of Adenosine by rapid intravenous push (IVP) over 1 to 2 seconds. Should the initial 6 mg dose not eliminate the PSVT within 1 to 2 minutes, guidelines dictate that another 12 mg of Adenosine IVP should be administered where the PSVT persists, followed by another 12 mg dose 1 to 2 minutes later; for a total of 30 mg of Adenosine. Administering a total of 30 mg of Adenosine, involving three episodes of administration in a complete cycle of treatment as outlined above, **would** qualify for ALS2 payment.

Endotracheal (ET) intubation (which includes intubating and/or monitoring/maintaining an ET tube inserted prior to transport) is a service that qualifies for the ALS2 level of payment. Therefore, it is not necessary to consider medications administered by ET tube to determine whether the ALS2 rate is payable.

Advanced Life Support (ALS) Personnel

Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

Specialty Care Transport (SCT)

Definition: SCT is the interfacility transportation (as defined below) of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

Application: SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT. To be clear, if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a state, then that service does not qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

Paramedic Intercept (PI)

Definition: Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to March 1, 1999, Medicare payment could be made for these services, but could not be made directly to the intercept service provider; rather, Medicare payment could be made only when the claim was submitted by the entity that actually furnished the ambulance transport. In those areas where state laws prohibited volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all of the requirements in the following three conditions are met:

i. The intercept service(s) is:
   - Furnished in a rural area (as defined below);
   - Furnished under a contract with one or more volunteer ambulance services; and,
   - Medically necessary based on the condition of the beneficiary receiving the ambulance service.

ii. The volunteer ambulance service involved must:
   - Meet Medicare's certification requirements for furnishing ambulance services;
   - Furnish services only at the BLS level at the time of the intercept; and,
   - Be prohibited by state law from billing anyone for any service.

iii. The entity furnishing the ALS paramedic intercept service must:
   - Meet Medicare's certification requirements for furnishing ALS services, and,
   - Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a state law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register.

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See Pub. 100-04, Medicare Claims Processing Manual, Chapter 15, "Ambulance," §20.1.4 for payment of paramedic intercept services.

Services in a Rural Area

Definition: For purposes other than the paramedic intercept benefit (as defined above), services in a rural area are services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or, (2) an area identified as rural using the most recent version of the **Goldsmith Modification** even though the area is within an MSA.

Emergency Response

Definition: Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

The nature of an ambulance's response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient's condition at the time of transport.

Application: The phrase "911 call or the equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911 even in areas where a 911 call system exists. However, the determination to respond emergently with a BLS or ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, the protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the state, or if there is no similar jurisdiction, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

EMT-Intermediate

Definition: EMT-Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic

Definition: EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.

Interfacility Transportation

Definition: For purposes of SCT payment, an interfacility transportation is one in which the origin and destination are one of the following: a hospital or skilled nursing facility that participates in the Medicare program or a hospital-based facility that meets Medicare's requirements for provider-based status.

100-2, Chapter-12, 40.5

Respiratory Therapy Services

A respiratory therapy plan of treatment is wholly established and signed by the referring physician before the respiratory therapist initiates the actual treatment.

A. Definition

Respiratory therapy services include only those services that can be appropriately provided to CORF patients by a qualified respiratory therapist, as defined at 42CFR485.70 (j), under a physician-established respiratory therapy plan of treatment. The facility physician must be present in the facility for a sufficient time to provide, in accordance with accepted principles of medical practice, medical direction, medical care services and consultation. Respiratory therapy services include the physiological monitoring necessary to furnish these services. Payment for these services is bundled into the payment for respiratory therapy services and is not payable separately. Diagnostic and other medical services provided in the CORF setting are not considered CORF services, and therefore may not be included in a respiratory therapy plan of treatment because these are covered under separate benefit categories.

The respiratory therapist assesses the patient to determine the appropriateness of pursed lip breathing activity and may check the patient's oxygen saturation level (via pulse oximetry). If appropriate, the respiratory therapist then provides the initial training in order to ensure that the patient can accurately perform the activity. The respiratory therapist may again check the patient's oxygen saturation level, or perform peak respiratory flow, or check other respiratory parameters. These types of services are considered "physiological monitoring" and are bundled into the payment for HCPCS codes G0237, G0238 and G0239. Physiological monitoring also includes the provision of a 6-minute walk test that is typically conducted before the start of the patient's respiratory therapy activities. The time to provide this walk "test" assessment is included as part of the HCPCS code G0238. When provided as part of a CORF respiratory therapy plan of treatment, payment for these monitoring activities is bundled into the payment for other services provided by the respiratory therapist, such as the three respiratory therapy specific G-codes.

B. Guidelines for Applying Coverage Criteria

There are some conditions for which respiratory therapy services may be indicated. However, respiratory therapy performed as part of a standard protocol without regard to the individual patient's actual condition, capacity for improving, and the need for such services as established, is not reasonable and medically necessary. All respiratory therapy services must meet the test of being "reasonable and medically necessary" pursuant to §1862(a)(1)(A) of the Act. Determinations of medical necessity are made based on local contractor decisions on a claim-by-claim basis.

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The three HCPCS codes G0237, G0238, and G0239 are specific to services provided under the respiratory therapy plan of treatment and, as such, are not designated as subject to the therapy caps.

C. Patient Education Programs

Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the patient's respiratory therapy plan of treatment and can usually be given to a patient during the course of treatment by the respiratory therapist.

These educational instructions are bundled into the covered service and separate payment is not made.

100-2, Chapter-12, 40.8

Nursing Services

CORF nursing services may only be provided by an individual meeting the qualifications of a registered nurse, as defined at 42CFR485.70 (h). They must relate to, or be a part of, the rehabilitation plan of treatment.

CORF nursing services must be reasonable and medically necessary and are provided as an adjunct to the rehabilitation plan of treatment. For example, a registered nurse may perform or instruct a patient, as appropriate, in the proper procedure of "in and out" urethral catheterization, tracheostomy tube suctioning, or the cleaning for ileostomy or colostomy bags.

Nursing services may not substitute for or supplant the services of physical therapists, occupational therapists, speech-language pathologists and respiratory therapists, but instead must support or further the services and goals provided in the rehabilitation plan of treatment.

CORF nursing services must be provided by a registered nurse and may only be coded as HCPCS code G0128 indicating that CORF "nursing services" were provided.

100-2, Chapter-12, 40.11

Vaccines

A CORF may provide pneumococcal pneumonia, influenza virus, and Hepatitis B vaccines to its patients. While not included as a service under the CORF benefit, Medicare will make payment to the CORF for certain vaccines and their administration provided to CORF patients (CY 2008 PFS Rule 72 FR 66293).

The following three vaccinations are covered in a CORF if a physician who is a doctor of medicine or osteopathy orders it for a CORF patient:

- Pneumococcal pneumonia vaccine and its administration;
- Hepatitis B vaccine and its administration furnished to a beneficiary who is at high or intermediate risk of contracting Hepatitis B; and
- Influenza virus vaccine and its administration

Payment for covered pneumococcal pneumonia, influenza virus, and Hepatitis B vaccines provided in the CORF setting is based on 95 percent of the average wholesale price. The CORF registered nurse provides administration of any of these vaccines using HCPCS codes G0008, G0009 or G0010 with payment based on CPT® code 90471.

100-2, Chapter-15, 50

Drugs and Biologicals

The Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them.

Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see §50.1);
- They are of the type that are not usually self-administered. (see §50.2);
- They meet all the general requirements for coverage of items as incident to a physician's services (see §§50.1 and 50.3);
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see §50.4);
- They are not excluded as non covered immunizations (see §50.4.4.2); and
- They have not been determined by the FDA to be less than effective. (See §§50.4.4)

Medicare Part B does generally not cover drugs that can be self-administered, such as those in pill form, or are used for self-injection. However, the statute provides for the coverage of some self-administered drugs. Examples of self-administered drugs that are covered include blood-clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, osteoporosis drugs for certain homebound patients, and certain oral cancer drugs. (See §110.3 for coverage of drugs, which are necessary to the effective use of Durable Medical Equipment (DME) or prosthetic devices.)

100-2, Chapter-15, 50.4.2

Unlabeled Use of Drug

An unlabeled use of a drug is a use that is not included as an indication on the drugs label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice. In the case of drugs used in an anti-cancer chemotherapeutic regimen, unlabeled uses are covered for a medically accepted indication as defined in §50.5.

These decisions are made by the contractor on a case-by-case basis.

100-2, Chapter-15, 50.4.4.2

Immunizations

Vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered. However, pneumococcal, Hepatitis B, and influenza virus vaccines are exceptions to this rule. (See items A, B, and C below.) In cases where a

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vaccination or inoculation is excluded from coverage, related charges are also not covered.

A. Pneumococcal Pneumonia Vaccinations

1. Background and History of Coverage:

Section 1861(s)(10)(A) of the Social Security Act and regulations at 42 CFR 410.57 authorize Medicare coverage under Part B for pneumococcal vaccine and its administration.

For services furnished on or after May 1, 1981 through September 18, 2014, the Medicare Part B program covered pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Coverage included an initial vaccine administered only to persons at high risk of serious pneumococcal disease (including all people 65 and older; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness; and individuals with compromised immune systems), with revaccination administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years had passed since the previous dose of pneumococcal vaccine.

Those administering the vaccine did not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor were they compelled to review the patient's complete medical record if it was not available, relying on the patient's verbal history to determine prior vaccination status.

Effective for claims with dates of service on and after September 19, 2014, an initial pneumococcal vaccine may be administered to all Medicare beneficiaries who have never received a pneumococcal vaccination under Medicare Part B. A different, second pneumococcal vaccine may be administered 1 year after the first vaccine was administered (i.e., 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Effective July 1, 2000, Medicare no longer required for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, a beneficiary could receive the vaccine upon request without a physician's order and without physician supervision.

2. Coverage Requirements:

Effective July 1, 2021, the Centers for Medicare & Medicaid Services (CMS) updated the Medicare coverage requirements to align with ACIP recommendations. Adults age ≥65 years who have not previously received pneumococcal conjugate vaccine (PCV) or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PCV15 is used, it should be followed by a dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23).

For those adults age 19–64 years with certain underlying medical conditions or other risk factors who have not previously received PCV or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PCV15 is used, it should be followed by a dose of PPSV23. Underlying medical conditions or other risk factors include alcoholism, chronic heart disease, chronic liver disease, chronic lung disease, cigarette smoking, diabetes mellitus, cochlear implant, cerebrospinal fluid leak, congenital or acquired asplenia, sickle cell disease or other hemoglobinopathies, chronic renal failure, congenital or acquired immunodeficiencies, generalized malignancy, HIV infection, Hodgkin disease, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome and solid organ transplant.

Clinical guidance shows that when PCV15 is used, the recommended interval between administration of PCV15 and PPSV23 is ≥1 year. A minimum interval of 8 weeks can be considered for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak to minimize the risk for invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups. Immunocompromising conditions include chronic renal failure, congenital or acquired immunodeficiencies, generalized malignancy, HIV infection, Hodgkin disease, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplant, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies.

For adults who only received PPSV23, they may receive a PCV (either PCV20 or PCV15) ≥1 year after their last PPSV23 dose. When PCV15 is used in those with history of PPSV23 receipt, it need not be followed by another dose of PPSV23.

Effective October 19, 2022, CMS adds the following coverage requirements to align with additional ACIP recommendations and further clarifies the 2021 update.

For adults aged ≥65 years who completed their vaccine series with both PCV13 and PPSV23, but no PPSV23 was received at age ≥65, either one dose of PCV20 is recommended at least 5 years after the last pneumococcal vaccine dose, or complete the recommended PPSV23 series as previously recommended.

Shared clinical decision-making is recommended regarding administration of PCV20 for adults age ≥65 years who completed their vaccine series with both PCV13 and PPSV23, and PPSV was received at age ≥65. If a decision to administer PCV20 is made, a dose of PCV20 is recommended at least 5 years after the last pneumococcal vaccine dose.

In addition, adults age ≥65 years and adults age 19-64 years with certain underlying medical conditions or other risk factors who received PCV13 only are recommended to receive a dose of PCV20 at least 1 year after the PCV13 dose, or PPSV23 as previously recommended to complete their pneumococcal vaccine series.

ACIP recommends that adults age 19-64 years with certain underlying medical conditions or other risk factors who have received both PCV13 and PPSV23 with incomplete vaccination status are recommended to complete their pneumococcal vaccine series by receiving either a dose of PCV20 at least 5 years after the last pneumococcal vaccine dose, or PPSV23 as previously recommended.

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Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it to rely on the patient's verbal history to determine prior vaccination status.

Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

B. Hepatitis B Vaccine

Effective for services furnished on or after September 1, 1984, P.L. 98-369 provides coverage under Part B for Hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting Hepatitis B. This coverage is effective for services furnished on or after September 1, 1984. High-risk groups currently identified include (see exception below):

- ESRD patients;
- Hemophiliacs who receive Factor VIII or IX concentrates;
- Clients of institutions for the mentally retarded;
- Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
- Homosexual men;
- Illicit injectable drug abusers; and
- Persons diagnosed with diabetes mellitus.

Intermediate risk groups currently identified include:

- Staff in institutions for the mentally retarded; and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

EXCEPTION: Persons in both of the above-listed groups in paragraph B, would not be considered at high or intermediate risk of contracting Hepatitis B, however, if there were laboratory evidence positive for antibodies to Hepatitis B. (ESRD patients are routinely tested for Hepatitis B antibodies as part of their continuing monitoring and therapy.)

For Medicare program purposes, the vaccine may be administered upon the order of a doctor of medicine or osteopathy, by a doctor of medicine or osteopathy, or by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, and persons recognized under the incident to physicians' services provision of law.

A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

C. Influenza Virus Vaccine

Effective for services furnished on or after May 1, 1993, the Medicare Part B program covers influenza virus vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Typically, these vaccines are administered once a flu season. Medicare does not require, for coverage purposes, that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

D. COVID-19 Vaccine

Effective for services furnished on or after November 2, 2020, under the authority of section 1861(s)(10)(A) of the Act as amended by section 3713 of P.L. 116-136, the Medicare Part B program covers COVID-19 vaccines and their administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number.

Medicare does not require, for coverage purposes, that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

100-2, Chapter-15, 100

Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations

Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound caused by, or treated by, a surgical procedure that has been performed by a physician or other health care professional to the extent permissible under State law. In addition, surgical dressings required after debridement of a wound are also covered, irrespective of the type of debridement, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of his/her legal authority when performing this function. Surgical dressings are covered for as long as they are medically necessary.

Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings. Elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered as surgical dressings. Some items, such as transparent film, may be used as a primary or secondary dressing.

If a physician, certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist applies surgical dressings as part of a professional service that is billed to Medicare, the surgical dressings are considered incident to the professional services of the health care practitioner. (See §§60.1, 180, 190, 200, and 210.) When surgical dressings are not covered incident to the services of a health care practitioner and are obtained by the patient from a supplier (e.g., a drugstore, physician, or other health care practitioner that qualifies as a supplier) on an order from a physician or other health care professional authorized under State law or regulation to make such an order, the surgical dressings are covered separately under Part B.

Splints and casts, and other devices used for reductions of fractures and dislocations are covered under Part B of Medicare. This includes dental splints.

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100-2, Chapter-15, 110

Durable Medical Equipment -General

Expenses incurred by a beneficiary for the rental or purchases of durable medical equipment (DME) are reimbursable if the following three requirements are met:

- The equipment meets the definition of DME (§110.1);
- The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body member (§110.1); and
- The equipment is used in the patient's home.

The decision whether to rent or purchase an item of equipment generally resides with the beneficiary, but the decision on how to pay rests with CMS. For some DME, program payment policy calls for lump sum payments and in others for periodic payment. Where covered DME is furnished to a beneficiary by a supplier of services other than a provider of services other than a provider of services, the DME MAC makes the reimbursement. If a provider of services furnishes the equipment, the A/B MAC (A) or (HHH) makes the reimbursement. The payment method is identified in the annual fee schedule update furnished by CMS.

The CMS issues quarterly updates to a fee schedule file that contains rates by HCPCS code and also identifies the classification of the HCPCS code within the following categories.

Category Code	Definition
IN	Inexpensive and Other Routinely Purchased Items
FS	Frequently Serviced Items
CR	Capped Rental Items
OX	Oxygen and Oxygen Equipment
OS	Ostomy, Tracheostomy & Urological Items
SD	Surgical Dressings
PO	Prosthetics & Orthotics
SU	Supplies
TE	Transcutaneous Electrical Nerve Stimulators

The A/B MACs (A), (B), and (HHH), and DME MACs, where appropriate, use the CMS files to determine payment rules. See the Medicare Claims Processing Manual, Chapter 20, "Durable Medical Equipment, Surgical Dressings and Casts, Orthotics and Artificial Limbs, and Prosthetic Devices," for a detailed description of payment rules for each classification.

Payment may also be made for repairs, maintenance, and delivery of equipment and for expendable and nonreusable items essential to the effective use of the equipment subject to the conditions in §110.2.

See the Medicare Benefit Policy Manual, Chapter 11, "End Stage Renal Disease," for hemodialysis equipment and supplies.

100-2, Chapter-15, 110.1

Definition of Durable Medical Equipment

Durable medical equipment is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

The following describes the underlying policies for determining whether an item meets the definition of DME and may be covered.

A. Durability

An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinent pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

B. Medical Equipment

Medical equipment is equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no development will be needed to determine whether a specific item of equipment is medical in nature. However, some cases will require development to determine whether the item constitutes medical equipment. This development would include the advice of local medical organizations (hospitals, medical schools, medical societies) and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

1. Equipment Presumptively Medical

Items such as hospital beds, wheelchairs, hemodialysis equipment, iron lungs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines, and traction equipment presumptively constitute medical equipment. (Although hemodialysis equipment is covered as a prosthetic device (§120), it also meets the definition of DME, and reimbursement for the rental or purchase of such equipment for use in the beneficiary's home will be made only under the provisions for payment applicable to DME. See the Medicare Benefit Policy Manual, Chapter 11, "End Stage Renal Disease" §30.1, for coverage of home use of hemodialysis.)

NOTE: There is a wide variety in types of respirators and suction machines. The DME MACs medical staff should determine whether the apparatus specified in the claim is appropriate for home use.

2. Equipment Presumptively Nonmedical

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the medical insurance program. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient, an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of

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the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner cannot be deemed to be medical equipment for which payment can be made.

Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered DME. These include, for example, room heaters, humidifiers, dehumidifiers, and electric air cleaners. Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as elevators, stairway elevators, and posture chairs, do not constitute medical equipment. Similarly, physical fitness equipment (such as an exercycle), first-aid or precautionary-type equipment (such as preset portable oxygen units), self-help devices (such as safety grab bars), and training equipment (such as Braille training texts) are considered nonmedical in nature.

3. Special Exception Items

Specified items of equipment may be covered under certain conditions even though they do not meet the definition of DME because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

a. Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who had bed sores or there is medical evidence indicating that they are highly susceptible to such ulceration; and

b. Heat lamps for a medical rather than a soothing or cosmetic purpose, e.g., where the need for heat therapy has been established.

In establishing medical necessity for the above items, the evidence must show that the item is included in the physician's course of treatment and a physician is supervising its use.

NOTE: The above items represent special exceptions and no extension of coverage to other items should be inferred.

C. Necessary and Reasonable

Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member. These considerations will bar payment for equipment which cannot reasonably be expected to perform a therapeutic function in an individual case or will permit only partial therapeutic function in an individual case or will permit only partial payment when the type of equipment furnished substantially exceeds that required for the treatment of the illness or injury involved.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements;" §60, regarding the rules for providing advance beneficiary notices (ABNs) that advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to make an informed consumer decision about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions.

1. Necessity for the Equipment

Equipment is necessary when it can be expected to make a meaningful contribution to the treatment of the patient's illness or injury or to the improvement of his or her malformed body member. In most cases the physician's prescription for the equipment and other medical information available to the DME MAC will be sufficient to establish that the equipment serves this purpose.

2. Reasonableness of the Equipment

Even though an item of DME may serve a useful medical purpose, the DME MAC or A/B MAC (A) must also consider to what extent, if any, it would be reasonable for the Medicare program to pay for the item prescribed. The following considerations should enter into the determination of reasonableness:

1. Would the expense of the item to the program be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the equipment?
2. Is the item substantially more costly than a medically appropriate and realistically feasible alternative pattern of care?
3. Does the item serve essentially the same purpose as equipment already available to the beneficiary?

3. Payment Consistent With What is Necessary and Reasonable

Where a claim is filed for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition or where there exists a reasonably feasible and medically appropriate alternative pattern of care which is less costly than the equipment furnished, the amount payable is based on the rate for the equipment or alternative treatment which meets the patient's medical needs.

The acceptance of an assignment binds the supplier-assignee to accept the payment for the medically required equipment or service as the full charge and the supplier-assignee cannot charge the beneficiary the differential attributable to the equipment actually furnished.

4. Establishing the Period of Medical Necessity

Generally, the period of time an item of durable medical equipment will be considered to be medically necessary is based on the physician's estimate of the time that his or her patient will need the equipment. See the Medicare Program Integrity Manual, Chapters 5 and 6, for medical review guidelines.

D. Definition of a Beneficiary's Home

For purposes of rental and purchase of DME a beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for the mentally retarded (ICF/IID)). However, an institution may not be considered a beneficiary's home if it:

- Meets at least the basic requirement (see §1861(e)(1) of the Social Security Act (the Act)) in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement (see §1819(a)(1) of the Act) in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

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Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in the bullets above, the individual is not entitled to have separate Part B payment made for rental or purchase of DME. This is because such an institution may not be considered the individual's home. (see §§1861(s)(6) and 1861(n) of the Act, the implementing regulations at 42 CFR 410.38(b), and §2160B in the State Operations Manual (SOM, Pub. 100-07), Chapter 2).

As indicated in §2164 of the SOM, Chapter 2, all hospitals and SNFs that are Medicare certified are automatically considered to meet the basic requirement described in the applicable bullet above by reason of the Medicare certification itself. Moreover, even an institution (or portion of an institution) that is not certified for Medicare is precluded from being considered a patient's home in this context if it meets either of these basic requirements. See §2166 of the SOM, Chapter 2, for the administrative criteria used in determining whether the basic requirement in the "SNF" definition is met by a nursing home that is not Medicare-certified (including the non-Medicare portion of an institution that also contains a Medicare-certified distinct part SNF).

If the patient is at home for part of a month and, for part of the same month is in an institution that cannot qualify as his or her home, or is outside the U.S., monthly payments may be made for the entire month. Similarly, if DME is returned to the provider before the end of a payment month because the beneficiary died in that month or because the equipment became unnecessary in that month, payment may be made for the entire month.

100-2, Chapter-15, 110.2

Repairs, Maintenance, Replacement, and Delivery

Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the user enrolled in Part B of the program. However, do not pay for repair, maintenance, or replacement of equipment in the frequent and substantial servicing or oxygen equipment payment categories. In addition, payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.

A. Repairs

To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. However, do not pay for repair of previously denied equipment or equipment in the frequent and substantial servicing or oxygen equipment payment categories. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess. (See subsection C where claims for repairs suggest malicious damage or culpable neglect.)

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental, and inexpensive or routinely purchased payment categories which are being rented.

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

For replacement items, see Subsection C below.

B. Maintenance

Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment, is not covered. The owner is expected to perform such routine maintenance rather than a retailer or some other person who charges the beneficiary. Normally, purchasers of DME are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary. Do not pay for maintenance of purchased items that require frequent and substantial servicing or oxygen equipment.

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for maintenance of rented equipment are generally not covered. Payment may not be made for maintenance of rented equipment other than the maintenance and servicing fee established for capped rental items. For capped rental items which have reached the 13-month rental cap, contractors pay claims for maintenance and servicing fees after 6 months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. See the Medicare Claims Processing Manual, Chapter 20, "Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS)," for additional instruction and an example.

A new CMN and/or physician's order is not needed for covered maintenance.

In cases where one or more monthly rental payments have been made in accordance with 42 CFR 414.229 for a capped rental DME item, medical necessity for the equipment has been established. In cases where one or more rental payments have been made for an item classified as capped rental DME, and the supplier transfers title to the equipment prior to the end of a 13 month period of continuous use per 42 CFR 414.230, Medicare payment can be made for reasonable and necessary maintenance and servicing of the beneficiary-owned DME. Under the regulations at 42 CFR 414.210(e)(1), reasonable and necessary charges for maintenance and servicing are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. Charges for routine maintenance and servicing would not be covered. Charges for maintenance and servicing that exceed the purchase price of the equipment (i.e., the capped rental monthly fee multiplied by 10) would not be reasonable and necessary and should be denied.

C. Replacement

Replacement refers to the provision of an identical or nearly identical item. Situations involving the provision of a different item because of a change in medical condition are not addressed in this section.

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Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood). A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item.

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

The reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, A/B MACS (B) may determine the reasonable useful lifetime of equipment, but in no case can it be less than 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary. (See subsection A.)

Charges for the replacement of oxygen equipment, items that require frequent and substantial servicing or inexpensive or routinely purchased items which are being rented are not covered.

Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment should be investigated and denied where the DME MACs determines that it is unreasonable to make program payment under the circumstances. DME MACs refer such cases to the program integrity specialist in the RO.

D. Delivery

Payment for delivery of DME whether rented or purchased is generally included in the fee schedule allowance for the item. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, "Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS)," for the rules that apply to making reimbursement for exceptional cases.

100-2, Chapter-15, 110.3

Coverage of Supplies and Accessories

Payment may be made for supplies, e.g., oxygen, that are necessary for the effective use of durable medical equipment. Such supplies include those drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system. However, the coverage of such drugs or biologicals does not preclude the need for a determination that the drug or biological itself is reasonable and necessary for treatment of the illness or injury or to improve the functioning of a malformed body member.

In the case of prescription drugs, other than oxygen, used in conjunction with durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) or prosthetic devices, the entity that dispenses the drug must furnish it directly to the patient for whom a prescription is written. The entity that dispenses the drugs must have a Medicare supplier number, must possess a current license to dispense prescription drugs in the State in which the drug is dispensed, and must bill and receive payment in its own name. A supplier that is not the entity that dispenses the drugs cannot purchase the drugs used in conjunction with DME for resale to the beneficiary. Reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces, etc., for necessary DME, only if the beneficiary owns or is purchasing the equipment.

100-2, Chapter-15, 120

Prosthetic Devices

A. General

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician's order. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration, the test of permanence is considered met. (Such a device may also be covered under §60.1 as a supply when furnished incident to a physician's service.)

Examples of prosthetic devices include artificial limbs, parenteral and enteral (PEN) nutrition, cardiac pacemakers, prosthetic lenses (see subsection B), breast prostheses (including a surgical brassiere) for post mastectomy patients, maxillofacial devices, and devices which replace all or part of the ear or nose. A urinary collection and retention system with or without a tube is a prosthetic device replacing bladder function in case of permanent urinary incontinence. The Foley catheter is also considered a prosthetic device when ordered for a patient with permanent urinary incontinence. However, chucks, diapers, rubber sheets, etc., are supplies that are not covered under this provision. Although hemodialysis equipment is a prosthetic device, payment for the rental or purchase of such equipment in the home is made only for use under the provisions for payment applicable to durable medical equipment.

An exception is that if payment cannot be made on an inpatient's behalf under Part A, hemodialysis equipment, supplies, and services required by such patient could be covered under Part B as a prosthetic device, which replaces the function of a kidney. See the Medicare Benefit Policy Manual, Chapter 11, "End Stage Renal Disease," for payment for hemodialysis equipment used in the home. See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §10, for additional instructions on hospitalization for renal dialysis.

NOTE: Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully

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performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition.

Colostomy (and other ostomy) bags and necessary accouterments required for attachment are covered as prosthetic devices. This coverage also includes irrigation and flushing equipment and other items and supplies directly related to ostomy care, whether the attachment of a bag is required.

Accessories and/or supplies which are used directly with an enteral or parenteral device to achieve the therapeutic benefit of the prosthesis or to assure the proper functioning of the device may also be covered under the prosthetic device benefit subject to the additional guidelines in the Medicare National Coverage Determinations Manual.

Covered items include catheters, filters, extension tubing, infusion bottles, pumps (either food or infusion), intravenous (I.V.) pole, needles, syringes, dressings, tape, Heparin Sodium (parenteral only), volumetric monitors (parenteral only), and parenteral and enteral nutrient solutions. Baby food and other regular grocery products that can be blenderized and used with the enteral system are not covered. Note that some of these items, e.g., a food pump and an I.V. pole, qualify as DME. Although coverage of the enteral and parenteral nutritional therapy systems is provided on the basis of the prosthetic device benefit, the payment rules relating to lump sum or monthly payment for DME apply to such items.

The coverage of prosthetic devices includes replacement of and repairs to such devices as explained in subsection D.

Finally, the Benefits Improvement and Protection Act of 2000 amended §1834(h)(1) of the Act by adding a provision (1834 (h)(1)(G)(i)) that requires Medicare payment to be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary.

Payment may be made for the replacement of a prosthetic device that is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:

1. A change in the physiological condition of the patient;
2. An irreparable change in the condition of the device, or in a part of the device; or
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

This provision is effective for items replaced on or after April 1, 2001. It supersedes any rule that that provided a 5-year or other replacement rule with regard to prosthetic devices.

B. Prosthetic Lenses

The term "internal body organ" includes the lens of an eye. Prostheses replacing the lens of an eye include post-surgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed. In addition, permanent lenses are also covered when required by an individual lacking the organic lens of the eye because of surgical removal or congenital absence. Prosthetic lenses obtained on or after the beneficiary's date of entitlement to supplementary medical insurance benefits may be covered even though the surgical removal of the crystalline lens occurred before entitlement.

1. Prosthetic Cataract Lenses

One of the following prosthetic lenses or combinations of prosthetic lenses furnished by a physician (see §30.4 for coverage of prosthetic lenses prescribed by a doctor of optometry) may be covered when determined to be reasonable and necessary to restore essentially the vision provided by the crystalline lens of the eye:

- Prosthetic bifocal lenses in frames;
- Prosthetic lenses in frames for far vision, and prosthetic lenses in frames for near vision; or
- When a prosthetic contact lens(es) for far vision is prescribed (including cases of binocular and monocular aphakia), make payment for the contact lens(es) and prosthetic lenses in frames for near vision to be worn at the same time as the contact lens(es), and prosthetic lenses in frames to be worn when the contacts have been removed.

Lenses which have ultraviolet absorbing or reflecting properties may be covered, in lieu of payment for regular (untinted) lenses, if it has been determined that such lenses are medically reasonable and necessary for the individual patient.

Medicare does not cover cataract sunglasses obtained in addition to the regular (untinted) prosthetic lenses since the sunglasses duplicate the restoration of vision function performed by the regular prosthetic lenses.

2. Payment for Intraocular Lenses (IOLs) Furnished in Ambulatory Surgical Centers (ASCs)

Effective for services furnished on or after March 12, 1990, payment for intraocular lenses (IOLs) inserted during or subsequent to cataract surgery in a Medicare certified ASC is included with the payment for facility services that are furnished in connection with the covered surgery.

Refer to the Medicare Claims Processing Manual, Chapter 14, "Ambulatory Surgical Centers," for more information.

3. Limitation on Coverage of Conventional Lenses

One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery with insertion of an IOL is covered.

C. Dentures

Dentures are excluded from coverage. However, when a denture or a portion of the denture is an integral part (built-in) of a covered prosthesis (e.g., an obturator to fill an opening in the palate), it is covered as part of that prosthesis.

D. Supplies, Repairs, Adjustments, and Replacement

Supplies are covered that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient's condition is covered when ordered by a physician. General provisions relating to the repair and replacement of durable medical equipment in §110.2 for the repair and replacement of prosthetic devices are applicable. (See the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from Coverage," §40.4, for payment for devices replaced under a warranty.) Replacement of conventional eyeglasses or contact lenses furnished in accordance with §120.B.3 is not covered.

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Necessary supplies, adjustments, repairs, and replacements are covered even when the device had been in use before the user enrolled in Part B of the program, so long as the device continues to be medically required.

100-2, Chapter-15, 130

Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes

These appliances are covered under Part B when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace. Back braces include, but are not limited to, special corsets, e.g., sacroiliac, sacrolumbar, dorsolumbar corsets, and belts. A terminal device (e.g., hand or hook) is covered under this provision whether an artificial limb is required by the patient. Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

Adjustments to an artificial limb or other appliance required by wear or by a change in the patient's condition are covered when ordered by a physician.

Adjustments, repairs and replacements are covered even when the item had been in use before the user enrolled in Part B of the program so long as the device continues to be medically required.

100-2, Chapter-15, 140

Therapeutic Shoes for Individuals with Diabetes

Coverage of therapeutic shoes (depth or custom-molded) along with inserts for individuals with diabetes is available as of May 1, 1993. These diabetic shoes are covered if the requirements as specified in this section concerning certification and prescription are fulfilled. In addition, this benefit provides for a pair of diabetic shoes even if only one foot suffers from diabetic foot disease. Each shoe is equally equipped so that the affected limb, as well as the remaining limb, is protected. Claims for therapeutic shoes for diabetics are processed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Therapeutic shoes for diabetics are not DME and are not considered DME nor orthotics, but a separate category of coverage under Medicare Part B. (See §1861(s)(12) and §1833(o) of the Act.)

A. Definitions

The following items may be covered under the diabetic shoe benefit:

1. Custom-Molded Shoes

Custom-molded shoes are shoes that:

- Are constructed over a positive model of the patient's foot;
- Are made from leather or other suitable material of equal quality;
- Have removable inserts that can be altered or replaced as the patient's condition warrants; and
- Have some form of shoe closure.

2. Depth Shoes

Depth shoes are shoes that:

- Have a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- Are made from leather or other suitable material of equal quality;
- Have some form of shoe closure; and
- Are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard last sizing schedule or its equivalent. (The American standard last sizing schedule is the numerical shoe sizing system used for shoes sold in the United States.)

3. Inserts

Inserts are total contact, multiple density, removable inlays that are directly molded to the patient's foot or a model of the patient's foot or directly carved from a patient-specific, rectified electronic model and that are made of a suitable material with regard to the patient's condition.

B. Coverage

1. Limitations

For each individual, coverage of the footwear and inserts is limited to one of the following within one calendar year:

- No more than one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts; or
- No more than one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes).

2. Coverage of Diabetic Shoes and Brace

Orthopedic shoes, as stated in the Medicare Claims Processing Manual, Chapter 20, "Durable Medical Equipment, Surgical Dressings and Casts, Orthotics and Artificial Limbs, and Prosthetic Devices," generally are not covered. This exclusion does not apply to orthopedic shoes that are an integral part of a leg brace. In situations in which an individual qualifies for both diabetic shoes and a leg brace, these items are covered separately. Thus, the diabetic shoes may be covered if the requirements for this section are met, while the brace may be covered if the requirements of §130 are met.

3. Substitution of Modifications for Inserts

An individual may substitute modification(s) of custom-molded or depth shoes instead of obtaining a pair(s) of inserts in any combination. Payment for the modification(s) may not exceed the limit set for the inserts for which the individual is entitled. The following is a list of the most common shoe modifications available, but it is not meant as an exhaustive list of the modifications available for diabetic shoes:

- **Rigid Rocker Bottoms -** These are exterior elevations with apex positions for 51 percent to 75 percent distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapered off sharply to the front tip of the sole. Apex height helps to eliminate pressure at the metatarsal heads. Rigidity is ensured by the steel in the shoe. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel;

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- ***Roller Bottoms (Sole or Bar)*** - These are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole;
- ***Metatarsal Bars*** - An exterior bar is placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose;
- ***Wedges (Posting)*** - Wedges are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight bearing upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance; and
- ***Offset Heels*** - This is a heel flanged at its base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.

Other modifications to diabetic shoes include, but are not limited to flared heels, Velcro closures, and inserts for missing toes.

4. Separate Inserts

Inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found above for depth shoes and custom-molded shoes.

C. Certification

The need for diabetic shoes must be certified by a physician who is a doctor of medicine or a doctor of osteopathy and who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. This managing physician must:

- Document in the patient's medical record that the patient has diabetes;
- Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
- Document in the patient's record that the patient has one or more of the following conditions:
  - Peripheral neuropathy with evidence of callus formation;
  - History of pre-ulcerative calluses;
  - History of previous ulceration;
  - Foot deformity;
  - Previous amputation of the foot or part of the foot; or
  - Poor circulation.

D. Prescription

Following certification by the physician managing the patient's systemic diabetic condition, a podiatrist or other qualified physician who is knowledgeable in the fitting of diabetic shoes and inserts may prescribe the particular type of footwear necessary.

E. Furnishing Footwear

The footwear must be fitted and furnished by a podiatrist or other qualified individual such as a pedorthist, an orthotist, or a prosthetist. The certifying physician may not furnish the diabetic shoes unless the certifying physician is the only qualified individual in the area. It is left to the discretion of each A/B MAC (B) to determine the meaning of "in the area."

100-2, Chapter-15, 150

Dental Services

As indicated under the general exclusions from coverage in 42 CFR 411.15(i), and subject to exceptions, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Two statutory exceptions to this policy allow for Medicare payment for inpatient hospital services in connection with the provision of dental services if the individual, because of the individual's underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.

There are some other instances where medical services necessary to diagnose and treat the individual's underlying medical condition may require the performance of certain dental services and the dental exclusion may not apply. Dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services are not excluded. Such non-excluded dental services could include dental and oral examinations as well as medically necessary diagnostic and treatment services to eliminate an oral or dental infection. We note that the necessary treatment to eradicate an infection may not include the totality of recommended dental services for a given patient. For example, if an infected tooth is identified in a patient requiring an organ transplant, cardiac valve replacement, or valvuloplasty procedure, the necessary treatment would be to eradicate the infection, which could result in the tooth being extracted. Additional dental services, such as a dental implant or crown, may not be considered immediately necessary to eliminate or eradicate the infection or its source prior to surgery. Therefore, such additional services would not be inextricably linked to, and substantially related and integral to the clinical success of, the organ transplant, cardiac valve replacement, or valvuloplasty services. As such, no Medicare payment would be made for the additional services that are not immediately necessary prior to surgery to eliminate or eradicate the infection.

Payment may be made under Medicare Parts A and B for dental services, prior to or, in certain circumstances, contemporaneously with, certain covered medical services furnished in the inpatient or outpatient setting. Scenarios in which Medicare payment for dental services is not excluded include, but are not limited to, the examples below.

EXAMPLE 1:

Dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare-covered organ transplant, cardiac valve replacement, or valvuloplasty procedures; and, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, the organ transplant, cardiac valve replacement, or valvuloplasty procedure. For purposes of this manual only, hematopoietic stem cell and bone marrow transplants have a similar risk of infection to organ transplants, and an oral examination and subsequent necessary diagnostic and treatment services, performed in either the inpatient or outpatient setting would be payable under this example. (The term "organ transplant" may not be considered to include bone marrow or hematopoietic stem cell transplants in all contexts. These services are not

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considered organs for purposes of the definition of organs in 42 CFR 486.302 or Medicare payment policies for organ procurement organizations.)

EXAMPLE 2:

The reconstruction of a ridge performed as a result of and at the same time as the surgical removal of a tumor. The reconstruction of a ridge performed primarily to prepare the mouth for dentures is a noncovered procedure.

EXAMPLE 3:

The stabilization or immobilization of teeth in connection with the reduction of a jaw fracture, and dental splints only when used in conjunction with covered treatment of a covered medical condition such as dislocated jaw joints.

EXAMPLE 4:

The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

See Pub 100-01, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, Definitions for provisions applicable to doctors of dental surgery or dental medicine.

CMS makes payment for covered dental services furnished by a physician, including a doctor of dental medicine or dental surgery, or a non-physician practitioner in accordance with state law and scope of practice in the state where the service is furnished.

Medicare Part A and Part B payment is made for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services. Integration between the health care professionals furnishing dental and other covered services is a key component in assessing whether dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered medical services. This integration could take the form of a referral or other exchange of information between the physicians, nonphysician practitioners, or other practitioners involved in the delivery of dental and other covered medical services.

This coordination should occur between the health care professionals furnishing the dental and other covered services regardless of whether both individuals are affiliated with or employed by the same entity. If there is no exchange of information, or integration, between the health care professionals regarding the dental services, then there would not be an inextricable link between the dental and covered medical services within the meaning of our regulation at § 411.15(i)(3). This is because the professionals would not have the necessary information to decide that the dental service(s) is inextricably linked to a covered medical service, and therefore, not subject to the statutory payment exclusion under section 1862(a)(12) of the Act.

Payment may also be made for covered dental services and supplies furnished incident to the professional services of the billing physician or practitioner by auxiliary personnel. For example, services performed by a dental technician, dental hygienist, dental therapist, or registered nurse who is under the direct supervision of the physician, including a dentist, are covered if the services meet the requirements for "incident to" services as described in 42 CFR § 410.26.

Ancillary services and supplies furnished incident to covered dental services are also not excluded, and Medicare payment may be made under Part A or Part B, as applicable, regardless of whether the service is performed in the inpatient or outpatient setting, including, but not limited to the administration of anesthesia, diagnostic X-rays, use of operating room, and other related, otherwise covered procedures.

No payment is made for dental services that may be inextricably linked to, and substantially related and integral to the clinical success of other non-covered services. Such services remain subject to the statutory exclusion at § 1862(a)(12) for items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. More specifically, dental services inextricably linked to a non-covered medical service(s) are not covered or payable. For example, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. Similarly, with rare exception, the removal of a torus palatinus (a bony protuberance of the hard palate) is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, Medicare does not pay for this procedure.

MACs have the flexibility to determine on a claim-by-claim basis whether a patient's circumstances do or do not fit within the terms of the statutory preclusion or exceptions specified in section 1862(a)(12) of the Act and our regulation at 42 CFR § 411.15(i). These policies do not prevent a MAC from making a determination that payment can be made for dental services in other circumstances under which the dental services are inextricably linked to, and substantially related and integral to the clinical success of, certain covered medical services, but are not specifically addressed in final rules, manual provisions, and the finalized amendments to§ 411.15(i).

100-2, Chapter-15, 150.1

Treatment of Temporomandibular Joint (TMJ) Syndrome

There are a wide variety of conditions that can be characterized as TMJ, and an equally wide variety of methods for treating these conditions. Many of the procedures fall within the Medicare program's statutory exclusion that prohibits payment for items and services that have not been demonstrated to be reasonable and necessary for the diagnosis and treatment of illness or injury (§1862(a)(1) of the Act). Other services and appliances used to treat TMJ fall within the Medicare program's statutory exclusion at 1862(a)(12), which prohibits payment "for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth...." For these reasons, a diagnosis of TMJ on a claim is insufficient. The actual condition or symptom must be determined.

100-2, Chapter-15, 230

Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology

A. Group Therapy Services. Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.

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B. Therapy Students

1. General

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. Pay for the direct (one-to-one) patient contact services of the physician or therapist provided to Medicare Part B patients. Group therapy services performed by a therapist or physician may be billed when a student is also present "in the room".

EXAMPLES

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's service, not for the student's services).

2. Therapy Assistants as Clinical Instructors

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

3. Services Provided Under Part A and Part B

The payment methodologies for Part A and B therapy services rendered by a student are different. Under the MPFS (Medicare Part B), Medicare pays for services provided by physicians and practitioners that are specifically authorized by statute. Students do not meet the definition of practitioners under Medicare Part B. Under SNF PPS, payments are based upon the case mix or Resource Utilization Group (RUG) category that describes the patient. In the rehabilitation groups, the number of therapy minutes delivered to the patient determines the RUG category. Payment levels for each category are based upon the costs of caring for patients in each group rather than providing specific payment for each therapy service as is done in Medicare Part B.

100-2, Chapter-15, 231

Pulmonary Rehabilitation (PR) Program Services Effective For Dates of Service On Or After January 1, 2024

Pulmonary rehabilitation (PR) means a physician or nonphysician practitioner supervised program for chronic obstructive pulmonary disease (COPD) and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy. Nonphysician practitioner means a physician assistant, nurse practitioner, or clinical nurse specialist as those terms are defined in section 1861(aa)(5)(A) of the Social Security Act (the Act).

Effective January 1, 2010, Medicare Part B pays for PR if specific criteria are met by the Medicare beneficiary, the PR program itself, the setting in which it is administered, and the physician administering the program, as outlined below.

Covered Conditions:

As specified in 42 CFR 410.47, Medicare Part B covers PR for beneficiaries:

- With moderate to very severe COPD (defined as GOLD classification II, III, and IV), when referred by the physician treating the chronic respiratory disease;
- Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks (effective January 1, 2022);
- Additional medical indications for coverage for PR program services may be established through a national coverage determination (NCD).

PR must include all of the following components:

Physician-prescribed exercise. Physician-prescribed exercise means aerobic exercise combined with other types of exercise (such as conditioning, breathing retraining, step, and strengthening) as determined to be appropriate for individual patients by a physician. Each PR session must include physician prescribed exercise.

Education or training. Education or training that is closely and clearly related to the individual's care and treatment which is tailored to the individual's needs and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life. Education must include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.

Psychosocial assessment. Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

Outcomes assessment. Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes the following: (i) Evaluations, based on patient-centered outcomes, which must be measured by the physician or program staff at the beginning and end of the program. Evaluations measured by program staff must be considered by the physician in developing and/or reviewing individualized treatment plans. (ii) Objective clinical measures of exercise performance and self-reported measures of shortness of breath and behavior.

Individualized treatment plan. Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following: (i) A description of the individual's diagnosis. (ii) The type, amount, frequency, and duration of the items and services furnished under the plan. (iii) The goals set for the individual under the plan. The individualized treatment plan detailing how components are utilized for each patient, must be established, reviewed, and signed by a physician every 30 days.

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As specified at 42 CFR 410.47(e), the number of PR sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor (MAC).

PR Settings:

Medicare Part B pays for PR in a physician's office or a hospital outpatient setting. All settings must have the following: (i) A physician or nonphysician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician or nonphysician practitioner meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27, and (ii) The necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

PR Medical Director Standards:

Medical director means the physician who oversees the PR program at a particular site. The medical director is the physician responsible for a PR program and, in consultation with staff, is involved in directing the progress of individuals in the program and must possess all of the following: (1) Expertise in the management of individuals with respiratory pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support. (3) Be licensed to practice medicine in the State in which the PR program is offered.

Supervising Practitioner Standards:

Supervising practitioner means a physician or nonphysician practitioner that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under PR programs. Physicians or nonphysician practitioners acting as the supervising practitioner must possess all of the following: (1) Expertise in the management of individuals with respiratory pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(See Publication 100-04, Claims Processing Manual, chapter 32, section 140.4, for PR claims processing, coding, and billing requirements.)

100-2, Chapter-15, 232

Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Effective For Dates of Service On Or After January 1, 2024

Cardiac rehabilitation (CR) means a physician or nonphysician practitioner supervised program that furnishes physician prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Intensive cardiac rehabilitation (ICR) program means a physician or nonphysician practitioner supervised program that furnishes CR and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in 42 CFR 410.49(c).

Nonphysician practitioner means a physician assistant, nurse practitioner, or clinical nurse specialist as those terms are defined in section 1861(aa)(5)(A) of the Social Security Act (the Act).

Effective January 1, 2010, Medicare Part B pays for CR/ICR if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered, and the physician administering the program, as outlined below.

Covered Conditions:

As specified in 42 CFR 410.49, Medicare Part B covers CR and ICR for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction (MI) within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;
- A heart or heart-lung transplant.
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 18, 2014, for CR and on or after February 9, 2018, for ICR; or
- Other cardiac conditions as specified through a national coverage determination (NCD). The NCD process may also be used to specify non-coverage of a cardiac condition for ICR if coverage is not supported by clinical evidence.

CR and ICR must include all of the following components:

Physician-prescribed exercise. Physician-prescribed exercise means aerobic exercise combined with other types of exercise (such as strengthening and stretching) as

determined to be appropriate for individual patients by a physician each day CR/ICR items and services are furnished.

Cardiac risk factor modification. Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the individual's needs.

Psychosocial assessment. Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

Outcomes assessment. Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following: (i) Evaluations, based on patient-centered outcomes, which must be measured by the physician or program staff at the beginning and end of the program. Evaluations measured by program staff must be considered by the physician in developing and/or reviewing individualized treatment plans. (ii) Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

Individualized treatment plan. Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following: (i) A description of the individual's diagnosis. (ii) The type, amount, frequency, and duration of the items and services furnished under the plan. (iii) The goals set

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for the individual under the plan. The individualized treatment plan detailing how components are utilized for each patient, must be established, reviewed, and signed by a physician every 30 days.

As specified at 42 CFR 410.49(f)(1), the number of CR sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare Administrative Contractor (MAC).

As specified at 42 CFR 410.49(f)(2), ICR sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

CR and ICR Settings:

Medicare Part B pays for CR and ICR in a physician's office or a hospital outpatient setting. All settings must have a physician or nonphysician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician or nonphysician practitioner meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27.

Standards for an ICR Program:

To be approved as an ICR program, a program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following for its patients:

(i) Positively affected the progression of coronary heart disease. (ii) Reduced the need for coronary bypass surgery. (iii) Reduced the need for percutaneous coronary interventions.

An ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before CR services to after CR services: (i) Low density lipoprotein. (ii) Triglycerides. (iii) Body mass index. (iv) Systolic blood pressure. (v) Diastolic blood pressure. (vi) The need for cholesterol, blood pressure, and diabetes medications.

A list of approved ICR programs, identified through the NCD process, will be listed in the Federal Register and is available on the CMS website at https://www.cms.gov/Medicare/Medicare-GeneralInformation/MedicareApprovedFacilitie/ICR. All prospective ICR sites must apply to enroll as an ICR program site using the designated forms as specified at 42 CFR 424.510, and report specialty code 31 to be identified as an enrolled ICR supplier. For purposes of appealing an adverse determination concerning site approval, an ICR site is considered a supplier (or prospective supplier) as defined in 42 CFR 498.2.

CR and ICR Medical Director Standards:

Medical director means the physician who oversees the CR or ICR program at a particular site. The medical director is the physician responsible for a CR or ICR program and, in consultation with staff, is involved in directing the progress of individuals in the program and must possess all of the following: (1) Expertise in the management of individuals with cardiac pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support. (3) Be licensed to practice medicine in the State in which the CR or ICR program is offered.

Supervising Practitioner Standards:

Supervising practitioner means a physician or nonphysician practitioner that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under CR and ICR programs. Physicians or nonphysician practitioners acting as the supervising practitioner must possess all of the following: (1) Expertise in the management of individuals with cardiac pathophysiology. (2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(See Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, section 20.10.1, Pub. 100-04, Medicare Claims Processing Manual, Chapter 32, section 140, Pub. 100-08, Medicare Program Integrity Manual, Chapter 10, section 10.2.2.5, for CR and ICR claims processing, coding, and billing requirements.)

100-2, Chapter-15, 270

Telehealth Services

For information on telehealth services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.

100-2, Chapter-15, 280.5

Annual Wellness Visit (AWV) Providing Personalized Prevention Plan Services (PPPS)

A. General

Pursuant to section 4103 of the Affordable Care Act of 2010 (the ACA), the; Centers for Medicare & Medicaid Services (CMS) amended section 42 CFR 411.15(a)(1) and 42 CFR 411.15(k)(15) (list of examples of routine physical examinations excluded from coverage), effective for services furnished on or after January 1, 2011. This expanded coverage, as established at 42 CFR 410.15, is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV) providing personalized prevention plan services (PPPS), when performed by a health professional (as defined in this section), for an individual who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

The AWV will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B. Definitions relative to the AWV are included below.

Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional; and,
2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months.

Sections 4103 and 4104 of the ACA also provide for a waiver of the Medicare coinsurance and Part B deductible requirements for an AWV effective for services furnished on or after January 1, 2011.

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B. Definitions Relative to the AWV:

Detection of any cognitive impairment: The assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient reports, concerns raised by family members, friends, caretakers, or others.

Eligible beneficiary: An individual who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period and who has not received either an IPPE or an AWV providing PPPS within the past 12 months.

Establishment of, or an update to, the individual's medical/family history:

At a minimum, the collection and documentation of the following:

a. Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.
b. Use or exposure to medications and supplements, including calcium and vitamins.
c. Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

First AWV providing PPPS: The provision of the following services to an eligible beneficiary by a health professional that include, and take into account the results of, a health risk assessment as those terms are defined in this section:

a. Review (and administration if needed) of a health risk assessment (as defined in this section).
b. Establishment of an individual's medical/family history.
c. Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
d. Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
e. Detection of any cognitive impairment that the individual may have as defined in this section.
f. Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
g. Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
h. Establishment of the following:
    1. A written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), and the individual's health risk assessment (as that term is defined in this section), the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
    2. A list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
i. Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
j. Any other element determined appropriate through the National Coverage Determination (NCD) process.

Health professional:

a. A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,
b. A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,
c. A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in 42CFR 410.32(b)(3)(ii)) of a physician as defined in this section.

Health Risk Assessment means, for the purposes of the annual wellness visit, an evaluation tool that meets the following criteria:

a. collects self-reported information about the beneficiary.
b. can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter.
c. is appropriately tailored to and takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs.
d. takes no more than 20 minutes to complete.
e. addresses, at a minimum, the following topics:
    1. demographic data, including but not limited to age, gender, race, and ethnicity.
    2. self-assessment of health status, frailty, and physical functioning.
    3. psychosocial risks, including but not limited to, depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue.
    4. Behavioral risks, including but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (seat belt use), and home safety.
    5. Activities of daily living (ADLs), including but not limited to, dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.

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6. Instrumental activities of daily living (IADLs), including but not limited to, shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

Review of the individual's functional ability and level of safety: At a minimum, includes assessment of the following topics:

a. Hearing impairment,
b. Ability to successfully perform activities of daily living,
c. Fall risk, and,
d. Home safety.

Subsequent AWV providing PPPS: The provision of the following services to an eligible beneficiary by a health professional that include, and take into account the results of an updated health risk assessment, as those terms are defined in this section:

a. Review (and administration if needed) of an updated health risk assessment (as defined in this section).
b. An update of the individual's medical/family history.
c. An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS or the previous subsequent AWV providing PPPS.
d. Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
e. Detection of any cognitive impairment that the individual may have as defined in this section.
f. An update to the following:
    1. The written screening schedule for the individual as that schedule is defined in this section, that was developed at the first AWV providing PPPS, and,
    2. The list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPPS or the previous subsequent AWV providing PPPS.
g. Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined for the first AWV providing PPPS.
h. Any other element determined appropriate by the Secretary through the NCD process.

See Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 140, for detailed claims processing and billing instructions.

100-2, Chapter-15, 290

Foot Care

A. Treatment of Subluxation of Foot

Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

However, medical or surgical treatment of subluxation of the ankle joint (talo-crural joint) is covered. In addition, reasonable and necessary medical or surgical services, diagnosis, or treatment for medical conditions that have resulted from or are associated with partial displacement of structures is covered. For example, if a patient has osteoarthritis that has resulted in a partial displacement of joints in the foot, and the primary treatment is for the osteoarthritis, coverage is provided.

B. Exclusions from Coverage

The following foot care services are generally excluded from coverage under both Part A and Part B. (See §290.F and §290.G for instructions on applying foot care exclusions.)

1. Treatment of Flat Foot

The term "flat foot" is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are not covered.

2. Routine Foot Care

Except as provided above, routine foot care is excluded from coverage. Services that normally are considered routine and not covered by Medicare include the following:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

3. Supportive Devices for Feet

Orthopedic shoes and other supportive devices for the feet generally are not covered. However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics.

C. Exceptions to Routine Foot Care Exclusion

1. Necessary and Integral Part of Otherwise Covered Services

In certain circumstances, services ordinarily considered to be routine may be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds, or infections.

2. Treatment of Warts on Foot

The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

3. Presence of Systemic Condition

The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. (See subsection A.)

In these instances, certain foot care procedures that otherwise are considered routine (e.g., cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may

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pose a hazard when performed by a nonprofessional person on patients with such systemic conditions. (See §290.G for procedural instructions.)

4. Mycotic Nails

In the absence of a systemic condition, treatment of mycotic nails may be covered.

The treatment of mycotic nails for an ambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

The treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

For the purpose of these requirements, documentation means any written information that is required by the carrier in order for services to be covered. Thus, the information submitted with claims must be substantiated by information found in the patient's medical record. Any information, including that contained in a form letter, used for documentation purposes is subject to carrier verification in order to ensure that the information adequately justifies coverage of the treatment of mycotic nails.

D. Systemic Conditions That Might Justify Coverage

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care.

Diabetes mellitus *

Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)

Buerger's disease (thromboangiitis obliterans)

Chronic thrombophlebitis *

Peripheral neuropathies involving the feet-

Associated with malnutrition and vitamin deficiency *

- Malnutrition (general, pellagra)
- Alcoholism
- Malabsorption (celiac disease, tropical sprue)
- Pernicious anemia

Associated with carcinoma *

Associated with diabetes mellitus *

Associated with drugs and toxins *

Associated with multiple sclerosis *

Associated with uremia (chronic renal disease) *

Associated with traumatic injury

Associated with leprosy or neurosyphilis

Associated with hereditary disorders

- Hereditary sensory radicular neuropathy
- Angiokeratoma corporis diffusum (Fabry's)
- Amyloid neuropathy

When the patient's condition is one of those designated by an asterisk (*), routine procedure s are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

E. Supportive Devices for Feet

Orthopedic shoes and other supportive devices for the feet generally are not covered. However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics.

F. Presumption of Coverage

In evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For purposes of applying this presumption the following findings are pertinent:

Class A Findings

Nontraumatic amputation of foot or integral skeletal portion thereof.

Class B Findings

Absent posterior tibial pulse;

Advanced trophic changes as: hair growth (decrease or absence) nail changes (thickening) pigmentary changes (discoloration) skin texture (thin, shiny) skin color (rubor or redness) (Three required); and

Absent dorsalis pedis pulse.

Class C Findings

Claudication;

Temperature changes (e.g., cold feet);

Edema;

Paresthesias (abnormal spontaneous sensations in the feet); and

Burning.

The presumption of coverage may be applied when the physician rendering the routine foot care has identified:

1. A Class A finding;
2. Two of the Class B findings; or
3. One Class B and two Class C findings

Cases evidencing findings falling short of these alternatives may involve podiatric treatment that may constitute covered care and should be reviewed by the intermediary's medical staff and developed as necessary.

For purposes of applying the coverage presumption where the routine services have been rendered by a podiatrist, the contractor may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the 6-month period prior to the rendition of the routine-type services. The intermediary may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

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Services ordinarily considered routine might also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

G. Application of Foot Care Exclusions to Physician's Services

The exclusion of foot care is determined by the nature of the service. Thus, payment for an excluded service should be denied whether performed by a podiatrist, osteopath, or a doctor of medicine, and without regard to the difficulty or complexity of the procedure.

When an itemized bill shows both covered services and noncovered services not integrally related to the covered service, the portion of charges attributable to the noncovered services should be denied. (For example, if an itemized bill shows surgery for an ingrown toenail and also removal of calluses not necessary for the performance of toe surgery, any additional charge attributable to removal of the calluses should be denied.)

In reviewing claims involving foot care, the A/B MAC (B) should be alert to the following exceptional situations:

1. Payment may be made for incidental noncovered services performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if trimming of toenails is required for application of a cast to a fractured foot, the A/B MAC (B) need not allocate and deny a portion of the charge for the trimming of the nails. However, a separately itemized charge for such excluded service should be disallowed. When the primary procedure is covered the administration of anesthesia necessary for the performance of such procedure is also covered.
2. Payment may be made for **initial** diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.

The name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim. In those cases, where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.

NOTE: Section 939 of P.L. 96-499 removed "warts" from the routine foot care exclusion effective July 1, 1981.

Relatively few claims for routine-type care are anticipated considering the severity of conditions contemplated as the basis for this exception. Claims for this type of foot care should not be paid in the absence of convincing evidence that nonprofessional performance of the service would have been hazardous for the beneficiary because of an underlying systemic disease. The mere statement of a diagnosis such as those mentioned in §D above does not of itself indicate the severity of the condition. Where development is indicated to verify diagnosis and/or severity the A/B MAC (B) should follow existing claims processing practices, which may include review of A/B MAC (B) history and medical consultation as well as physician contacts.

The rules in §290.F concerning presumption of coverage also apply.

Codes and policies for routine foot care and supportive devices for the feet are not exclusively for the use of podiatrists. These codes must be used to report foot care services regardless of the specialty of the physician who furnishes the services. A/B MACs (B) must instruct physicians to use the most appropriate code available when billing for routine foot care.

100-2, Chapter-15, 300

Diabetes Self-Management Training Services

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards. This program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and
- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in a file that includes the original order from the physician and any special conditions noted by the physician.

When the training under the order is changed, the training order/referral must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

NOTE: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

100-2, Chapter-15, 300.2

Certified Providers

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to the contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. The CMS is designating all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers as certified. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002,

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as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement.

The CMS will not reimburse services on a fee-for-service basis rendered to a beneficiary under Part A.

NOTE: While separate payment is not made for this service to Rural Health Clinics (RHCs), the service is covered but is considered included in the all-inclusive encounter rate. Effective January 1, 2006, payment for DSMT provided in a Federally Qualified Health Clinic (FQHC) that meets all of the requirements identified in Pub. 100-04, chapter 18, section 120 may be made in addition to one other visit the beneficiary had during the same day.

All DSMT programs must be accredited as meeting quality standards by a CMS approved national accreditation organization. Currently, CMS recognizes the American Diabetes Association, American Association of Diabetes Educators and the Indian Health Service as approved national accreditation organizations. Programs without accreditation by a CMS-approved national accreditation organization are not covered. Certified providers may be asked to submit updated accreditation documents at any time or to submit outcome data to an organization designated by CMS.

Enrollment of DMEPOS Suppliers

The DMEPOS suppliers are reimbursed for diabetes training through A/B MACs (B). In order to file claims for DSMT, a DMEPOS supplier must be enrolled in the Medicare program with the National Supplier Clearinghouse (NSC). The supplier must also meet the quality standards of a CMS-approved national accreditation organization as stated above. DMEPOS suppliers must obtain a provider number from the A/B MAC (B) in order to bill for DSMT.

The A/B MAC (B) requires a completed Form CMS-855, along with an accreditation certificate as part of the provider application process. After it has been determined that the quality standards are met, a billing number is assigned to the supplier. Once a supplier has received a National Provider Identification (NPI) number, the supplier can begin receiving reimbursement for this service.

A/B MACs (B) should contact the National Supplier Clearinghouse (NSC) according to the instruction in Pub 100-08, the Medicare Program Integrity Manual, Chapter 10, "Healthcare Provider/Supplier Enrollment," to verify an applicant is currently enrolled and eligible to receive direct payment from the Medicare program.

The applicant is assigned specialty 87.

Any DMEPOS supplier that has its billing privileges deactivated or revoked by the NSC will also have the billing number deactivated by the A/B MAC (B).

100-2, Chapter-15, 300.3

Frequency of Training

A - Initial Training

The initial year for DSMT is the 12 month period following the initial date.

Medicare will cover initial training that meets the following conditions:

- Is furnished to a beneficiary who has not previously received initial or follow-up training under HCPCS codes G0108 or G0109;
- Is furnished within a continuous 12-month period;
- Does not exceed a total of 10 hours* (the 10 hours of training can be done in any combination of 1/2 hour increments);
- With the exception of 1 hour of individual training, training is usually furnished in a group setting, which can contain other patients besides Medicare beneficiaries, and;
- One hour of individual training may be used for any part of the training including insulin training.

* When a claim contains a DSMT HCPCS code and the associated units cause the total time for the DSMT initial year to exceed '10' hours, a CWF error will set.

B -Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than 2 hours individual or group training per beneficiary per year;
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
- Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;
- Follow-up training is furnished in increments of no less than one-half hour*; and
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

*When a claim contains a DSMT HCPCS code and the associated units cause the total time for any follow-up year to exceed 2 hours, a CWF error will set.

100-2, Chapter-15, 300.4

Coverage Requirements for Individual Training

Medicare covers training on an individual basis for a Medicare beneficiary under any of the following conditions.

- No group session is available within 2 months of the date the training is ordered;
- The beneficiary's physician (or qualified non-physician practitioner) documents in the beneficiary's medical record that the beneficiary has special needs resulting from conditions, such as severe vision, hearing or language limitations or other such special conditions as identified by the treating physician or non-physician practitioner, that will hinder effective participation in a group training session; or
- The physician orders additional insulin training.
- The need for individual training must be identified by the physician or non-physician practitioner in the referral.

NOTE: If individual training has been provided to a Medicare beneficiary and subsequently the A/B MAC (A) or (B) or intermediary determines that training should have been provided in a group, A/B MACs (A) and (B) down-code the reimbursement from individual to the group level and provider education would be the appropriate actions instead of denying the service as billed.

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100-2, Chapter-15, 310

Kidney Disease Patient Education Services

By definition, chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones. When CKD progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Patients can be classified into 5 stages based on their glomerular filtration rate (GFR, how quickly blood is filtered through the kidneys), with stage I having kidney damage with normal or increased GFR to stage V with kidney failure, also called end-stage renal disease (ESRD). Once patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, slow the progression of kidney disease, and reduce the risk of other diseases such as heart disease.

Beneficiaries with CKD may benefit from kidney disease education (KDE) interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

Effective for claims with dates of service on and after January 1, 2010, Section 152(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) covers KDE services under Medicare Part B. KDE services are designed to provide beneficiaries with Stage IV CKD comprehensive information regarding: the management of comorbidities, including delaying the need for dialysis; prevention of uremic complications; all therapeutic options (each option for renal replacement therapy, dialysis access options, and transplantation); ensuring that the beneficiary has opportunities to actively participate in his/her choice of therapy; and that the services be tailored to meet the beneficiary's needs.

Regulations for KDE services were established at 42 CFR 410.48. Claims processing instructions and billing requirements can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 32 –Billing Requirements for Special Services, Section 20.

100-2, Chapter-15, 310.1

Beneficiaries Eligible for Coverage

Medicare Part B covers outpatient, face-to-face KDE services for a beneficiary that:

- is diagnosed with Stage IV CKD, using the Modification of Diet in Renal Disease (MDRD) Study formula (severe decrease in GFR, GFR value of 15-29 mL/min/1.73 m^2), and
- obtains a referral from the physician managing the beneficiary's kidney condition. The referral should be documented in the beneficiary's medical records.

100-2, Chapter-15, 310.2

Qualified Person

Medicare Part B covers KDE services provided by a 'qualified person,' meaning a:

- physician (as defined in section 30 of this chapter),
- physician assistant, nurse practitioner, or clinical nurse specialist (as defined in sections 190, 200, and 210 of this chapter),
- hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, if the KDE services are provided in a rural area (using the actual geographic location core based statistical area (CBSA) to identify facilities located in rural areas), or
- hospital or CAH that is treated as being rural (was reclassified from urban to rural status per 42 CFR 412.103).

NOTE: The "incident to" requirements at section 1861(s)(2)(A) of the Social Security Act (the Act) do not apply to KDE services.

The following providers are not 'qualified persons' and are excluded from furnishing KDE services:

- A hospital, CAH, SNF, CORF, HHA, or hospice located outside of a rural area (using the actual geographic location CBSA to identify facilities located outside of a rural area), unless the services are furnished by a hospital or CAH that is treated as being in a rural area; and
- Renal dialysis facilities.

100-2, Chapter-15, 310.3

Limitations for Coverage

Medicare Part B covers KDE services:

- Up to six (6) sessions as a beneficiary lifetime maximum. A session is 1 hour. In order to bill for a session, a session must be at least 31 minutes in duration. A session that lasts at least 31 minutes, but less than 1 hour still constitutes 1 session.
- On an individual basis or in group settings; if the services are provided in a group setting, a group consists of 2 to 20 individuals who need not all be Medicare beneficiaries.

NOTE: Two HCPCS codes were created for this benefit and one or the other must be present, along with the appropriate ICD diagnosis codes.

The diagnosis codes are:

- ICD-9-CM - code 585.4 (chronic kidney disease, Stage IV (severe)), or
- ICD-10-CM - code N18.4 (chronic kidney disease, Stage IV).

The HCPCS codes are:

- G0420: Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
- G0421: Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour

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100-2, Chapter-15, 310.4

Standards for Content

Medicare Part B covers KDE services, provided by a qualified person, which provide comprehensive information regarding:

A. The management of comorbidities, including delaying the need for dialysis, which includes, but is not limited to, the following topics:
   - Prevention and treatment of cardiovascular disease,
   - Prevention and treatment of diabetes,
   - Hypertension management,
   - Anemia management,
   - Bone disease and disorders of calcium and phosphorus metabolism management,
   - Symptomatic neuropathy management, and
   - Impairments in functioning and well-being.

B. Prevention of uremic complications, which includes, but is not limited to, the following topics
   - Information on how the kidneys work and what happens when the kidneys fail,
   - Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival,
   - Diet and fluid restrictions, and
   - Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision making if the patient decides not to take a specific drug.

C. Therapeutic options, treatment modalities and settings, advantages and disadvantages of each treatment option, and how the treatments replace the kidney, including, but not limited to, the following topics:
   - Hemodialysis, both at home and in-facility;
   - Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility;
   - All dialysis access options for hemodialysis and peritoneal dialysis; and
   - Transplantation.

D. Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved, which includes, but is not limited to, the following topics:
   - Physical symptoms,
   - Impact on family and social life,
   - Exercise,
   - The right to refuse treatment,
   - Impact on work and finances,
   - The meaning of test results, and
   - Psychological impact.

100-2, Chapter-15, 310.5

Outcomes Assessment

Qualified persons that provide KDE services must develop outcomes assessments that are designed to measure beneficiary knowledge about CKD and its treatment. The assessment must be administered to the beneficiary during a KDE session, and be made available to the Centers for Medicare & Medicaid Services (CMS) upon request. The outcomes assessments serve to assist KDE educators and CMS in improving subsequent KDE programs, patient understanding, and assess program effectiveness of:

- Preparing the beneficiary to make informed decisions about their healthcare options related to CKD, and
- Meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

100-2, Chapter-16, 10

General Exclusions From Coverage

No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services, when the following conditions exist:

- Not reasonable and necessary (§20);
- No legal obligation to pay for or provide (§40);
- Paid for by a governmental entity (§50);
- Not provided within United States (§60);
- Resulting from war (§70);
- Personal comfort (§80);
- Routine services and appliances (§90);
- Custodial care (§110);
- Cosmetic surgery (§120);
- Charges by immediate relatives or members of household (§130);
- Dental services (§140);
- Paid or expected to be paid under workers' compensation (§150);
- Non-physician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital (§170);
- Services Related to and Required as a Result of Services Which are not Covered Under Medicare (§180);
- Excluded foot care services and supportive devices for feet (§30); or,
- Excluded investigational devices (See Chapter 14).

100-2, Chapter-16, 20

Services Not Reasonable and Necessary

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered, e.g., payment cannot be made for the rental of a special hospital bed to be used by the patient in their home unless it was a reasonable and necessary part of the patient's treatment. See also §80.

A health care item or service for the purpose of causing, or assisting to cause, the death of any individual (assisted suicide) is not covered. This prohibition does not apply to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing death.

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100-2, Chapter-16, 90

Routine Services and Appliances

Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The routine physical checkup exclusion does not apply to the following services (as noted in section 42 CFR 411.15(a)(1)):

- Screening mammography,
- Colorectal cancer screening tests,
- Screening pelvic exams,
- Prostate cancer screening tests,
- Glaucoma screening exams,
- Ultrasound screening for abdominal aortic aneurysms (AAA),
- cardiovascular disease screening tests,
- diabetes screening tests,
- screening electrocardiogram,
- Initial preventive physical examinations,
- Annual wellness visits providing personalized prevention plan services, and
- Additional preventive services that meet the criteria specified in 42 CFR 410.64.

If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, "Black Lung Benefits," the service is not covered under Medicare and the claimant should be advised to contact their Social Security office regarding the filing of a claim for reimbursement under the "Black Lung" program.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ -the lens of the eye. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §120).

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

A. Immunizations

Vaccinations or inoculations are excluded as immunizations unless they are either:

- Directly related to the treatment of an injury or direct exposure to a disease or condition, such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. (In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered.); or
- Specifically covered by statute, as described in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

B. Antigens

Prior to the Omnibus Reconciliation Act of 1980, a physician who prepared an antigen for a patient could not be reimbursed for that service unless the physician also administered the antigen to the patient. Effective January 1, 1981, payment may be made for a reasonable supply of antigens that have been prepared for a particular patient even though they have not been administered to the patient by the same physician who prepared them if:

- The antigens are prepared by a physician who is a doctor of medicine or osteopathy, and
- The physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.

A reasonable supply of antigens is considered to be not more than a 12 month supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.1)

100-2, Chapter-16, 140

Dental Services Exclusion

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process. However, payment may be made for certain other services of a dentist. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §150.)

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. In like manner, the removal of the torus palatinus (a bony protuberance of the hard palate) could be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, reimbursement is not made for this purpose.

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an

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exception to the requirement that to be covered, a noncovered procedure or service performed by a dentist must be an incident to and an integral part of a covered procedure or service performed by the dentist. Ordinarily, the dentist extracts the patient's teeth, but another physician, e.g., a radiologist, administers the radiation treatments.

Whether such services as the administration of anesthesia, diagnostic X-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is covered. Thus, an X-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single X-ray or X-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.

See also the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §70, and Chapter 15, "Covered Medical and Other Health Services," §150 for additional information on dental services.

100-3, Chapter-1, Part 1, 10.2

Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain

The use of transcutaneous electrical nerve stimulation (TENS) for the relief of acute post-operative pain is covered under Medicare. TENS may be covered whether used as an adjunct to the use of drugs, or as an alternative to drugs, in the treatment of acute pain resulting from surgery.

The TENS devices, whether durable or disposable, may be used in furnishing this service. When used for the purpose of treating acute post-operative pain, TENS devices are considered supplies. As such they may be hospital supplies furnished inpatients covered under Part A, or supplies incident to a physician's service when furnished in connection with surgery done on an outpatient basis, and covered under Part B.

It is expected that TENS, when used for acute post-operative pain, will be necessary for relatively short periods of time, usually 30 days or less. In cases when TENS is used for longer periods, A/B MACs should attempt to ascertain whether TENS is no longer being used for acute pain but rather for chronic pain, in which case the TENS device may be covered as durable medical equipment as described in §160.27.

Cross-references:

Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §40;

Medicare Benefit Policy Manual, Chapter 2, "Hospital Services Covered Under Part B," §§20, 20.4, and 80; Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and other Health Services, §110."

100-3, Chapter-1, Part 1, 20.21

Chelation Therapy for Treatment of Atherosclerosis

Chelation therapy is the application of chelation techniques for the therapeutic or preventive effects of removing unwanted metal ions from the body. The application of chelation therapy using ethylenediamine-tetra-acetic acid (EDTA) for the treatment and prevention of atherosclerosis is controversial. There is no widely accepted rationale to explain the beneficial effects attributed to this therapy. Its safety is questioned and its clinical effectiveness has never been established by well-designed, controlled clinical trials. It is not widely accepted and practiced by American physicians. EDTA chelation therapy for atherosclerosis is considered experimental. For these reasons, EDTA chelation therapy for the treatment or prevention of atherosclerosis is not covered. Some practitioners refer to this therapy as chemoendarterectomy and may also show a diagnosis other than atherosclerosis, such as arteriosclerosis or calcinosis. Claims employing such variant terms should also be denied under this section.

Cross-reference: §20.22

100-3, Chapter-1, Part 1, 20.22

Ethylenediamine-Tetra-Acetic (EDTA) Chelation Therapy for Treatment of Atherosclerosis

The use of EDTA as a chelating agent to treat atherosclerosis, arteriosclerosis, calcinosis, or similar generalized condition not listed by the FDA as an approved use is not covered. Any such use of EDTA is considered experimental. See §20.21 for an explanation of this conclusion.

100-3, Chapter-1, Part 1, 40.7

Outpatient Intravenous Insulin Treatment (Effective December 23, 2009)

A. General

The term outpatient intravenous (IV) insulin therapy (OIVIT) refers to an outpatient regimen that integrates pulsatile or continuous intravenous infusion of insulin via any means, guided by the results of measurement of:

- respiratory quotient; and/or
- urine urea nitrogen (UUN); and/or
- arterial, venous, or capillary glucose; and/or
- potassium concentration; and

performed in scheduled recurring periodic intermittent episodes.

This regimen is also sometimes termed Cellular Activation Therapy (CAT), Chronic Intermittent Intravenous Insulin Therapy (CIIT), Hepatic Activation Therapy (HAT), Intercellular Activation Therapy (iCAT), Metabolic Activation Therapy (MAT), Pulsatile Intravenous Insulin Treatment (PIVIT), Pulse Insulin Therapy (PIT), and Pulsatile Therapy (PT).

In OIVIT, insulin is intravenously administered in the outpatient setting for a variety of indications. Most commonly, it is delivered in pulses, but it may be delivered as a more conventional drip solution. The insulin administration is adjunctive to the patient's routine diabetic management regimen (oral agent or insulin-based) or other disease management regimen, typically performed on an intermittent basis (often weekly), and frequently performed chronically without duration limits. Glucose or other carbohydrate is available ad libitum (in accordance with patient desire).

B. Nationally Covered Indications

N/A

C. Nationally Non-Covered Indications

Effective for claims with dates of service on and after December 23, 2009, the Centers for Medicare and Medicaid Services (CMS) determines that the evidence does not support a conclusion that OIVIT improves health outcomes in Medicare beneficiaries. Therefore, CMS has determined that OIVIT is not reasonable and necessary for any indication under section 1862(a)(1)(A) of the Social Security Act. Services

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comprising an OIVIT regimen are nationally non-covered under Medicare when furnished pursuant to an OIVIT regimen (see subsection A. above).

D. Other

Individual components of OIVIT may have medical uses in conventional treatment regimens for diabetes and other conditions. Coverage for such other uses may be determined by other local or national Medicare determinations, and do not pertain to OIVIT. For example, see Pub. 100-03, NCD Manual, Section 40.2, Home Blood Glucose Monitors, Section 40.3, Closed-loop Blood Glucose Control Devices (CBGCD), Section 190.20, Blood Glucose Testing, and Section 280.14, Infusion Pumps, as well as Pub. 100-04, Claims Processing Manual, Chapter 18, Section 90, Diabetics Screening.

(This NCD last reviewed December 2009.)

100-3, Chapter-1, Part 1, 80.2

Photodynamic Therapy

Photodynamic therapy is a medical procedure which involves the infusion of a photosensitive (light-activated) drug with a very specific absorption peak. This drug is chemically designed to have a unique affinity for the diseased tissue intended for treatment. Once introduced to the body, the drug accumulates and is retained in diseased tissue to a greater degree than in normal tissue. Infusion is followed by the targeted irradiation of this tissue with a non-thermal laser, calibrated to emit light at a wavelength that corresponds to the drug's absorption peak. The drug then becomes active and locally treats the diseased tissue.

Ocular Photodynamic Therapy (OPT)

Ocular Photodynamic Therapy (OPT) is used in the treatment of ophthalmologic diseases. OPT is only covered when used in conjunction with verteporfin (see section 80.3, "Photosensitive Drugs").

- Classic Subfoveal Choroidal Neovascular (CNV) Lesions -OPT is covered with a diagnosis of neovascular age-related macular degeneration (AMD) with predominately classic subfoveal choroidal neovascular (CNV) lesions (where the area of classic CNV occupies ≥ 50 % of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram. Subsequent follow-up visits will require either an optical coherence tomography (OCT) or a fluorescein angiogram (FA) to access treatment response. There are no requirements regarding visual acuity, lesion size, and number of re-treatments.
- Occult Subfoveal Choroidal Neovascular (CNV) Lesions -OPT is noncovered for patients with a diagnosis of age-related macular degeneration (AMD) with occult and no classic CNV lesions.

Other Conditions -Use of OPT with verteporfin for other types of AMD (e.g., patients with minimally classic CNV lesions, atrophic, or dry AMD) is noncovered. OPT with verteporfin for other ocular indications such as pathologic myopia or presumed ocular histoplasmosis syndrome, is eligible for coverage through individual contractor discretion.

100-3, Chapter-1, Part 1, 80.2.1

Ocular Photodynamic Therapy (OPT) - Effective April 3, 2013

A. General

Ocular Photodynamic Therapy (OPT) is used in the treatment of ophthalmologic diseases; specifically, for age-related macular degeneration (AMD), a common eye disease among the elderly. OPT involves the infusion of an intravenous photosensitizing drug called verteporfin followed by exposure to a laser. OPT is only covered when used in conjunction with verteporfin.

Effective July 1, 2001, OPT with verteporfin was approved for a diagnosis of neovascular AMD with predominately classic subfoveal choroidal neovascularization (CNV) lesions (where the area of classic CNV occupies ≥ 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram (FA).

On October 17, 2001, the Centers for Medicare & Medicaid Services (CMS) announced its "intent to cover" OPT with verteporfin for AMD patients with occult and no classic subfoveal CNV as determined by an FA. The October 17, 2001, decision was never implemented.

On March 28, 2002, after thorough review and reconsideration of the October 17, 2001, intent to cover policy, CMS determined that the current non-coverage policy for OPT for verteporfin for AMD patients with occult and no classic subfoveal CNV as determined by an FA should remain in effect.

Effective August 20, 2002, CMS issued a non-covered instruction for OPT with verteporfin for AMD patients with occult and no classic subfoveal CNV as determined by an FA.

B. Nationally Covered Indications

Effective April 1, 2004, OPT with verteporfin continues to be approved for a diagnosis of neovascular AMD with predominately classic subfoveal CNV lesions (where the area of classic CNV occupies ≥ 50% of the area of the entire lesion) at the initial visit as determined by an FA. (CNV lesions are comprised of classic and/or occult components.) Subsequent follow-up visits require either an optical coherence tomography (OCT) (effective April 3. 2013) or an FA (effective April 1, 2004) to access treatment response. There are no requirements regarding visual acuity, lesion size, and number of re-treatments when treating predominantly classic lesions.

In addition, after thorough review and reconsideration of the August 20, 2002, non-coverage policy, CMS determines that the evidence is adequate to conclude that OPT with verteporfin is reasonable and necessary for treating:

1. Subfoveal occult with no classic CNV associated with AMD; and,
2. Subfoveal minimally classic CNV (where the area of classic CNV occupies <50% of the area of the entire lesion) associated with AMD.

The above 2 indications are considered reasonable and necessary only when:

1. The lesions are small (4 disk areas or less in size)at the time of initial treatment or within the 3 months prior to initial treatment; and,
2. The lesions have shown evidence of progression within the 3 months prior to initial treatment. Evidence of progression must be documented by deterioration

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of visual acuity (at least 5 letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion.

C. Nationally Non-Covered Indications

Other uses of OPT with verteporfin to treat AMD not already addressed by CMS will continue to be non-covered. These include, but are not limited to, the following AMD indications:

- Juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea),
- Inability to obtain a fluorescein angiogram,
- Atrophic or "dry" AMD.

D. Other

The OPT with verteporfin for other ocular indications, such as pathologic myopia or presumed ocular histoplasmosis syndrome, continue to be eligible for local coverage determinations through individual A/B MAC discretion.

100-3, Chapter-1, Part 1, 80.3

Photosensitive Drugs

Photosensitive drugs are the light-sensitive agents used in photodynamic therapy. Once introduced into the body, these drugs selectively identify and adhere to diseased tissue. The drugs remain inactive until they are exposed to a specific wavelength of light, by means of a laser, that corresponds to their absorption peak. The activation of a photosensitive drug results in a photochemical reaction which treats the diseased tissue without affecting surrounding normal tissue.

Verteporfin

Verteporfin, a benzoporphyrin derivative, is an intravenous lipophilic photosensitive drug with an absorption peak of 690 nm. This drug was first approved by the Food and Drug Administration (FDA) on April 12, 2000, and subsequently, approved for inclusion in the United States Pharmacopoeia on July 18, 2000, meeting Medicare's definition of a drug when used in conjunction with ocular photodynamic therapy (OPT) (see section 80.2, "Photodynamic Therapy") when furnished intravenously incident to a physician's service. For patients with age-related macular degeneration (AMD), Verteporfin is only covered with a diagnosis of neovascular age-related macular degeneration with predominately classic subfoveal choroidal neovascular (CNV) lesions (where the area of classic CNV occupies ≥ 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram (FA). Subsequent follow-up visits will require either an optical coherence tomography (OCT) or an FA to access treatment response. OPT with verteporfin is covered for the above indication and will remain non-covered for all other indications related to AMD (see section 80.2). OPT with Verteporfin for use in non-AMD conditions is eligible for coverage through individual A/B MAC discretion.

100-3, Chapter-1, Part 1, 80.3.1

Verteporfin -Effective April 3, 2013

A. General

Verteporfin, a benzoporphyrin derivative, is an intravenous lipophilic photosensitive drug with an absorption peak of 690 nm. Verteporfin was first approved by the Food and Drug Administration on April 12, 2000, and subsequently approved for inclusion in the United States Pharmacopoeia on July 18, 2000, meeting Medicare's definition of a drug as defined under §1861(t)(1) of the Social Security Act. Verteporfin is only covered when used in conjunction with ocular photodynamic therapy OPT) when furnished intravenously incident to a physician's service.

B. Nationally Covered Indications

Effective April 1, 2004, OPT with verteporfin is covered for patients with a diagnosis of neovascular age-related macular degeneration (AMD) with:

- Predominately classic subfoveal choroidal neovascularization (CNV) lesions (where the area of classic CNV occupies ≥ 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram. (CNV lesions are comprised of classic and/or occult components.) Subsequent follow-up visits require either an optical coherence tomography (OCT) (effective April 3, 2013) or a fluorescein angiogram (FA) (effective April 1, 2004) to access treatment response.

  There are no requirements regarding visual acuity, lesion size, and number of retreatments when treating predominantly classic lesions.

- Subfoveal occult with no classic associated with AMD.
- Subfoveal minimally classic CNV (where the area of classic CNV occupies <50% of the area of the entire lesion) associated with AMD.
- The above 2 indications are considered reasonable and necessary only when:

  1. The lesions are small (4 disk areas or less in size) at the time of initial treatment or within the 3 months prior to initial treatment; and,
  2. The lesions have shown evidence of progression within the 3 months prior to initial treatment. Evidence of progression must be documented by deterioration of visual acuity (at least 5 letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion.

C. Nationally Non-Covered Indications

Other uses of OPT with verteporfin to treat AMD not already addressed by the Centers for Medicare & Medicaid Services will continue to be non-covered. These include, but are not limited to, the following AMD indications: juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea), inability to obtain an FA, or atrophic or "dry" AMD.

D. Other

The OPT with verteporfin for other ocular indications, such as pathologic myopia or presumed ocular histoplasmosis syndrome, continue to be eligible for local coverage determinations through individual A/B MAC discretion.

100-3, Chapter-1, Part 2, 90.1

Pharmacogenomic Testing to Predict Warfarin Responsiveness (Effective August 3, 2009)

A. General

Warfarin sodium is an orally administered anticoagulant drug that is marketed most commonly as Coumadin®. (The Food and Drug Administration (FDA) approved labeling for Coumadin® includes a Black Box Warning dating back to 2007.) Anticoagulant drugs are sometimes referred to as blood thinners by the lay public. Warfarin affects the vitamin K-dependent clotting factors II, VII, IX, and X. Warfarin is

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thought to interfere with clotting factor synthesis by inhibition of the C1 subunit of the vitamin K epoxide reductase (VKORC1) enzyme complex, thereby reducing the regeneration of vitamin K1 epoxide. The elimination of warfarin is almost entirely by metabolic conversion to inactive metabolites by cytochrome P450 (CYP) enzymes in liver cells. CYP2C9 is the principal cytochrome P450 enzyme that modulates the anticoagulant activity of warfarin. From results of clinical studies, genetic variation in the CYP2C9 and/or VKORC1 genes can, in concert with clinical factors, predict how each individual responds to warfarin.

Pharmacogenomics denotes the study of how an individual's genetic makeup, or genotype, affects the body's response to drugs. Pharmacogenomics as a science examines associations among variations in genes with individual responses to a drug or medication. In application, pharmacogenomic results (i.e., information on the patient's genetic variations) can contribute to predicting a patient's response to a given drug: good, bad, or none at all. Pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict a patient's response to warfarin occurs ideally prior to initiation of the drug. This would be an once-in-a-lifetime test, absent any reason to believe that the patient's personal genetic characteristics would change over time. Although such pharmacogenomic testing would be used to attempt to better approximate the best starting dose of warfarin, it would not eliminate the need for periodic PT/INR testing, a standard diagnostic test for coagulation activity and for assessing how a patient is reacting to a warfarin dose.

Nationally Covered Indications

Effective August 3, 2009, the Centers for Medicare & Medicaid Services (CMS) believes that the available evidence supports that coverage with evidence development (CED) under §1862(a)(1)(E) of the Social Security Act (the Act) is appropriate for pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness by any method, and is therefore covered only when provided to Medicare beneficiaries who are candidates for anticoagulation therapy with warfarin who:

1. Have not been previously tested for CYP2C9 or VKORC1 alleles; and
2. Have received fewer than five days of warfarin in the anticoagulation regimen for which the testing is ordered; and
3. Are enrolled in a prospective, randomized, controlled clinical study when that study meets the following standards.

A clinical study seeking Medicare payment for pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness provided to the Medicare beneficiary who is a candidate for anticoagulation therapy with warfarin pursuant to CED must address one or more aspects of the following question:

Prospectively, in Medicare-aged subjects whose warfarin therapy management includes pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin response, what is the frequency and severity of the following outcomes, compared to subjects whose warfarin therapy management does not include pharmacogenomic testing?

- Major hemorrhage
- Minor hemorrhage
- Thromboembolism related to the primary indication for anticoagulation
- Other thromboembolic event
- Mortality

The study must adhere to the following standards of scientific integrity and relevance to the Medicare population:

a. The principal purpose of the research study is to test whether a particular intervention potentially improves the participants' health outcomes.

b. The research study is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

c. The research study does not unjustifiably duplicate existing studies.

d. The research study design is appropriate to answer the research question being asked in the study.

e. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.

f. The research study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in the Code of Federal Regulations (CFR) at 45 CFR Part 46. If a study is regulated by the FDA, it also must be in compliance with 21 CFR Parts 50 and 56.

g. All aspects of the research study are conducted according to the appropriate standards of scientific integrity.

h. The research study has a written protocol that clearly addresses, or incorporates by reference, the Medicare standards.

i. The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life-threatening as defined in 21 CFR § 312.81(a) and the patient has no other viable treatment options.

j. The clinical research study is registered on the www.ClinicalTrials.gov website by the principal sponsor/investigator prior to the enrollment of the first study subject.

k. The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors. However, a full report of the outcomes must be made public no later than 3 years after the end of data collection.

l. The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria affect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

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m. The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

B. Nationally Non-Covered Indications

The CMS believes that the available evidence does not demonstrate that pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness improves health outcomes in Medicare beneficiaries outside the context of CED, and is therefore not reasonable and necessary under §1862(a)(1)(A) of the Act.

C. Other

This NCD does not determine coverage to identify CYP2C9 or VKORC1 alleles for other purposes, nor does it determine national coverage to identify other alleles to predict warfarin responsiveness.

(This NCD last reviewed August 2009.)

100-3, Chapter-1, Part 2, 110.22

Autologous Cellular Immunotherapy Treatment (Effective June 30, 2011)

A. General

Prostate cancer is the most common non-cutaneous cancer in men in the United States. In 2009, an estimated 192,280 new cases of prostate cancer were diagnosed and an estimated 27,360 deaths were reported. The National Cancer Institute states that prostate cancer is predominantly a cancer of older men; the median age at diagnosis is 72 years. Once the patient has castration-resistant, metastatic prostate cancer the median survival is generally less than two years.

In 2010 the Food and Drug Administration (FDA) approved sipuleucel-T (PROVENGE®; APC8015), for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.

The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent, the proliferation of cancer cells. Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

Sipuleucel-T differs from other infused anti-cancer therapies. Most such anti-cancer therapies are manufactured and sold by a biopharmaceutical company and then purchased by and dispensed from a pharmacy. In contrast, once the decision is made to treat with sipuleucel-T, a multi-step process is used to produce sipuleucel-T. Sipuleucel-T is made individually for each patient with his own white blood cells. The patient's white blood cells are removed via a procedure called leukapheresis. In a laboratory the white blood cells are exposed to PA2024, which is a molecule created by linking prostatic acid phosphatase (PAP) with granulocyte/macrophage-colony stimulating factor (GM-CSF). PAP is an antigen specifically associated with prostate cancer cells; GM-CSF is a protein that targets a receptor on the surface of white blood cells. Hence, PAP serves to externally manipulate the immunological functioning of the patient's white blood cells while GM-CSF serves to stimulate the white blood cells into action. As noted in the FDA's clinical review, each dose of sipuleucel-T contains a minimum of 40 million treated white blood cells, however there is "high inherent variability" in the yield of sipuleucel-T from leukapheresis to leukapheresis in the same patient as well as from patient to patient. The treated white blood cells are then infused back into the same patient. The FDA-approved dosing regimen is three doses with each dose administered two weeks apart.

Indications and Limitations of Coverage

B. Nationally Covered Indications

Effective for services performed on or after June 30, 2011, The Centers for Medicare and Medicaid Services (CMS) proposes that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment -sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer, and thus is reasonable and necessary for this on-label indication under 1862(a)(1)(A) of the Social Security Act.

C. Nationally Non-Covered Indications

N/A

D. Other

Effective for services performed on or after June 30, 2011, coverage of all off-label uses of autologous cellular immunotherapy treatment –sipuleucel-T; PROVENGE® for the treatment of pro state cancer is left to the discretion of the local Medicare Administrative Contractors.

(NCD last reviewed June 2011.)

100-3, Chapter-1, Part 2, 150.11

Thermal Intradiscal Procedures (TIPs) (Effective September 29, 2008)

A. General

Percutaneous thermal intradiscal procedures (TIPs) involve the insertion of a catheter(s)/probe(s) in the spinal disc under fluoroscopic guidance for the purpose of producing or applying heat and/or disruption within the disc to relieve low back pain.

The scope of this national coverage determination on TIPs includes percutaneous intradiscal techniques that employ the use of a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for coagulation and/or decompression of disc material to treat symptomatic patients with annular disruption of a contained herniated disc, to seal annular tears or fissures, or destroy nociceptors for the purpose of relieving pain. This includes techniques that use single or multiple probe(s)/catheter(s), which utilize a resistance coil or other delivery system technology, are flexible or rigid, and are placed within the nucleus, the nuclear-annular junction, or the annulus.

Although not intended to be an all-inclusive list, TIPs are commonly identified as intradiscal electrothermal therapy (IDET), intradiscal thermal annuloplasty (IDTA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), radiofrequency annuloplasty (RA), intradiscal biacuplasty (IDB), percutaneous (or plasma) disc decompression (PDD)

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or coblation, or targeted disc decompression (TDD). At times, TIPs are identified or labeled based on the name of the catheter/probe that is used (e.g., SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes). Each technique or device has its own protocol for application of the therapy. Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy procedure) are not within the scope of this NCD.

B. Nationally Covered Indications

N/A

C. Nationally Non-Covered Indications

Effective for services performed on or after September 29, 2008, the Centers for Medicare and Medicaid Services has determined that TIPs are not reasonable and necessary for the treatment of low back pain. Therefore, TIPs, which include procedures that employ the use of a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for the treatment of low back pain, are **noncovered**.

D. Other

N/A

(This NCD last reviewed September 2008.)

100-3, Chapter-1, Part 2, 150.12

Collagen Meniscus Implant (Effective May 25, 2010)

A. General

The knee menisci are wedge-shaped, semi-lunar discs of fibrous tissue located in the knee joint between the ends of the femur and the tibia and fibula. There is a lateral and medial meniscus in each knee. It is known now that the menisci provide mechanical support, localized pressure distribution, and lubrication of the knee joint. Initially, meniscal tears were treated with total meniscectomy; however, as knowledge of the function of the menisci and the potential long term effects of total meniscectomy on the knee joint evolved, treatment of symptomatic meniscal tears gravitated to repair of the tear, when possible, or partial meniscectomy.

The collagen meniscus implant (also referred to as collagen scaffold (CS), CMI or Menaflex™ meniscus implant throughout the published literature) is used to fill meniscal defects that result from partial meniscectomy. The collagen meniscus implant is not intended to replace the entire meniscus at it requires a meniscal rim for attachment. The literature describes the placement of the collagen meniscus implant through an arthroscopic procedure with an additional incision for capture of the repair needles and tying of the sutures. After debridement of the damaged meniscus, the implant is trimmed to the size of meniscal defect and sutured into place. The collagen meniscus implant is described as a tissue engineered scaffold to support the generation of new meniscus-like tissue. The collagen meniscus implant is manufactured from bovine collagen and should not be confused with the meniscus transplant which involves the replacement of the meniscus with a transplant meniscus from a cadaver donor. The meniscus transplant is not addressed under this national coverage determination.

B. Nationally Covered Indications

N/A

C. Nationally Non-Covered Indications

Effective for claims with dates of service performed on or after May 25, 2010, the Centers for Medicare & Medicaid Services has determined that the evidence is adequate to conclude that the collagen meniscus implant does not improve health outcomes and, therefore, is not reasonable and necessary for the treatment of meniscal injury/tear under section 1862(a)(1)(A) of the Social Security Act. Thus, the collagen meniscus implant is non-covered by Medicare.

D. Other

N/A

(This NCD last reviewed May 2010.)

100-3, Chapter-1, Part 2, 160.13

Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES)

Transcutaneous Electrical Nerve Stimulation (TENS) and/or Neuromuscular Electrical Stimulation (NMES) can ordinarily be delivered to patients through the use of conventional electrodes, adhesive tapes and lead wires. There may be times, however, where it might be medically necessary for certain patients receiving TENS or NMES treatment to use, as an alternative to conventional electrodes, adhesive tapes and lead wires, a form-fitting conductive garment (i.e., a garment with conductive fibers which are separated from the patients' skin by layers of fabric).

A form-fitting conductive garment (and medically necessary related supplies) may be covered under the program only when:

1. It has received permission or approval for marketing by the Food and Drug Administration;
2. It has been prescribed by a physician for use in delivering covered TENS or NMES treatment; and
3. One of the medical indications outlined below is met:
   - The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes and lead wires;
   - The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes and lead wires;
   - The patient has a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes and lead wires;
   - The patient requires electrical stimulation beneath a cast either to treat disuse atrophy, where the nerve supply to the muscle is intact, or to treat chronic intractable pain; or
   - The patient has a medical need for rehabilitation strengthening (pursuant to a written plan of rehabilitation) following an injury where the nerve supply to the muscle is intact.

A conductive garment is not covered for use with a TENS device during the trial period specified in §160.3 unless:

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4. The patient has a documented skin problem prior to the start of the trial period; and
5. The A/B MAC (B)'s medical consultants are satisfied that use of such an item is medically necessary for the patient.

(See conditions for coverage of the use of TENS in the diagnosis and treatment of chronic intractable pain in §§160.3, 160.13, and 160.27, and the use of NMES in the treatment of disuse atrophy in §150.4.)

100-3, Chapter-1, Part 2, 160.27

Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)

The TENS is a type of electrical nerve stimulator that is employed to treat chronic intractable pain. This stimulator is attached to the surface of the patient's skin over the peripheral nerve to be stimulated. It may be applied in a variety of settings (in the patient's home, a physician's office, or in an outpatient clinic). Payment for TENS may be made under the durable medical equipment benefit.

A. General

For the purposes of this decision chronic low back pain (CLBP) is defined as:

1. an episode of low back pain that has persisted for three months or longer; and
2. is not a manifestation of a clearly defined and generally recognizable primary disease entity. For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom; and certain systemic diseases such as rheumatoid arthritis and multiple sclerosis manifest many debilitating symptoms of which low back pain is not the primary focus.

B. Nationally Covered Indications

Effective June 8, 2012, the Centers for Medicare & Medicaid Services (CMS) will allow coverage for Transcutaneous Electrical Nerve Stimulation (TENS) for CLBP only when all of the following conditions are met.

In order to support additional research on the use of TENS for CLBP, we will cover this item under section 1862(a)(1)(E) of the Social Security Act (the Act) subject to all of the following conditions:

1. Coverage under this section expires three years after the publication of this decision on the CMS website.
2. The beneficiary is enrolled in an approved clinical study meeting all of the requirements below. The study must address one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.
   i. Does the use of TENS provide clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
   ii. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
   iii. Does the use of TENS impact the utilization of other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

The study must adhere to the following standards of scientific integrity and relevance to the Medicare population:

a. The principal purpose of the research study is to test whether a particular intervention potentially improves the participants' health outcomes.
b. The research study is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
c. The research study does not unjustifiably duplicate existing studies.
d. The research study design is appropriate to answer the research question being asked in the study.
e. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.
f. The research study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR Part 46. If a study is regulated by the Food and Drug Administration (FDA), it must be in compliance with 21 CFR parts 50 and 56.
g. All aspects of the research study are conducted according to appropriate standards of scientific integrity (see http://www.icmje.org).
h. The research study has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for CED coverage.
i. The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR §312.81(a) and the patient has no other viable treatment options.
j. The clinical research study is registered on the ClinicalTrials.gov website by the principal sponsor/investigator prior to the enrollment of the first study subject.
k. The research study protocol specifies the method and timing of public release of all prespecified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (http://www.icmje.org).
l. The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

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m. The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

C. Nationally Non-Covered Indications

TENS is not reasonable and necessary for the treatment of CLBP under section 1862(a)(1)(A) of the Act.

D. Other

See§160.13 for an explanation of coverage of medically necessary supplies for the effective use of TENS. See §160.7.1 for an explanation of coverage for assessing patients suitability for electrical nerve stimulation therapy. See §10.2 for an explanation of coverage of transcutaneous electrical nerve stimulation (TENS) for acute post-operative pain. Please note, §280.13 Transcutaneous Electrical Nerve Stimulators (TENS) NCD has been removed from the NCD manual and incorporated into NCD 160.27

(This NCD last reviewed June 2012.)

100-3, Chapter-1, Part 2, 160.7.1

Assessing Patients Suitability for Electrical Nerve Stimulation Therapy

Electrical nerve stimulation is an accepted modality for assessing a patient's suitability for ongoing treatment with a transcutaneous or an implanted nerve stimulator.

Accordingly, program payment may be made for the following techniques when used to determine the potential therapeutic usefulness of an electrical nerve stimulator:

A. Transcutaneous Electrical Nerve Stimulation (TENS)

This technique involves attachment of a transcutaneous nerve stimulator to the surface of the skin over the peripheral nerve to be stimulated. It is used by the patient on a trial basis and its effectiveness in modulating pain is monitored by the physician, or physical therapist. Generally, the physician or physical therapist is able to determine whether the patient is likely to derive a significant therapeutic benefit from continuous use of a transcutaneous stimulator within a trial period of one month; in a few cases this determination may take longer to make. Document the medical necessity for such services which are furnished beyond the first month.(See §160.13 for an explanation of coverage of medically necessary supplies for the effective use of TENS.)

If TENS significantly alleviates pain, it may be considered as primary treatment; if it produces no relief or greater discomfort than the original pain electrical nerve stimulation therapy is ruled out. However, where TENS produces incomplete relief, further evaluation with percutaneous electrical nerve stimulation may be considered to determine whether an implanted peripheral nerve stimulator would provide significant relief from pain.

Usually, the physician or physical therapist providing the services will furnish the equipment necessary for assessment. Where the physician or physical therapist advises the patient to rent the TENS from a supplier during the trial period rather than supplying it himself/herself, program payment may be made for rental of the TENS as well as for the services of the physician or physical therapist who is evaluating its use. However, the combined program payment which is made for the physician's or physical therapist's services and the rental of the stimulator from a supplier should not exceed the amount which would be payable for the total service, including the stimulator, furnished by the physician or physical therapist alone.

B. Percutaneous Electrical Nerve Stimulation (PENS)

This diagnostic procedure which involves stimulation of peripheral nerves by a needle electrode inserted through the skin is performed only in a physician's office, clinic, or hospital outpatient department. Therefore, it is covered only when performed by a physician or incident to physician's service. If pain is effectively controlled by percutaneous stimulation, implantation of electrodes is warranted.

As in the case of TENS (described in subsection A), generally the physician should be able to determine whether the patient is likely to derive a significant therapeutic benefit from continuing use of an implanted nerve stimulator within a trial period of 1 month. In a few cases, this determination may take longer to make. The medical necessity for such diagnostic services which are furnished beyond the first month must be documented.

NOTE: Electrical nerve stimulators do not prevent pain but only alleviate pain as it occurs. A patient can be taught how to employ the stimulator, and once this is done, can use it safely and effectively without direct physician supervision. Consequently, it is inappropriate for a patient to visit his/her physician, physical therapist, or an outpatient clinic on a continuing basis for treatment of pain with electrical nerve stimulation. Once it is determined that electrical nerve stimulation should be continued as therapy and the patient has been trained to use the stimulator, it is expected that a stimulator will be implanted or the patient will employ the TENS on a continual basis in his/her home. Electrical nerve stimulation treatments furnished by a physician in his/her office, by a physical therapist or outpatient clinic are excluded from coverage by §1862(a)(1) of the Act. (See §160.7 for an explanation of coverage of the therapeutic use of implanted peripheral nerve stimulators under the prosthetic devices benefit.) See §160.27 for an explanation of coverage of the therapeutic use of TENS under the durable medical equipment benefit.

100-3, Chapter-1, Part 3, 190.11

Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management –Effective March 19, 2008

A. General

Use of the International Normalized Ratio (INR) or prothrombin time (PT) -standard measurement for reporting the blood's clotting time) -allows physicians to determine the level of anticoagulation in a patient independent of the laboratory reagents used. The INR is the ratio of the patient's PT (extrinsic or tissue-factor dependent coagulation pathway) compared to the mean PT for a group of normal individuals. Maintaining patients within his/her prescribed therapeutic range minimizes adverse events associated with inadequate or excessive anticoagulation such as serious bleeding or thromboembolic events. Patient self-testing and self-management through the use of a home INR monitor may be used to improve the time in therapeutic rate (TTR) for select groups of patients. increased TTR leads to improved clinical outcomes and reductions in thromboembolic and hemorrhagic events.

Warfarin (also prescribed under other trade names, e.g., Coumadin®) is a self-administered, oral anticoagulant (blood

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thinner) medication that affects the vitamin K-dependent clotting factors II, VII, IX and X. It is widely used for various medical conditions, and has a narrow therapeutic index, meaning it is a drug with less than a 2-fold difference between median lethal dose and median effective dose. For this reason, since October 4, 2006, it falls under the category of a Food and Drug Administration (FDA) "black-box" drug whose dosage must be closely monitored to avoid serious complications. A PT/INR monitoring system is a portable testing device that includes a finger-stick and an FDA-cleared meter that measures the time it takes for a person's blood plasma to clot.

B. Nationally Covered Indications

For services furnished on or after March 19, 2008, Medicare will cover the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin. The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a), and all of the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device; and,
2. The patient must undergo a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home; and,
3. The patient continues to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring; and,
4. Self-testing with the device should not occur more frequently than once a week.

C. Nationally Non-Covered Indications

N/A

D. Other

1. All other indications for home PT/INR monitoring not indicated as nationally covered above remain at local Medicare contractor discretion.
2. This national coverage determination (NCD) is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17 of Publication 100-03 of the NCD Manual.

(This NCD last reviewed March 2008.)

100-3, Chapter-1, Part 3, 190.14

Human Immunodeficiency Virus (HIV) Testing (Diagnosis)

Diagnosis of HIV infection is primarily made through the use of serologic assays. These assays take one of two forms: antibody detection assays and specific HIV antigen (p24) procedures. The antibody assays are usually enzyme immunoassays (EIA), which are used to confirm exposure of an individual's immune system to specific viral antigens. These assays may be formatted to detect HIV-1, HIV-2, or HIV-1 and 2 simultaneously, and to detect both IgM and IgG. When the initial EIA test is repeatedly positive or indeterminant, an alternative test is used to confirm the specificity of the antibodies to individual viral components. The most commonly used method is the Western Blot.

The HIV-1 core antigen (p24) test detects circulating viral antigen which may be found prior to the development of antibodies and may also be present in later stages of illness in the form of recurrent or persistent antigenemia. Its prognostic utility in HIV infection has been diminished as a result of development of sensitive viral RNA assays, and its primary use today is as a routine screening tool in potential blood donors.

In several unique situations, serologic testing alone may not reliably establish an HIV infection. This may occur because the antibody response (particularly the IgG response detected by Western Blot) has not yet developed (that is, acute retroviral syndrome) or is persistently equivocal because of inherent viral antigen variability. It is also an issue in perinatal HIV infection due to transplacental passage of maternal HIV antibody. In these situations, laboratory evidence of HIV in blood by culture, antigen assays, or proviral DNA or viral RNA assays, is required to establish a definitive determination of HIV infection.

Indications

Diagnostic testing to establish HIV infection may be indicated when there is a strong clinical suspicion supported by one or more of the following clinical findings:

1. The patient has a documented, otherwise unexplained, AIDS-defining or AIDS-associated opportunistic infection.
2. The patient has another documented sexually transmitted disease, which identifies significant risk of exposure to HIV and the potential for an early or subclinical infection.
3. The patient has documented acute or chronic Hepatitis B or C infection that identifies a significant risk of exposure to HIV and the potential for an early or subclinical infection.
4. The patient has a documented AIDS-defining or AIDS-associated neoplasm.
5. The patient has a documented AIDS-associated neurologic disorder or otherwise unexplained dementia.
6. The patient has another documented AIDS-defining clinical condition, or a history of other severe, recurrent, or persistent conditions which suggest an underlying immune deficiency (for example, cutaneous or mucosal disorders).
7. The patient has otherwise unexplained generalized signs and symptoms suggestive of a chronic process with an underlying immune deficiency (for example, fever, weight loss, malaise, fatigue, chronic diarrhea, failure to thrive, chronic cough, hemoptysis, shortness of breath, or lymphadenopathy).
8. The patient has otherwise unexplained laboratory evidence of a chronic disease process with an underlying immune deficiency (for example, anemia, leukopenia, pancytopenia, lymphopenia, or low CD4+ lymphocyte count).
9. The patient has signs and symptoms of acute retroviral syndrome with fever, malaise, lymphadenopathy, and skin rash.
10. The patient has documented exposure to blood or body fluids known to be capable of transmitting HIV (for example, needle sticks and other significant blood exposures) and antiviral therapy is initiated or anticipated to be initiated.
11. The patient is undergoing treatment for rape. (HIV testing is part of the rape treatment protocol.)

Limitations

1. HIV antibody testing in the United States is usually performed using HIV-1 or HIV-1/2 combination tests. HIV-2 testing is indicated if clinical circumstances suggest

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HIV-2 is likely (that is, compatible clinical finding and HIV-1 test negative). HIV-2 testing may also be indicated in areas of the country where there is greater prevalence of HIV-2 infections.

2. The Western Blot test should be performed only after documentation that the initial EIA tests are repeatedly positive or equivocal on a single sample.
3. The HIV antigen tests currently have no defined diagnostic usage.
4. Direct viral RNA detection may be performed in those situations where serologic testing does not establish a diagnosis but strong clinical suspicion persists (for example, acute retroviral syndrome, nonspecific serologic evidence of HIV, or perinatal HIV infection).
5. If initial serologic tests confirm an HIV infection, repeat testing is not indicated.
6. If initial serologic tests are HIV EIA negative and there is no indication for confirmation of infection by viral RNA detection, the interval prior to retesting is 3-6 months.
7. Testing for evidence of HIV infection using serologic methods may be medically appropriate in situations where there is a risk of exposure to HIV.
8. The CPT® Editorial Panel has issued a number of codes for infectious agent detection by direct antigen or nucleic acid probe techniques that have not yet been developed or are only being used on an investigational basis. Laboratory providers are advised to remain current on FDA-approved status for these tests.

100-3, Chapter-1, Part 4, 210.3

Colorectal Cancer Screening Tests

A. General

Sections 1861(s)(2)(R) and 1861(pp) of the Social Security Act (the Act) and regulations at 42 CFR 410.37 authorize Medicare coverage for screening colorectal cancer tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to tests and procedures for colorectal cancer screening) as the Secretary finds appropriate based on consultation with appropriate organizations.

B. Nationally Covered Indications

1. **Fecal Occult Blood Tests (FOBT) (effective January 1, 2004)**

   Fecal occult blood tests (FOBTs) are generally divided into two types: immunoassay and guaiac types. Immunoassay (or immunochemical) fecal occult blood tests (iFOBT) use "antibodies directed against human globin epitopes. While most iFOBTs use spatulas to collect stool samples, some use a brush to collect toilet water surrounding the stool. Most iFOBTs require laboratory processing.

   Guaiac fecal occult blood tests (gFOBT) use a peroxidase reaction to indicate presence of the heme portion of hemoglobin. Guaiac turns blue after oxidation by oxidants or peroxidases in the presence of an oxygen donor such as hydrogen peroxide. Most FOBTs use sticks to collect stool samples and may be developed in a physician's office or a laboratory. In 1998, Medicare began reimbursement for guaiac FOBTs, but not immunoassay type tests for colorectal cancer screening. Since the fundamental process is similar for other iFOBTs, the Centers for Medicare & Medicaid Services evaluated colorectal cancer screening using immunoassay FOBTs in general.

   Effective for dates of service on and after January 1, 2004, Medicare covers one screening FOBT per annum for the early detection of colorectal cancer. This means that Medicare will cover one gFOBT or one iFOBT at a frequency of every 12 months; i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed, for beneficiaries aged 50 years and older. The beneficiary completes the existing gFOBT by taking samples from two different sites of three consecutive stools; the beneficiary completes the iFOBT by taking the appropriate number of stool samples according to the specific manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician. ("Attending physician" means a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

   Effective January 1, 2023, the minimum age for FOBT is reduced to 45 years and older.

2. **The Cologuard™ – Multi-target Stool DNA (sDNA) Test (effective October 9, 2014)**

   Screening stool or fecal DNA (deoxyribonucleic acid, sDNA) testing detects molecular markers of altered DNA that are contained in the cells shed by colorectal cancer and pre- malignant colorectal epithelial neoplasia into the lumen of the large bowel. Through the use of selective enrichment and amplification techniques, sDNA tests are designed to detect very small amounts of DNA markers to identify colorectal cancer or pre-malignant colorectal neoplasia. The CologuardTM – multi-target sDNA test is a proprietary in vitro diagnostic device that incorporates both sDNA and fecal immunochemical test techniques and is designed to analyze patients' stool samples for markers associated with the presence of colorectal cancer and pre-malignant colorectal neoplasia.

   Effective for dates of service on or after October 9, 2014, The Cologuard™ test is covered once every three years for Medicare beneficiaries that meet all of the following criteria:

   - Age 50 to 85 years, and,
   - Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test (gFOBT) or fecal immunochemical test (iFOBT)), and,
   - At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

   Effective January 1, 2023, the minimum age for sDNA test is reduced to 45 years and older.

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3. **Blood-based Biomarker Tests (effective January 19, 2021)**

Blood-based DNA testing detects molecular markers of altered DNA that are contained in the cells shed into the blood by colorectal cancer and pre-malignant colorectal epithelial neoplasia.

Effective for dates of service on or after January 19, 2021, a blood-based biomarker test is covered as an appropriate colorectal cancer screening test once every 3 years for Medicare beneficiaries when performed in a Clinical Laboratory Improvement Act (CLIA)-certified laboratory, when ordered by a treating physician and when all of the following requirements are met: The patient is:

- age 50-85 years, and,
- asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test), and,
- at average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer). The blood-based biomarker screening test must have all of the following:
- Food and Drug Administration (FDA) market authorization with an indication for colorectal cancer screening; and,
- proven test performance characteristics for a blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in the detection of colorectal cancer compared to the recognized standard (accepted as colonoscopy at this time), as minimal threshold levels, based on the pivotal studies included in the FDA labeling.

Effective January 1, 2023, the minimum age for blood-based biomarker test is reduced to 45 years and older.

C. Nationally Non-Covered Indications

All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified above remain nationally non-covered. Non- coverage specifically includes:

(1) All screening sDNA tests, effective April 28, 2008, through October 8, 2014. Effective for dates of service on or after October 9, 2014, all other screening sDNA tests not otherwise specified above remain nationally non-covered.

(2) Screening computed tomographic colonography (CTC), effective May 12, 2009.

D. Other

N/A

(This NCD was last reviewed January 2023 and includes policy updates finalized in the Calendar Year 2023 Physician Fee Schedule final rule 87 FR 69404)

100-3, Chapter-1, Part 4, 210.4

Smoking and Tobacco-Use Cessation Counseling (RETIRED)

Effective September 30, 2015 this section is deleted and the remaining NCD entitled Counseling to Prevent Tobacco Use (210.4.1) remains effective.

100-3, Chapter-1, Part-4, 210.7

Screening for Human Immunodeficiency Virus (HIV)

A. General

Human Immunodeficiency Virus (HIV) is an infection caused by a retrovirus that affects the immune system. HIV infection causes acquired immune deficiency syndrome (AIDS), a disease which severely compromises an individual's immune system. It is currently generally accepted that antiretroviral therapy (ART) has significantly reduced HIV-associated morbidity and mortality throughout the world and the United States, and has transformed HIV disease for many, into a chronic, manageable condition. There is also evidence that the use of ART is associated with a substantially decreased risk for transmission of the virus to uninfected persons.

Effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is allowed to add coverage of "additional preventive services" through the national coverage determination (NCD) process if certain statutory requirements are met, as provided in 42 C.F.R. §410.64 (CMS began covering HIV screening effective December 8, 2009). One of those requirements is that the service(s) be categorized as a Grade A (strongly recommends) or Grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF).

The USPSTF gives a Grade A recommendation to screening for HIV in:

- All adolescents and adults between the ages of 15 to 65 years,
- Younger adolescents and older adults who are at increased risk of HIV infection, and,
- All pregnant women.

B. Nationally Covered Indications

Effective for claims with dates of service on and after April 13, 2015, CMS has determined that the evidence is adequate to conclude that screening for HIV infection for all individuals between the ages of 15 and 65 years, as recommended with a Grade of A by the USPSTF, is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS shall cover screening for HIV with the appropriate U.S. Food and Drug Administration (FDA)-approved laboratory tests and point-of-care tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary's physician or practitioner within the context of a healthcare setting and performed by an eligible Medicare provider for these services, for beneficiaries who meet one of the following conditions:

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for all adolescents and adults between the age of 15 and 65, without regard to perceived risk.

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2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:

   Men who have sex with men,

   Men and women having unprotected vaginal or anal intercourse,

   - Past or present injection drug users,
   - Men and women who exchange sex for money or drugs, or have sex partners who do,
   - Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users,
   - Persons who have acquired or request testing for other sexually transmitted infectious diseases,
   - Persons with a history of blood transfusions between 1978 and 1985,
   - Persons who request an HIV test despite reporting no individual risk factors,
     Persons with new sexual partners,
   - Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of "increased risk" for HIV infection is identified by the health care practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical recommendation should be a reflection of the service provided.

3. A maximum of three, voluntary, HIV screenings of pregnant Medicare beneficiaries: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and, (3) at labor, if ordered by the woman's clinician.

C. Nationally Non-Covered Indications

Effective for claims with dates of service on and after April 13, 2015:

-Medicare beneficiaries with any known diagnosis of an HIV-related illness are not eligible for this screening test.

-Medicare beneficiaries between the ages of 15 and 65 who have had a prior HIV screening test within 1 year are not eligible for HIV screening (i.e., at least 11 full months must have elapsed following the month in which the previous test was performed in order for the subsequent test to be covered).

-Medicare beneficiaries younger than 15 or older than 65, at increased risk for HIV-related illnesses, who have had a prior HIV screening test within 1 year are not eligible for HIV screening (i.e., at least 11 full months must have elapsed following the month in which the previous test was performed in order for the subsequent test to be covered).

-Pregnant Medicare beneficiaries who have had three specified screening tests within each respective term of pregnancy are not eligible for further HIV screening during their pregnancy.

D. Other

N/A

(This NCD last reviewed April 2015.)

100-3, Chapter-1, Part-4, 210.8

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (Effective October 14, 2011)

A. General

Based upon authority to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on annual screening and brief behavioral counseling in primary care to reduce alcohol misuse in adults, including pregnant women. Annual screening and behavioural counseling for alcohol misuse in adults is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Part A and Part B.

CMS will cover annual alcohol screening and up to four, brief face-to-face behavioral counseling in primary care settings to reduce alcohol misuse. CMS does not identify specific alcohol misuse screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Various screening tools are available for screening for alcohol misuse.

B. Nationally Covered Indications

Effective for claims with dates of service on or after October 14, 2011, CMS will cover annual alcohol screening, and for those that screen positive, up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the behavioral counseling interventions should be consistent with the 5A's approach that has been adopted by the USPSTF to describe such services. They are:

1. Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/ methods.
2. Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to

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adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

For the purposes of this policy, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition.

For the purposes of this policy a "primary care physician" and "primary care practitioner" are to be defined based on two existing sections of the Social Security Act, §1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II):

§1833(u)

6. Physician Defined.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2)(A)(i)

i. is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

ii. is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)).

C. Nationally Non-Covered Indications

1. Alcohol screening is non-covered when performed more than one time in a 12-month period.
2. Brief face-to-face behavioral counseling interventions are non-covered when performed more than once a day; that is, two counseling interventions on the same day are non-covered.
3. Brief face-to-face behavioral counseling interventions are non-covered when performed more than four times in a 12-month period.

D. Other

Medicare coinsurance and Part B deductible are waived for this preventive service.

(This NCD last reviewed October 2011.)

100-3, Chapter-1, Part-4, 210.10

Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

A. General

Sexually transmitted infections (STIs) are infections that are passed from one person to another through sexual contact. STIs remain an important cause of morbidity in the United States and have both health and economic consequences. Many of the complications of STIs are borne by women and children Often, STIs do not present any symptoms so can go untreated for long periods of time The presence of an STI during pregnancy may result in significant health complications for the woman and infant. In fact, any person who has an STI may develop health complications. Screening tests for the STIs in this national coverage determination (NCD) are laboratory tests.

Under §1861(ddd) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) has the authority to add coverage of additional preventive services if certain statutory requirements are met. The regulations provide:

§410.64 Additional preventive services

a. Medicare Part B pays for additional preventive services not described in paragraph (1) or (3) of the definition of "preventive services" under §410.2, that identify medical conditions or risk factors for individuals if the Secretary determines through the national coverage determination process (as defined in section 1869(f)(1)(B) of the Act) that these services are all of the following: (1) reasonable and necessary for the prevention or early detection of illness or disability.(2)recommended with a grade of A or B by the United States Preventive Services Task Force, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

b. In making determinations under paragraph (a) of this section regarding the coverage of a new preventive service, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such services and may take into account the results of such an assessment in making such national coverage determinations.

The scope of the national coverage analysis for this NCD evaluated the evidence for the following STIs and high intensity behavioral counseling (HIBC) to prevent STIs for which the United States Preventive Services Task Force (USPSTF) has issued either an A or B recommendation:

- Screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk,
- Screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk,
- Screening for gonorrhea infection in all sexually active women, including those who are pregnant, if they are at increased risk,
- Screening for syphilis infection for all pregnant women and for all persons at increased risk,
- Screening for Hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit,
- HIBC for the prevention of STIs for all sexually active adolescents, and for adults at increased risk for STIs.

B. Nationally Covered Indications

CMS has determined that the evidence is adequate to conclude that screening for chlamydia, gonorrhea, syphilis, and Hepatitis B, as well as HIBC to prevent STIs, consistent with the grade A and B recommendations by the USPSTF, is reasonable and necessary for the early detection or prevention of an illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Therefore, effective for claims with dates of services on or after November 8, 2011, CMS will cover screening for these USPSTF-indicated STIs with the appropriate Food and Drug Administration (FDA) -approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations,

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when ordered by the primary care physician or practitioner, and performed by an eligible Medicare provider for these services.

Screening for chlamydia and gonorrhea:

- Pregnant women who are 24 years old or younger when the diagnosis of pregnancy is known, and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test.
- Pregnant women who are at increased risk for STIs when the diagnosis of pregnancy is known, and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test.
- Women at increased risk for STIs annually.

Screening for syphilis:

- Pregnant women when the diagnosis of pregnancy is known, and then repeat screening during the third trimester and at delivery if high-risk sexual behaviour has occurred since the previous screening test.
- Men and women at increased risk for STIs annually.

Screening for Hepatitis B:

- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known, and then rescreening at time of delivery for those with new or continuing risk factors.

In addition, effective for claims with dates of service on or after November 8, 2011, CMS will cover up to two individual 20-to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs, for all sexually active adolescents, and for adults at increased risk for STIs, if referred for this service by a primary care physician or practitioner, and provided by a Medicare eligible primary care provider in a primary care setting. Coverage of HIBC to prevent STIs is consistent with the USPSTF recommendation. HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance, which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements:

- education,
- skills training,
- guidance on how to change sexual behavior.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners
- Using barrier protection inconsistently
- Having sex under the influence of alcohol or drugs
- Having sex in exchange for money or drugs
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea)
- Having an STI within the past year
- IV drug use (for Hepatitis B only)
- In addition for men - men having sex with men (MSM) and engaged in high risk sexual behavior, but no regard to age

In addition to individual risk factors, in concurrence with the USPSTF recommendations, community social factors such as high prevalence of STIs in the community populations should be considered in determining high/increased risk for chlamydia, gonorrhea, syphilis, and for recommending HIBC.

High/increased risk sexual behavior for STIs is determined by the primary care provider by assessing the patient's sexual history which is part of any complete medical history, typically part of an annual wellness visit or prenatal visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

For the purposes of this NCD, a **primary care setting** defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

For the purposes of this NCD, a "**primary care physician**" and "**primary care practitioner**" will be defined based on existing sections of the Social Security Act (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§1833(u)

(6) Physician Defined.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2)(A)(i)

i. is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

ii. is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5));

C. Nationally Non-Covered Indications

Unless specifically covered in this NCD, any other NCD, or in statute, preventive services are non-covered by Medicare.

D. Other

Medicare coinsurance and Part B deductible are waived for these preventive services.

HIBC to prevent STIs may be provided on the same date of services as an annual wellness visit, evaluation and management (E&M) service, or during the global billing period for obstetrical car, but only one HIBC may be provided on any one date of service. See the claims processing manual for further instructions on claims processing.

For services provided on an annual basis, this is defined as a 12-Month period.

(This NCD last reviewed November 2011.)

100-3, Chapter-1, Part-4, 210.11

Intensive Behavioral Therapy for Cardiovascular Disease (CVD) (Effective November 8, 2011)

A. General

Cardiovascular disease (CVD) is the leading cause of mortality in the United States. CVD, which is comprised of hypertension, coronary heart disease (such as myocardial infarction and

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angina pectoris), heart failure and stroke, is also the leading cause of hospitalizations. Although the overall adjusted mortality rate from heart disease has declined over the past decade, opportunities for improvement still exist. Risk factors for CVD include being overweight, obesity, physical inactivity, diabetes, cigarette smoking, high blood pressure, high blood cholesterol, family history of myocardial infarction, and older age.

Under §1861(ddd) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) has the authority to add coverage of additional preventive services through the National Coverage Determination (NCD) process if certain statutory requirements are met. Following its review, CMS has determined that the evidence is adequate to conclude that intensive behavioral therapy for CVD is reasonable and necessary for the prevention or early detection of illness or disability, is appropriate for individuals entitled to benefits under Part A or enrolled under Part B, and is comprised of components that are recommended with a grade of A or B by the U.S. Preventive Services Task Force (USPSTF).

B. Nationally Covered Indications

Effective for claims with dates of service on or after November 8, 2011, CMS covers intensive behavioral therapy for CVD (referred to below as a CVD risk reduction visit), which consists of the following three components:

- encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
- screening for high blood pressure in adults age 18 years and older; and
- intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular-and diet-related chronic disease.

We note that only a small proportion (about 4%) of the Medicare population is under 45 years (men) or 55 years (women), therefore the vast majority of beneficiaries should receive all three components. Intensive behavioral counseling to promote a healthy diet is broadly recommended to cover close to 100% of the population due to the prevalence of known risk factors.

Therefore, CMS covers one, face-to-face CVD risk reduction visit per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the Five As approach that has been adopted by the USPSTF to describe such services:

- **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/ methods.
- **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
- **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
- **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

For the purpose of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

For the purpose of this NCD, a "primary care physician" and "primary care practitioner" are defined consistent with existing sections of the Act (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§1833(u)

(6) Physician Defined.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1)and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2) (A) Primary care practitioner.—The term "primary care practitioner" means an individual—

(i) who—

I. is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

II. is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)).

C. Nationally Non-Covered Indications

Unless specifically covered in this NCD, any other NCD, or in statute, preventive services are non-covered by Medicare.

D. Other

Medicare coinsurance and Part B deductible are waived for this preventive service.

(This NCD last reviewed November 2011.)

100-3, Chapter-1, Part-4, 210.12

Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)

A. General

Based upon authority to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on intensive behavioral therapy for obesity. Screening for obesity in adults is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Part A and Part B.

The Centers for Disease Control (CDC) reported that "obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States." In the

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Medicare population over 30% of men and women are obese. Obesity is directly or indirectly associated with many chronic diseases including cardiovascular disease, musculoskeletal conditions and diabetes.

B. Nationally Covered Indications

Effective for claims with dates of service on or after November 29, 2011, CMS covers intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m2, for the prevention or early detection of illness or disability.

Intensive behavioral therapy for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m2);
2. Dietary (nutritional) assessment; and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

The intensive behavioral intervention for obesity should be consistent with the 5-A framework that has been highlighted by the USPSTF:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/ methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

For Medicare beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, CMS covers:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement during the first six months as discussed below.

At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.

For the purposes of this decision memorandum, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition.

For the purposes of this decision memorandum a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (§1833(u)(6), §1833(x)(2)(A)(i)(I) and §1833(x)(2)(A)(i)(II)).

§1833(u)

(6) Physician Defined.—For purposes of this paragraph, the term "physician" means a physician described in section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

§1833(x)(2)(A)

Primary care practitioner—The term "primary care practitioner" means an individual—

(i) who—

I. is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

II. is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)).

C. Nationally Non-Covered Indications

All other indications remain non-covered.

D. Other

Medicare coinsurance and Part B deductible are waived for this service.

(This NCD last reviewed November 2011)

100-3, Chapter-1, Part-4, 220.6

Positron Emission Tomography (PET) Scans (RETIRED)

Effective January 1, 2022, the Centers for Medicare & Medicaid Services removed the umbrella national coverage determination (NCD) for Positron Emission Tomography (PET) Scans. In the absence of an NCD, coverage determinations for all oncologic and non-oncologic uses of PET that are not included in another NCD under section 220.6 will be made by the Medicare Administrative Contractors under section 1862(a)(1)(A) of the Social Security Act. All PET indications currently covered or non-covered under NCDs under section 220.6 remain unchanged and MACs shall not alter coverage for indications covered under NCDs.

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100-3, Chapter-1, Part-4, 220.6.1

PET for Perfusion of the Heart (Various Effective Dates)

1. Rubidium 82 (Effective March 14, 1995)

Effective for services performed on or after March 14, 1995, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA approved radiopharmaceutical Rubidium 82 (Rb 82) are covered, provided the requirements below are met:

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT); or
- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test(s) whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)
- For any PET scan for which Medicare payment is claimed for dates of services prior to July 1, 2001, the claimant must submit additional specified information on the claim form (including proper codes and/or modifiers), to indicate the results of the PET scan. The claimant must also include information on whether the PET scan was performed after an inconclusive non-invasive cardiac test. The information submitted with respect to the previous noninvasive cardiac test must specify the type of test performed prior to the PET scan and whether it was inconclusive or unsatisfactory. These explanations are in the form of special G codes used for billing PET scans using Rb 82. Beginning July 1, 2001, claims should be submitted with the appropriate codes.

2. Ammonia N-13 (Effective October 1, 2003)

Effective for services performed on or after October 1, 2003, PET scans performed at rest or with pharmacological stress used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease using the FDA approved radiopharmaceutical ammonia N-13 are covered, provided the requirements below are met:

- The PET scan, whether at rest alone, or rest with stress, is performed in place of, but not in addition to, a SPECT; or
- The PET scan, whether at rest alone or rest with stress, is used following a SPECT that was found to be inconclusive. In these cases, the PET scan must have been considered necessary in order to determine what medical or surgical intervention is required to treat the patient. (For purposes of this requirement, an inconclusive test is a test whose results are equivocal, technically uninterpretable, or discordant with a patient's other clinical data and must be documented in the beneficiary's file.)

(This NCD last reviewed March 2005.)

100-3, Chapter-1, Part-4, 220.6.17

Positron Emission Tomography (FDG PET) for Oncologic Conditions (Effective June 11, 2013)

A. General

FDG (2-[F18] fluoro-2-deoxy-D-glucose) Positron Emission Tomography (PET) is a minimally-invasive diagnostic imaging procedure used to evaluate glucose metabolism in normal tissue as well as in diseased tissues in conditions such as cancer, ischemic heart disease, and some neurologic disorders. FDG is an injected radionuclide (or radiopharmaceutical) that emits sub-atomic particles, known as positrons, as it decays. FDG PET uses a positron camera (tomograph) to measure the decay of FDG. The rate of FDG decay provides biochemical information on glucose metabolism in the tissue being studied. As malignancies can cause abnormalities of metabolism and blood flow, FDG PET evaluation may indicate the probable presence or absence of a malignancy based upon observed differences in biologic activity compared to adjacent tissues.

The Centers for Medicare and Medicaid Services (CMS) was asked by the National Oncologic PET Registry (NOPR) to reconsider section 220.6 of the National Coverage Determinations (NCD) Manual to end the prospective data collection requirements under Coverage with Evidence Development (CED) across all oncologic indications of FDG PET imaging. The CMS received public input indicating that the current coverage framework of prospective data collection under CED be ended for all oncologic uses of FDG PET imaging.

1. Framework

Effective for claims with dates of service on and after June 11, 2013, CMS is adopting a coverage framework that ends the prospective data collection requirements by NOPR under CED for all oncologic uses of FDG PET imaging. CMS is making this change for all NCDs that address coverage of FDG PET for oncologic uses addressed in this decision. This decision does not change coverage for any use of PET imaging using radiopharmaceuticals NaF-18 (fluorine-18 labeled sodium fluoride), ammonia N-13, or rubidium-82 (Rb-82).

2. Initial Anti-Tumor Treatment Strategy

CMS continues to believe that the evidence is adequate to determine that the results of FDG PET imaging are useful in determining the appropriate initial anti-tumor treatment strategy for beneficiaries with suspected cancer and improve health outcomes and thus are reasonable and necessary under §1862(a)(1)(A) of the Social Security Act (the Act).

Therefore, CMS continues to nationally cover one FDG PET study for beneficiaries who have cancers that are biopsy proven or strongly suspected based on other diagnostic testing when the beneficiary's treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to the initial anti-tumor treatment strategy:

- To determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; or
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

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See the table at the end of this section for a synopsis of all nationally covered and non-covered oncologic uses of FDG PET imaging.

B.1. Initial Anti-Tumor Treatment Strategy Nationally Covered Indications

a. CMS continues to nationally cover FDG PET imaging for the initial anti-tumor treatment strategy for male and female breast cancer only when used in staging distant metastasis.

b. CMS continues to nationally cover FDG PET to determine initial anti-tumor treatment strategy for melanoma other than for the evaluation of regional lymph Nodes.

c. CMS continues to nationally cover FDG PET imaging for the detection of pre-treatment metastasis (i.e., staging) in newly diagnosed cervical cancers.

C.1 Initial Anti-Tumor Treatment Strategy Nationally Non-Covered Indications

a. CMS continues to nationally non-cover initial anti-tumor treatment strategy in Medicare beneficiaries who have adenocarcinoma of the prostate.

b. CMS continues to nationally non-cover FDG PET imaging for diagnosis of breast cancer and initial staging of axillary nodes.

c. CMS continues to nationally non-cover FDG PET imaging for initial anti-tumor treatment strategy for the evaluation of regional lymph nodes in melanoma.

d. CMS continues to nationally non-cover FDG PET imaging for the diagnosis of cervical cancer related to initial anti-tumor treatment strategy.

3. Subsequent Anti-Tumor Treatment Strategy

B.2. Subsequent Anti-Tumor Treatment Strategy Nationally Covered Indications

Three FDG PET scans are nationally covered when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy. Coverage of more than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy shall be determined by the MACs.

4. Synopsis of Coverage of FDG PET for Oncologic Conditions

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

FDG PET for Cancers Tumor Type	Initial Treatment Strategy (formerly "diagnosis" & "staging"	Subsequent Treatment Strategy (formerly "restaging" & "monitoring response to treatment"
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and Neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover with exceptions *	Cover
Small cell lung	Cover	Cover
Soft tissue sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Prostate	Non-cover	Cover
Thyroid	Cover	Cover
Breast (male and female)	Cover with exceptions *	Cover
Melanoma	Cover with exceptions *	Cover
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover
All other cancers not listed	Cover	Cover

*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

*Breast: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

D. Other

N/A

100-3, Chapter-1, Part-4, 220.6.19

Positron Emission Tomography NaF-18 (NaF-18 PET) to Identify Bone Metastasis of Cancer (Effective February 26, 2010)

A. General

Positron Emission Tomography (PET) is a minimally-invasive, diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the body. A positron camera (tomograph) is used to produce crosssectional tomographic images, which are obtained from positron-emitting radioactive tracer substances (radiopharmaceuticals) such as F-18 sodium fluoride (NaF-18).

B. Nationally Covered Indications

The confirmatory analyses were not published during the 24-month time period.

Therefore, effective December 15, 2017, CMS determines that there are no nationally covered indications for PET NaF-18.

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C. Nationally Non-Covered Indications

Effective December 15, 2017, CMS determines that PET NaF-18 PET is nationally non-covered.

D. Other

Other PET radiopharmaceutical tracers for cancer can be covered at local Medicare Administrative Contractor discretion when used according to their FDA-approved indication(s).

(This NCD last reviewed December 2017.)

100-3, Chapter-1, Part-4, 240.4

Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) (Effective April 4, 2005) (Effective March 13, 2008)

A. General

Continuous Positive Airway Pressure (CPAP) is a non-invasive technique for providing single levels of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation.

The AHI and/or RDI may be measured by polysomnography (PSG) in a facility-based sleep study laboratory, or by a Type II home sleep test (HST) monitor, a Type III HST monitor, or a Type IV HST monitor measuring at least 3 channels.

B. Nationally Covered Indications

Effective for claims with dates of service on and after March 13, 2008, the Centers for Medicare & Medicaid Services (CMS) determines that CPAP therapy when used in adult patients with OSA is considered reasonable and necessary under the following situations:

1. The use of CPAP is covered under Medicare when used in adult patients with OSA. Coverage of CPAP is initially limited to a 12-week period to identify beneficiaries diagnosed with OSA as subsequently described who benefit from CPAP. CPAP is subsequently covered only for those beneficiaries diagnosed with OSA who benefit from CPAP during this 12-week period.
2. The provider of CPAP must conduct education of the beneficiary prior to the use of the CPAP device to ensure that the beneficiary has been educated in the proper use of the device. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate the CPAP device.
3. A positive diagnosis of OSA for the coverage of CPAP must include a clinical evaluation and a positive:
   a. attended PSG performed in a sleep laboratory; or
   b. unattended HST with a Type II home sleep monitoring device; or
   c. unattended HST with a Type III home sleep monitoring device; or
   d. unattended HST with a Type IV home sleep monitoring device that measures at least 3 channels.
4. The sleep test must have been previously ordered by the beneficiary's treating physician and furnished under appropriate physician supervision.
5. An initial 12-week period of CPAP is covered in adult patients with OSA if either of the following criterion using the AHI or RDI are met:
   a. AHI or RDI greater than or equal to 15 events per hour, or
   b. AHI or RDI greater than or equal to 5 events and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.
6. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing must be at a minimum the number of events that would have been required in a 2-hour period.
7. Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation.
8. Coverage with Evidence Development (CED): Medicare provides the following limited coverage for CPAP in adult beneficiaries who do not qualify for CPAP coverage based on criteria 1-7 above. A clinical study seeking Medicare payment for CPAP provided to a beneficiary who is an enrolled subject in that study must address one or more of the following questions:
   a. In Medicare-aged subjects with clinically identified risk factors for OSA, how does the diagnostic accuracy of a clinical trial of CPAP compare with PSG and Type II, III & IV HST in identifying subjects with OSA who will respond to CPAP?
   b. In Medicare-aged subjects with clinically identified risk factors for OSA who have not undergone confirmatory testing with PSG or Type II, III & IV HST, does CPAP cause clinically meaningful harm?
   c. The study must meet the following additional standards:
   d. The principal purpose of the research study is to test whether a particular intervention potentially improves the participants' health outcomes.
   e. The research study is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
   f. The research study does not unjustifiably duplicate existing studies.
   g. The research study design is appropriate to answer the research question being asked in the study.
   h. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.

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i. The research study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR Part 46. If a study is Food and Drug Administration-regulated, it also must be in compliance with 21 CFR Parts 50 and 56.

j. All aspects of the research study are conducted according to the appropriate standards of scientific integrity.

k. The research study has a written protocol that clearly addresses, or incorporates by reference, the Medicare standards.

l. The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life-threatening as defined in 21 CFR §312.81(a) and the patient has no other viable treatment options.

m. The clinical research study is registered on the ClinicalTrials.gov Web site by the principal sponsor/investigator prior to the enrollment of the first study subject.

n. The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured, including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned for publication in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors. However, a full report of the outcomes must be made public no later than 3 years after the end of data collection.

o. The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria affect enrollment of these populations, and a plan for the retention and reporting of said populations in the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

p. The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

C. Nationally Non-covered Indications

Effective for claims with dates of services on and after March 13, 2008, other diagnostic tests for the diagnosis of OSA, other than those noted above for prescribing CPAP, are not sufficient for the coverage of CPAP.

D. Other

N/A

(This NCD last reviewed March 2008.)

100-3, Chapter-1, Part-4, 240.4.1

Sleep Testing for Obstructive Sleep Apnea (OSA) (Effective March 3, 2009)

A. General

Obstructive sleep apnea (OSA) is the collapse of the oropharyngeal walls and the obstruction of airflow occurring during sleep. Diagnostic tests for OSA have historically been classified into four types. The most comprehensive is designated Type I attended facility based polysomnography (PSG), which is considered the reference standard for diagnosing OSA. Attended facility based polysomnogram is a comprehensive diagnostic sleep test including at least electroencephalography (EEG), electro-oculography (EOG), electromyography (EMG), heart rate or electrocardiography (ECG), airflow, breathing/respiratory effort, and arterial oxygen saturation (SaO2) furnished in a sleep laboratory facility in which a technologist supervises the recording during sleep time and has the ability to intervene if needed. Overnight PSG is the conventional diagnostic test for OSA. The American Thoracic Society and the American Academy of Sleep Medicine have recommended supervised PSG in the sleep laboratory over 2 nights for the diagnosis of OSA and the initiation of continuous positive airway pressure (CPAP).

Three categories of portable monitors (used both in attended and unattended settings) have been developed for the diagnosis of OSA. Type II monitors have a minimum of 7 channels (e.g., EEG, EOG, EMG, ECG-heart rate, airflow, breathing/respiratory effort, SaO2)-this type of device monitors sleep staging, so AHI can be calculated). Type III monitors have a minimum of 4 monitored channels including ventilation or airflow (at least two channels of respiratory movement or respiratory movement and airflow), heart rate or ECG, and oxygen saturation. Type IV devices may measure one, two, three or more parameters but do not meet all the criteria of a higher category device. Some monitors use an actigraphy algorithm to identify periods of sleep and wakefulness.

B. Nationally Covered Indications

Effective for claims with dates of service on and after March 3, 2009, the Centers for Medicare & Medicaid Services finds that the evidence is sufficient to determine that the results of the sleep tests identified below can be used by a beneficiary's treating physician to diagnose OSA, that the use of such sleep testing technologies demonstrates improved health outcomes in Medicare beneficiaries who have OSA and receive the appropriate treatment, and that these tests are thus reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act.

1. Type I PSG is covered when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
2. Type II or Type III sleep testing devices are covered when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
3. Type IV sleep testing devices measuring three or more channels, one of which is airflow, are covered when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

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4. Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, are covered when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

C. Nationally Non-Covered Indications

Effective for claims with dates of services on and after March 3, 2009, other diagnostic sleep tests for the diagnosis of OSA, other than those noted above for prescribing CPAP, are not sufficient for the coverage of CPAP and are not covered.

D. Other

N/A

(This NCD last reviewed March 2009.)

100-3, Chapter-1, Part-4, 250.5

Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) - Effective March 23, 2010

A. General

Treatment of persons infected with the human immunodeficiency virus (HIV) or persons who have Acquired Immune Deficiency Syndrome (AIDS) may include highly active antiretroviral therapy (HAART). Drug reactions commonly associated with long-term use of HAART include metabolic complications such as, lipid abnormalities, e.g., hyperlipidemia, hyperglycemia, diabetes, lipodystrophy, and heart disease. Lipodystrophy is characterized by abnormal fat distribution in the body.

The LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. The patient's physical appearance may contribute to psychological conditions (e.g., depression) or adversely impact a patient's adherence to antiretroviral regimens (therefore jeopardizing their health) and both of these are important health-related outcomes of interest in this population. Therefore, improving a patient's physical appearance through the use of dermal injections could improve these health-related outcomes.

B. Nationally Covered Indications

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression.

C. Nationally Non-Covered Indications

1. Dermal fillers that are not approved by the FDA for the treatment of LDS.
2. Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

D. Other

N/A

(This NCD last reviewed March 2010.)

100-3, Chapter-1, Part-4, 260.6

Dental Examination Prior to Kidney Transplantation

Despite the "dental services exclusion" in §1862(a)(12) of the Act (see the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions From Coverage," §140;), an oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery is a covered service. This is because the purpose of the examination is not for the care of the teeth or structures directly supporting the teeth. Rather, the examination is for the identification, prior to a complex surgical procedure, of existing medical problems where the increased possibility of infection would not only reduce the chances for successful surgery but would also expose the patient to additional risks in undergoing such surgery.

Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital's staff, or under Part B if performed by a physician. (When performing a dental or oral examination, a dentist is not recognized as a physician under §1861(r) of the Act.) (See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," §70.2, and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §150.)

100-3, Chapter-1, Part-4, 270.3

Blood-Derived Products for Chronic Non-Healing Wounds

A. General

Wound healing is a dynamic, interactive process that involves multiple cells and proteins. There are three progressive stages of normal wound healing, and the typical wound healing duration is about 4 weeks. While cutaneous wounds are a disruption of the normal, anatomic structure and function of the skin, subcutaneous wounds involve tissue below the skin's surface. Wounds are categorized as either acute, where the normal wound healing stages are not yet completed but it is presumed they will be, resulting in orderly and timely wound repair, or chronic, where a wound has failed to progress through the normal wound healing stages and repair itself within a sufficient time period.

Platelet-rich plasma (PRP) is produced in an autologous or homologous manner. Autologous PRP is comprised of blood from the patient who will ultimately receive the PRP. Alternatively, homologous PRP is derived from blood from multiple donors.

Blood is donated by the patient and centrifuged to produce an autologous gel for treatment of chronic, non-healing cutaneous wounds that persist for 30 days or longer and fail to properly complete the healing process. Autologous blood derived products for chronic, non-healing wounds includes both: (1) platelet derived growth factor (PDGF) products, and (2) PRP (such as AutoloGel).

The PRP is different from previous products in that it contains whole cells including white cells, red cells, plasma, platelets, fibrin, stem cells, and fibrocyte precursors.

The PRP is used by physicians in clinical settings in treating chronic, non-healing wounds, open, cutaneous wounds, soft tissue and bone. Alternatively, PDGF does not contain cells and was previously marketed as a product to be used by patients at home.

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B. Nationally Covered Indications

Effective for services performed on or after April 13, 2021, the Centers for Medicare & Medicaid Services (CMS) will cover autologous PRP for the treatment of chronic nonhealing diabetic wounds under section 1862(a)(1)(A) of the Social Security Act (the Act) for a duration of 20 weeks, when prepared by devices whose Food and Drug Administration-cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers.

C. Nationally Non-Covered Indications

Autologous PDGF for the treatment of chronic, non-healing cutaneous wounds, and, Becaplermin, a non-autologous growth factor for chronic, non-healing subcutaneous wounds, and, Autologous PRP for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision, or for dehiscent wounds.

D. Other

Effective for services performed on or after April 13, 2021:

Coverage of autologous PRP for the treatment of chronic non-healing diabetic wounds beyond 20 weeks will be determined by the local Medicare Administrative Contractors (MACs).

Coverage of autologous PRP for the treatment of all other chronic non-healing wounds will be determined by the local MACs under section 1862(a)(1)(A) of the Act.

(This NCD last reviewed April 2021.)

100-4, Chapter-1, 30.3.1

Mandatory Assignment on Carrier Claims

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

NOTE: The provider type Mass Immunization Roster Biller can only bill for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20 percent coinsurance.

- Ambulatory surgical center services; (No deductible and 25% coinsurance for colorectal cancer screening colonoscopies (G0105 and G0121) and effective for dates of service on or after January 1, 2008 G0104 also applies);
- Home dialysis supplies and equipment paid under Method II for dates of service prior to January 1, 2011. Refer to Section 30.3.8 for information regarding the elimination of Method II home dialysis for dates of service on and after January 1, 2011;
- Drugs and biologicals; and,
- Ambulance services.

When these claims are inadvertently submitted as unassigned, carriers process them as assigned.

Note that, unlike physicians, practitioners, or suppliers bound by a participation agreement, practitioners/entities providing the services/supplies identified above are required to accept assignment only with respect to these services/supplies (unless they have signed participation agreements which blanket the full range of their services).

The carrier system must be able to identify (and update) the codes for those services subject to the assignment mandate.

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS Web site.

Future updates to this section will be communicated in a Recurring Update Notification.

100-4, Chapter-1, 30.3.5

Effect of Assignment Upon Purchase of Cataract Glasses From Participating Physician or Supplier on Claims Submitted to Carriers

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A pair of cataract glasses is comprised of two distinct products: a professional product (the prescribed lenses) and a retail commercial product (the frames). The frames serve not only as a holder of lenses but also as an article of personal apparel. As such, they are usually selected on the basis of personal taste and style. Although Medicare will pay only for standard frames, most patients want deluxe frames. Participating physicians and suppliers cannot profitably furnish such deluxe frames unless they can make an extra (noncovered) charge for the frames even though they accept assignment.

Therefore, a participating physician or supplier (whether an ophthalmologist, optometrist, or optician) who accepts assignment on cataract glasses with deluxe frames may charge the Medicare patient the difference between his/her usual charge to private pay patients for glasses with standard frames and his/her usual charge to such patients for glasses with deluxe frames, in addition to the applicable deductible and coinsurance on glasses with standard frames, if all of the following requirements are met:

A. The participating physician or supplier has standard frames available, offers them for sale to the patient, and issues and ABN to the patient that explains the price and

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other differences between standard and deluxe frames. Refer to Chapter 30.

B. The participating physician or supplier obtains from the patient (or his/her representative) and keeps on file the following signed and dated statement:

Name of Patient Medicare Claim Number

Having been informed that an extra charge is being made by the physician or supplier for deluxe frames, that this extra charge is not covered by Medicare, and that standard frames are available for purchase from the physician or supplier at no extra charge, I have chosen to purchase deluxe frames.

Signature Date

C. The participating physician or supplier itemizes on his/her claim his/her actual charge for the lenses, his/her actual charge for the standard frames, and his/her actual extra charge for the deluxe frames (charge differential).

Once the assigned claim for deluxe frames has been processed, the carrier will follow the ABN instructions as described in §60.

100-4, Chapter-4, 10.4

Packaging

Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

A. Packaging for Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting. Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT® and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

B. Packaging for Claims Resulting in No APC Payments

If the claim contains only services payable under cost reimbursement, such as corneal tissue, and services that would be packaged services if an APC were payable, then the packaged services are not separately payable. In addition, these charges for the packaged services are not used to calculate TOPs.

If the claim contains only services payable under a fee schedule, such as clinical diagnostic laboratory tests, and also contains services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs.

If a claim contains services payable under cost reimbursement, services payable under a fee schedule, and services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs payments.

C. Packaging Types Under the OPPS

1. Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indictor of N. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for the most recent Addendum B (HCPCS codes with status indicators). In general, the charges for unconditionally packaged services are used to calculate outlier and TOPS payments when they appear on a claim with a service that is separately paid under the OPPS because the packaged service is considered to be part of the package of services for which payment is being made through the APC payment for the separately paid service.
2. STV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, or V reported on the same claim. If a claim includes a service that is assigned status indicator S, T, or V reported on the same claim as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator Q1. See the OPPS Webpage at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of STV-packaged codes.
3. T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same claim as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q2. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of T-packaged codes.
4. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q3. See the discussion of composite APCs in section 10.2.1.
5. Q4 services are assigned to laboratory HCPCS codes that appear on the Clinical Laboratory Fee Schedule (CLFS). Status indicator Q4 designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." When a Q4 service is not billed on the same claim as another separately payable service then the IOCE automatically changes their status indicator to "A" and separate payment is made at the CLFS payment rate.

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6. J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service. See the discussion of comprehensive APCs in section 10.2.3.
7. J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. Payment for all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service when certain conditions are met. See the discussion of comprehensive APCs in section 10.2.3.

100-4, Chapter-4, 160

Clinic and Emergency Visits

CMS has acknowledged from the beginning of the OPPS that CMS believes that CPT® Evaluation and Management (E/M) codes were designed to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients. While awaiting the development of a national set of facility-specific codes and guidelines, providers should continue to apply their current internal guidelines to the existing CPT® codes. Each hospital's internal guidelines should follow the intent of the CPT® code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes.

Effective January 1, 2007, CMS is distinguishing between two types of emergency departments: Type A emergency departments and Type B emergency departments.

A Type A emergency department is defined as an emergency department that is available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable State law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

A Type B emergency department is defined as an emergency department that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the EMTALA regulations. It must meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Hospitals must bill for visits provided in Type A emergency departments using CPT® emergency department E/M codes.

Hospitals must bill for visits provided in Type B emergency departments using the G-codes that describe visits provided in Type B emergency departments.

Hospitals that will be billing the new Type B ED visit codes may need to update their internal guidelines to report these codes.

Emergency department and clinic visits are paid in some cases separately and in other cases as part of a composite APC payment. See section 10.2.1 of this chapter for further details.

100-4, Chapter-4, 200.1

Billing for Corneal Tissue

Corneal tissue will be paid on a cost basis, not under OPPS, only when it is used in a corneal transplant procedure described by one of the following CPT® codes: 65710, 65730, 65750, 65755, 65756, 65765, 65767, and any successor code or new code describing a new type of corneal transplant procedure that uses eye banked corneal tissue. In all other procedures cornea tissue is packaged. To receive cost based reimbursement hospitals must bill charges for corneal tissue using HCPCS code V2785.

100-4, Chapter-4, 200.2

Hospital Dialysis Services For Patients With and Without End Stage Renal Disease (ESRD)

Effective with claims with dates of service on or after August 1, 2000, hospital-based End Stage Renal Disease (ESRD) facilities must submit services covered under the ESRD benefit in 42 CFR 413.174 (maintenance dialysis and those items and services directly related to dialysis such as drugs, supplies) on a separate claim from services not covered under the ESRD benefit. Items and services not covered under the ESRD benefit must be billed by the hospital using the hospital bill type and be paid under the Outpatient Prospective Payment System (OPPS) (or to a CAH at reasonable cost). Services covered under the ESRD benefit in 42 CFR 413.174 must be billed on the ESRD bill type and must be paid under the ESRD PPS. This requirement is necessary to properly pay only unrelated ESRD services (those not covered under the ESRD benefit) under OPPS (or to a CAH at reasonable cost).

Medicare does not allow payment for routine or related dialysis treatments, which are covered and paid under the ESRD PPS, when furnished to ESRD patients in the outpatient department of a hospital. However, in certain medical situations in which the ESRD outpatient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments (which are not covered under the ESRD benefit) furnished to ESRD outpatients in the outpatient department of a hospital. Payment for unscheduled dialysis furnished to ESRD outpatients and paid under the OPPS is limited to the following circumstances:

- Dialysis performed following or in connection with a dialysis-related procedure such as vascular access procedure or blood transfusions;
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment; or
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

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In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using the Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

HCPCS code G0257 may only be reported on type of bill 13X (hospital outpatient service) or type of bill 85X (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients. Effective for services on and after October 1, 2012, claims containing HCPCS code G0257 will be returned to the provider for correction if G0257 is reported with a type of bill other than 13X or 85X (such as a 12x inpatient claim).

HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

1. The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See Benefits Policy Manual 100-02 Chapter 15 section 120. A. The service must be reported on a type of bill 12X or type of bill 85X. See the Benefits Policy Manual 100-02 Chapter 6 section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals) for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or
2. A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or type of bill 85X.

CPT® code 90945 (Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous replacement therapies)), with single physician evaluation, may be reported by a hospital paid under the OPPS or CAH method I or method II on type of bill 12X, 13X or 85X.

100-4, Chapter-4, 200.4

Billing for Amniotic Membrane

Hospitals should report HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to report amniotic membrane tissue when the tissue is used. A specific procedure code associated with use of amniotic membrane tissue is CPT® code 65780 (Ocular surface reconstruction; amniotic membrane transplantation). Payment for the amniotic membrane tissue is packaged into payment for CPT® code 65780 or other procedures with which the amniotic membrane is used.

100-4, Chapter-4, 200.6

Billing and Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services

For CY 2008, the CPT® Editorial Panel has created two new Category I CPT® codes for reporting alcohol and/or substance abuse screening and intervention services. They are CPT® code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT® code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). However, screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, beginning January 1, 2008, the OPPS recognizes two parallel G-codes (HCPCS codes G0396 and G0397) to allow for appropriate reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury.

Contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes), only when reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Act.

HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. Hospital resources expended performing services described by HCPCS codes G0396 and G0397 may not be counted as resources for determining the level of a visit service and vice versa (i.e., hospitals may not double count the same facility resources in order to reach a higher level clinic or emergency department visit). However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPCS codes, but the hospital resources expended should be included in determining the level of the visit service reported.

100-4, Chapter-4, 200.7.2

Cardiac Echocardiography With Contrast

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 200.7.2 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms.

Table 200.7.2 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	*Long Descriptor*
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-Time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study

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C8925 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

C8926 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report

C8927 Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

C8928 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

C8929 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography

C8930 Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

100-4, Chapter-4, 230.2

Coding and Payment for Drug Administration

A. Overview

Drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) during CY 2005 were reported using CPT® codes 90780, 90781, and 96400-96459.

Effective January 1, 2006, some of these CPT® codes were replaced with more detailed CPT® codes incorporating specific procedural concepts, as defined and described by the CPT® manual, such as initial, concurrent, and sequential.

Hospitals are instructed to use the full set of CPT® codes, including those codes referencing concepts of initial, concurrent, and sequential, to bill for drug administration services furnished in the hospital outpatient department beginning January 1, 2007. In addition, hospitals are instructed to continue billing the HCPCS codes that most accurately describe the service(s) provided.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services.

B. Billing for Infusions and Injections

Beginning in CY 2007, hospitals were instructed to use the full set of drug administration CPT® codes (90760-90779; 96401-96549), (96413-96523 beginning in CY 2008) (96360-96549 beginning in CY 2009) when billing for drug administration services provided in the hospital outpatient department. In addition, hospitals are to continue to bill HCPCS code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump) when appropriate. Hospitals are expected to report all drug administration CPT® codes in a manner consistent with their descriptors, CPT® instructions, and correct coding principles. Hospitals should note the conceptual changes between CY 2006 drug administration codes effective under the OPPS and the CPT® codes in effect beginning January 1, 2007, in order to ensure accurate billing under the OPPS. Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid or their payment is packaged.

Medicare's general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT® codes 90760-90779, 96401-96549, (96413-96523 beginning in CY 2008). (Reference: Pub.100-02, Medicare Benefit Policy Manual, Chapter 6, §20.4.)

Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more than 1 calendar day.

C. Payments For Drug Administration Services

For CY 2007, OPPS drug administration APCs were restructured, resulting in a six-level hierarchy where active HCPCS codes have been assigned according to their clinical coherence and resource use. Contrary to the CY 2006 payment structure that bundled payment for several instances of a type of service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) into a per-encounter APC payment, structure introduced in CY 2007 provides a separate APC payment for each reported unit of a separately payable HCPCS code.

Hospitals should note that the transition to the full set of CPT® drug administration codes provides for conceptual differences when reporting, such as those noted below.

- In CY 2006, hospitals were instructed to bill for the first hour (and any additional hours) by each type of infusion service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy). Beginning in CY 2007, the first hour concept no longer exists. CPT® codes in CY 2007 and beyond allow for only one initial service per encounter, for each vascular access site, no matter how many types of infusion services are provided; however, hospitals will receive an APC payment for the initial service and separate APC payment(s) for additional hours of infusion or other drug administration services provided that are separately payable.
- In CY 2006, hospitals were instructed to bill for the first hour (and any additional hours) by each type of infusion service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy). Beginning in CY 2007, the

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first hour concept no longer exists. CPT® codes in CY 2007 and beyond allow for only one initial service per encounter, for each vascular access site, no matter how many types of infusion services are provided; however, hospitals will receive an APC payment for the initial service and separate APC payment(s) for additional hours of infusion or other drug administration services provided that are separately payable.

(***NOTE:*** This list above provides a brief overview of a limited number of the conceptual changes between CY 2006 OPPS drug administration codes and CY 2007 OPPS drug administration codes - this list is not comprehensive and does not include all items hospitals will need to consider during this transition).

For APC payment rates, refer to the most current quarterly version of Addendum B on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

D. Infusions Started Outside the Hospital

Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g., a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. This includes hospitals reporting an initial hour of infusion, even if the hospital did not initiate the infusion, and additional HCPCS codes for additional or sequential infusion services if needed.

100-4, Chapter-4, 240

Inpatient Part B Hospital Services

Medicare pays for hospital (including CAH) inpatient Part B services in the circumstances provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, § 10 ("Medical and Other Health Services Furnished to Inpatients of Participating Hospitals"). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient claim is subject to the statutory time limit for filing Part B claims described in chapter 1, §70 of this manual.

Inpatient Part B services include inpatient ancillary services that do not require an outpatient status and are not strictly provided in an outpatient setting. Services that require an outpatient status and are provided only in an outpatient setting are not payable inpatient Part B services, including Clinic Visits, Emergency Department Visits, and Observation Services (this is not a complete listing).

Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge—sometimes referred to as the "Room and Board" charge. They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A. Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some provider's customary charging practice has established separate charges for these services following the PRM–1 instructions, however, in order for a provider's customary charging practice to be recognized it must be consistently followed for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM–1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for service rendered and documentation meet the definition of the HCPCS in order to separately bill.

100-4, Chapter-4, 290.1

Observation Services Overview

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

100-4, Chapter-4, 290.2.2

Reporting Hours of Observation

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together

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to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

100-4, Chapter-4, 290.4.1

Billing and Payment for All Hospital Observation Services Furnished Between January 1, 2006 and December 31, 2007

Since January 1, 2006, two G-codes have been used to report observation services and direct referral for observation care. For claims for dates of service January 1, 2006 through December 31, 2007, the Integrated Outpatient Code Editor (I/OCE) determines whether the observation care or direct referral services are packaged or separately payable. Thus, hospitals provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT® codes 99217-99220 or 99234-99236 for observation services. In addition, the following HCPCS codes were discontinued as of January 1, 2006: G0244 (Observation care by facility to patient), G0263 (Direct Admission with congestive heart failure, chest pain or asthma), and G0264 (Assessment other than congestive heart failure, chest pain, or asthma).

The three discontinued G-codes and the CPT® codes that were no longer recognized were replaced by two new G-codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct referral for observation care, whether separately payable or packaged:

- G0378- Hospital observation service, per hour; and
- G0379- Direct admission of patient for hospital observation care.

The I/OCE determines whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter. Therefore, hospitals should bill HCPCS code G0378 when observation services are ordered and provided to any patient regardless of the patient's condition. The units of service should equal the number of hours the patient receives observation services.

Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly for observation care after being seen by a physician in the community (see §290.4.2 below).

Some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. See chapter 1, section 50.2.2 of this manual. It is vitally important that all of the charges that pertain to a non-repetitive, separately paid procedure or service be reported on the same claim with that procedure or service. It should also be emphasized that this relaxation of same day billing requirements for some non-repetitive services does not apply to non-repetitive services provided on the same day as either direct referral to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including diagnostic tests, lab services, hospital clinic visits, emergency department visits, critical care services, and status indicator T procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

100-4, Chapter-4, 290.4.2

Separate and Packaged Payment for Direct Referral for Observation Services Furnished Between January 1, 2006 and December 31, 2007

In order to receive separate payment for a direct referral for observation care (APC 0604), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service;
2. That no services with a status indicator T or V or Critical care (APC 0617) were provided on the same day of service as HCPCS code G0379; and
3. The observation care does not qualify for separate payment under APC 0339.

Only a direct referral for observation services billed on a 13X bill type may be considered for a separate APC payment.

Separate payment is not allowed for HCPCS code G0379, direct admission to observation care, when billed with the same date of service as a hospital clinic visit, emergency room visit, critical care service, or "T" status procedure.

If a bill for the direct referral for observation services does not meet the three requirements listed above, then payment for the direct referral service will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

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100-4, Chapter-4, 290.4.3

Separate and Packaged Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007

Separate payment may be made for observation services provided to a patient with congestive heart failure, chest pain, or asthma. The list of ICD-9-CM diagnosis codes eligible for separate payment is reviewed annually. Any changes in applicable ICD-9-CM diagnosis codes are included in the October quarterly update of the OPPS and also published in the annual OPPS Final Rule. The list of qualifying ICD-9-CM diagnosis codes is also published on the OPPS Web page.

All of the following requirements must be met in order for a hospital to receive a separate APC payment for observation services through APC 0339:

1. Diagnosis Requirements
   a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.
   b. Qualifying ICD-9-CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.
2. Observation Time
   a. Observation time must be documented in the medical record.
   b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
   c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
   d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.
3. Additional Hospital Services
   a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
      - An emergency department visit (APC 0609, 0613, 0614, 0615, 0616) or
      - A clinic visit (APC 0604, 0605, 0606, 0607, 0608); or
      - Critical care (APC 0617); or
      - Direct referral for observation care reported with HCPCS code G0379 (APC 0604); must be reported on the same date of service as the date reported for observation services.
   b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.
4. Physician Evaluation
   a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
   b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Only observation services that are billed on a 13X bill type may be considered for a separate APC payment.

Hospitals should bill all of the other services associated with the observation care, including direct referral for observation, hospital clinic visits, emergency room visits, critical care services, and T status procedures, on the same claim so that the claims processing logic may appropriately determine the payment status (either packaged or separately payable) of HCPCS codes G0378 and G0379.

If a bill for observation care does not meet all of the requirements listed above, then payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

100-4, Chapter-4, 290.5.1

Billing and Payment for Observation Services Beginning January 1, 2008 and December 31, 2015

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. Beginning January 1, 2014, in certain circumstances when observation care is billed in conjunction with a clinic visit, high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through APC 8009 (Extended Assessment and Management Composite) when certain criteria are met. Prior to January 1, 2014, in certain circumstances when observation care was billed in conjunction with a high level clinic visit (Level 5), high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment could be made for the entire extended care encounter through one of two composite APCs (APCs 8002 and 8003) when certain criteria were met. APCs 8002 and 8003 are deleted as of January 1, 2014. For information about payment for extended assessment and management composite APC, see §10.2.1 (Composite APCs) of this chapter.

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There is no limitation on diagnosis for payment of APC 8009; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time
   a. Observation time must be documented in the medical record.
   b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
   c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
   d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.
2. Additional Hospital Services
   a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
      - A Type A or B emergency department visit (CPT® codes 99284 or 99285 or HCPCS code G0384); or
      - A clinic visit (HCPCS code G0463 beginning January 1, 2014; CPT® code 99205 or 99215 prior to January 1, 2014); or
      - Critical care (CPT® code 99291); or
      - Direct referral for observation care reported with HCPCS code G0379 (APC 0633) must be reported on the same date of service as the date reported for observation services.
   b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.
3. Physician Evaluation.
   a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
   b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through extended assessment and management composite payment.

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

100-4, Chapter-4, 290.5.2

Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008

Direct referral for observation is reported using HCPCS code G0379 (Direct referral for hospital observation care). : Prior to January 1, 2010, the code descriptor for HCPCS code G0379 was (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care will be made either separately as a hospital visit under APC 5013 (Level 3 Examinations & Related Services) or packaged into payment for comprehensive APC 8011 (Comprehensive Observation Services) or packaged into the payment for other separately payable services provided in the same encounter. For information about comprehensive APCs, see §10.2.3 (Comprehensive APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC 0633 or APC 8009 include:

1. Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (Direct referral for hospital observation care) are reported with the same date of service.
2. No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only a direct referral for observation services billed on a 13X bill type may be considered for a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011).

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100-4, Chapter-4, 300.6

Common Working File (CWF) Edits

The Common Working File (CWF) edit will allow 3 hours of therapy for MNT in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary's medical condition, diagnosis, or treatment regimen and this change must be documented in the beneficiary's medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than 3 hours of therapy. Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.

Advance Beneficiary Notice (ABN)

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.

An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

Duplicate Edits

Although beneficiaries are allowed to receive training and therapy during the same time period Diabetes Self-Management and Training (DSMT) and Medical Nutrition Therapy (MNT) services may not be provided on the same day to the same beneficiary. Effective April 1, 2010 CWF shall implement a new duplicate crossover edit to identify and prevent claims for DSMT/MNT services from being billed with the same dates of services for the same beneficiaries submitted from institutional providers and from a professional provider.

100-4, Chapter-4, 320

Outpatient Intravenous Insulin Treatment (OIVIT)

Effective for claims with dates of service on and after December 23, 2009, the Centers for Medicare and Medicaid Services (CMS) determines that the evidence does not support a conclusion that OIVIT improves health outcomes in Medicare beneficiaries. Therefore, CMS has determined that OIVIT is not reasonable and necessary for any indication under section 1862(a)(1)(A) of the Social Security Act. Services comprising an OIVIT regimen are nationally non-covered under Medicare when furnished pursuant to an OIVIT regimen.

See Pub. 100-03, Medicare National Coverage Determinations Manual, Section 40.7, Outpatient Intravenous Insulin Treatment (Effective December 23, 2009), for general information and coverage indications.

100-4, Chapter-4, 320.1

HCPCS Coding for OIVIT

HCPCS code G9147, effective with the April IOCE and MPFSDB updates, is to be used on claims with dates of service on and after December 23, 2009, billing for non-covered OIVIT and any services comprising an OIVIT regimen.

NOTE: HCPCS codes 99199 or 94681(with or without diabetes related conditions 250.00-250.93) are not to be used on claims billing for non-covered OIVIT and any services comprising an OIVIT regimen when furnished pursuant to an OIVIT regimen. Claims billing for HCPCS codes 99199 and 94681 for non-covered OIVIT are to be returned to provider/returned as unprocessable.

100-4, Chapter-4, 320.2

Medicare Summary Notices (MSN), Reason Codes, and Remark Codes

Contractors shall return non-covered OIVIT claims billed with HCPCS 99199 to provider/return as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 16

RARC: MA66, N56

MSN: N/A

Contractors shall return non-covered OIVIT claims billed with HCPCS 94681 with or without diabetes-related conditions 250-00-250.93 to provider/return as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 16

RARC: MA66, N56

MSN: N/A

Contractors shall deny claims for non-covered OIVIT and any services comprising an OIVIT regimen billed with HCPCS code G9147.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 96

RARC: N386

MSN: 16.10

100-4, Chapter-5, 10.2

The Financial Limitation Legislation

A. Legislation on Limitations

The dollar amount of the limitations (caps) on outpatient therapy services is established by statute. The updated amount of the caps is released annually via Recurring Update Notifications and posted on the CMS Website www.cms.gov/TherapyServices, on contractor Websites, and on each beneficiary's Medicare Summary Notice. Medicare contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Act, required payment under a prospective payment system (PPS) for outpatient rehabilitation services (except those furnished by or

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under arrangements with a hospital). Outpatient rehabilitation services include the following services:

- Physical therapy
- Speech-language pathology; and
- Occupational therapy.

Section 4541(c) of the BBA required application of financial limitations to all outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). In 1999, an annual per beneficiary limit of $1,500 was applied, including all outpatient physical therapy services and speech-language pathology services. A separate limit applied to all occupational therapy services. The limits were based on incurred expenses and included applicable deductible and coinsurance. The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

Since the limitations apply to outpatient services, they do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including patients occupying swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services covered under prospective payment systems for home health or inpatient hospitals, including critical access hospitals.

The limitation is based on therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, and occupational therapists, as well as physicians and certain nonphysician practitioners, could render a therapy service.

B. Moratoria and Exceptions for Therapy Claims

Since the creation of therapy caps, Congress has enacted several moratoria. The Deficit Reduction Act of 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and the exceptions have been extended periodically. The cap exception for therapy services billed by outpatient hospitals was part of the original legislation and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions.

C. Repeal of Original Legislation and Replacement with Thresholds to Ensure Appropriate Therapy.

Section 50202 of the Bipartisan Budget Act of 2018 repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold of incurred expenses above which claims must include a modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. This is termed the KX modifier threshold.

Along with this KX modifier threshold, the new law retains the targeted medical review process but at a lower threshold amount of $3,000. For more information about the medical review (MR) threshold see the below section 10.3.4.

100-4, Chapter-5, 10.6

Functional Reporting

A. General

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Act to require a claims-based data collection system for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. 42 CFR 410.59, 410.60, 410.61, 410.62 and 410.105 implement this requirement. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures.

Beneficiary unction information is reported using 42 nonpayable functional G-codes and seven severity/complexity modifiers on claims for PT, OT, and SLP services. Functional reporting on one functional limitation at a time is required periodically throughout an entire PT, OT, or SLP therapy episode of care.

The nonpayable G-codes and severity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, including projected goal status, at specified points during treatment, and at the time of discharge. These G-codes, along with the associated modifiers, are required at specified intervals on all claims for outpatient therapy services – not just those over the cap.

In the CY 2019 Physician Fee Schedule final rule, CMS-1693-F, after consideration of stakeholders' requests for burden reduction, a review of all of the MCTRJCA requirements, and in light of the statutory amendments to section 1833(g) of the Act, via section 50202 of Bipartisan Budget Act of 2018 to repeal the therapy caps, CMS concluded that continued collection of functional reporting data through the same format would not yield additional information to inform future analyses or to serve as a basis for reforms to the payment system for therapy services. The rule ended the functional reporting requirements to reduce burden of reporting for providers of therapy services and revised regulation text at 42 CFR 410.59, 410.60, 410.61, 410.62, 410.105, accordingly.

The instructions below apply only to dates of service when the reporting requirement was effective, January 1, 2013 through December 31, 2018.

B. Application of Coding Requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013 and before January 1, 2019.

C. Services Affected

These requirements apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the CORF benefit. They also apply to the therapy services furnished personally by and incident to the service of a physician or a nonphysician practitioner (NPP), including a nurse practitioner (NP), a certified nurse specialist (CNS), or a physician assistant (PA), as applicable.

D. Providers and Practitioners Affected.

The functional reporting requirements apply to the therapy services furnished by the following providers: hospitals, CAHs, SNFs, CORFs, rehabilitation agencies, and HHAs (when the beneficiary is not under a home health plan of care). It applies to the following practitioners: physical therapists, occupational therapists, and speech-language pathologists in private practice (TPPs), physicians, and NPPs as noted above. The term "clinician" is applied to these practitioners throughout this manual section. (See definition section of Pub. 100-02, Chapter 15, section 220.)

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E. Function-related G-codes

There are 42 functional G-codes, 14 sets of three codes each. Six of the G-code sets are generally for PT and OT functional limitations and eight sets of G-codes are for SLP functional limitations.

The following G-codes are for functional limitations typically seen in beneficiaries receiving PT or OT services. The first four of these sets describe categories of functional limitations and the final two sets describe "other" functional limitations, which are to be used for functional limitations not described by one of the four categories.

NONPAYABLE G-CODES FOR FUNCTIONAL LIMITATIONS		
Code	**Long Descriptor**	**Short Descriptor**
Mobility G-code Set		
G8978	Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals	Mobility current status
G8979	Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Mobility goal status
G8980	Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting	Mobility D/C status
Changing & Maintaining Body Position G-code Set		
G8981	Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals	Body pos current status
G8982	Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Body pos goal status
G8983	Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting	Body pos D/C status
Carrying, Moving & Handling Objects G-code Set		
G8984	Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	Carry current status
G8985	Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Carry goal status
G8986	Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting	Carry D/C status
Self-Care G-code Set		
G8987	Self-care functional limitation, current status, at therapy episode outset and at reporting intervals	Self-care current status
G8988	Self-care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Self-care goal status
G8989	Self-care functional limitation, discharge status, at discharge from therapy or to end reporting	Self-care D/C status

The following "other PT/OT" functional G-codes are used to report:

- a beneficiary's functional limitation that is not defined by one of the above four categories;
- a beneficiary whose therapy services are not intended to treat a functional limitation;
- or a beneficiary's functional limitation when an overall, composite or other score from a functional assessment too is used and it does not clearly represent a functional limitation defined by one of the above four code sets.

Code	Long Descriptor	Short Descriptor
Other PT/OT Primary G-code Set		
G8990	Other physical or occupational therapy primary functional limitation, current status, at therapy episode outset and at reporting intervals	Other PT/OT current status
G8991	Other physical or occupational therapy primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Other PT/OT goal status
G8992	Other physical or occupational therapy primary functional limitation, discharge status, at discharge from therapy or to end reporting	Other PT/OT D/C status
Other PT/OT Subsequent G-code Set		
G8993	Other physical or occupational therapy subsequent functional limitation, current status, at therapy episode outset and at reporting intervals	Sub PT/OT current status
G8994	Other physical or occupational therapy subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Sub PT/OT goal status
G8995	Other physical or occupational subsequent functional limitation, discharge from therapy or end reporting.	Sub PT/OT D/C status

The following G-codes are for functional limitations typically seen in beneficiaries receiving SLP services. Seven are for specific functional communication measures, which are modeled after the National Outcomes Measurement System (NOMS), and one is for any "other" measure not described by one of the other seven.

Code	Long Descriptor	Short Descriptor
Swallowing G-code Set		
G8996	Swallowing functional limitation, current status, at therapy episode outset and at reporting intervals	Swallow current status
G8997	Swallowing functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Swallow goal status
G8998	Swallowing functional limitation, discharge status, at discharge from therapy or to end reporting	Swallow D/C status

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Motor Speech G-code Set (*NOTE:* These codes are not sequentially numbered)		
G8999	Motor speech functional limitation, current status, at therapy episode outset and at reporting intervals	Motor speech current status
G9186	Motor speech functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Motor speech goal status
G9158	Motor speech functional limitation, discharge status, at discharge from therapy or to end reporting	Motor speech D/C status
Spoken Language Comprehension G-code Set		
G9159	Spoken language comprehension functional limitation, current status, at therapy episode outset and at reporting intervals	Lang comp current status
G9160	Spoken language comprehension functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Lang comp goal status
G9161	Spoken language comprehension functional limitation, discharge status, at discharge from therapy or to end reporting	Lang comp D/C status
Spoken Language Expressive G-code Set		
G9162	Spoken language expression functional limitation, current status, at therapy episode outset and at reporting intervals	Lang express current status
G9163	Spoken language expression functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Lang press goal status
G9164	Spoken language expression functional limitation, discharge status, at discharge from therapy or to end reporting	Lang express D/C status
Attention G-code Set		
G9165	Attention functional limitation, current status, at therapy episode outset and at reporting intervals	Atten current status
G9166	Attention functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Atten goal status
G9167	Attention functional limitation, discharge status, at discharge from therapy or to end reporting	Atten D/C status
Memory G-code Set		
G9168	Memory functional limitation, current status, at therapy episode outset and at reporting intervals	Memory current status
G9169	Memory functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Memory goal status
G9170	Memory functional limitation, discharge status, at discharge from therapy or to end reporting	Memory D/C status
Voice G-code Set		
G9171	Voice functional limitation, current status, at therapy episode outset and at reporting intervals	Voice current status
G9172	Voice functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Voice goal status
G9173	Voice functional limitation, discharge status, at discharge from therapy or to end reporting	Voice D/C status

The following "other SLP" G-code set is used to report:

- on one of the other eight NOMS-defined functional measures not described by the above code sets; or
- to report an overall, composite or other score from assessment tool that does not clearly represent one of the above seven categorical SLP functional measures.

Code	Long Descriptor	Short Descriptor
Other Speech Language Pathology G-code Set		
G9174	Other speech language pathology functional limitation, current status, at therapy episode outset and at reporting intervals	Speech lang current status
G9175	Other speech language pathology functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Speech lang goal status
G9176	Other speech language pathology functional limitation, discharge status, at discharge from therapy or to end reporting	Speech lang D/C status

F. Severity/Complexity Modifiers

For each nonpayable functional G-code, one of the modifiers listed below must be used to report the severity/complexity for that functional limitation.

Modifier	Impairment Limitation Restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the clinician furnishing the therapy services.

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G. Required Reporting of Functional G-codes and Severity Modifiers

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

- At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service);
- At least once every 10 treatment days, which corresponds with the progress reporting period;
- When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT® codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97161, 97162 ,97163, 97164, 97165, 97166, 97167, 97168) is furnished and billed;
- At the time of discharge from the therapy episode of care–(i.e., on the date services related to the discharge [progress] report are furnished); and
- At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary.
- At the time reporting is begun for a new or different functional limitation within the same episode of care (i.e., after the reporting of the prior functional limitation is ended).

Functional reporting is required on claims throughout the entire episode of care. When the beneficiary has reached his or her goal or progress has been maximized on the initially selected functional limitation, but the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes. In these situations two or more functional limitations will be reported for a beneficiary during the therapy episode of care. Thus, reporting on more than one functional limitation may be required for some beneficiaries but not simultaneously.

When the beneficiary stops coming to therapy prior to discharge, the clinician should report the functional information on the last claim. If the clinician is unaware that the beneficiary is not returning for therapy until after the last claim is submitted, the clinician cannot report the discharge status.

When functional reporting is required on a claim for therapy services, two G-codes will generally be required.

Two exceptions exist:

1. Therapy services under more than one therapy POC — Claims may contain more than two nonpayable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-Time Therapy Visit — When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

Each reported functional G-code must also contain the following line of service information:

- Functional severity modifier
- Therapy modifier indicating the related discipline/POC — GP, GO or GN — for PT, OT, and SLP services, respectively
- Date of the related therapy service
- Nominal charge, e.g., a penny, for institutional claims submitted to the A/B MACs (A). For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

NOTE: The KX modifier is not required on the claim line for nonpayable G-codes, but would be required with the procedure code for medically necessary therapy services furnished once the beneficiary's annual cap has been reached.

The following example demonstrates how the G-codes and modifiers are used. In this example, the clinician determines that the beneficiary's mobility restriction is the most clinically relevant functional limitation and selects the Mobility G-code set (G8978 – G8980) to represent the beneficiary's functional limitation. The clinician also determines the severity/complexity of the beneficiary's functional limitation and selects the appropriate modifier. In this example, the clinician determines that the beneficiary has a 75 percent mobility restriction for which the CL modifier is applicable. The clinician expects that at the end of therapy the beneficiaries will have only a 15 percent mobility restriction for which the CI modifier is applicable. When the beneficiary attains the mobility goal, therapy continues to be medically necessary to address a functional limitation for which there is no categorical G-code. The clinician reports this using (G8990 – G8992).

At the outset of therapy — On the DOS for which the initial evaluative procedure is furnished or the initial treatment day of a therapy POC, the claim for the service will also include two G-codes as shown below.

- G8978-CL to report the functional limitation (Mobility with current mobility limitation of "at least 60 percent but less than 80 percent impaired, limited or restricted")
- G8979-CI to report the projected goal for a mobility restriction of "at least 1 percent but less than 20 percent impaired, limited or restricted."

At the end of each progress reporting period — On the claim for the DOS when the services related to the progress report (which must be done at least once each 10 treatment days) are furnished, the clinician will report the same two G-codes but the modifier for the current status may be different.

- G8978 with the appropriate modifier are reported to show the beneficiary's current status as of this DOS. So if the beneficiary has made no progress, this claim will include G8978-CL. If the beneficiary made progress and now has a mobility restriction of 65 percent CL would still be the appropriate modifier for 65 percent, and G8978-CL would be reported in this case. If the beneficiary now has a mobility restriction of 45 percent, G8978-CK would be reported.

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- G8979-CI would be reported to show the projected goal. This severity modifier would not change unless the clinician adjusts the beneficiary's goal.

This step is repeated as necessary and clinically appropriate, adjusting the current status modifier used as the beneficiary progresses through therapy.

At the time the beneficiary is discharged from the therapy episode. The final claim for therapy episode will include two G-codes.

- G8979-CI would be reported to show the projected goal. G8980-CI would be reported if the beneficiary attained the 15 percent mobility goal. Alternatively, if the beneficiary's mobility restriction only reached 25 percent; G8980-CJ would be reported.

To end reporting of one functional limitation — As noted above, functional reporting is required to continue throughout the entire episode of care. Accordingly, when further therapy is medically necessary after the beneficiary attains the goal for the first reported functional limitation, the clinician would end reporting of the first functional limitation by using the same G-codes and modifiers that would be used at the time of discharge. Using the mobility example, to end reporting of the mobility functional limitation, G8979-CI and G8980-CI would be reported on the same DOS that coincides with end of that progress reporting period.

To begin reporting of a second functional limitation. At the time reporting is begun for a new and different functional limitation, within the same episode of care (i.e., after the reporting of the prior functional limitation is ended). Reporting on the second functional limitation, however, is not begun until the DOS of the next treatment day — which is day one of the new progress reporting period. When the next functional limitation to be reported is NOT defined by one of the other three PT/OT categorical codes, the G-code set (G8990 - G8992) for the "other PT/OT primary" functional limitation is used, rather than the G-code set for the "other PT/OT subsequent" because it is the first reported "other PT/OT" functional limitation. This reporting begins on the DOS of the first treatment day following the mobility "discharge" reporting, which is counted as the initial service for the "other PT/OT primary" functional limitation and the first treatment day of the new progress reporting period. In this case, G8990 and G8991, along with the corresponding modifiers, are reported on the claim for therapy services.

The table below illustrates when reporting is required using this example and what G-codes would be used.

Example of Required Reporting

Key: Reporting Period (RP)	Begin RP #1 for Mobility at Episode Outset	End RP#1for Mobility at Progress Report	Mobility RP #2 Begins Next Treatment Day	End RP #2 for Mobility at Progress Report	Mobility RP #3 Begins Next Treatment Day	D/C or End Reporting for Mobility	Begin RP #1 for Other PT/OT Primary
Mobility: Walking & Moving Around							
G8978 – Current Status	X	X		X			
G 8979– Goal Status	X	X		X		X	
G8980 – Discharge Status						X	
Other PT/OT Primary							
G8990 – Current Status							X
G8991 – Goal Status							X
G8992 – Discharge Status							
No Functional Reporting Required			X		X		

H. Required Tracking and Documentation of Functional G-codes and Severity Modifiers

The clinician who furnishes the services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and severity modifiers used for this reporting in the beneficiary's medical record of therapy services.

For details related to the documentation requirements, refer to, Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, section 220.4 - Functional Reporting. For coverage rules related to MCTRJCA and therapy goals, refer to Pub. 100-02: a) for outpatient therapy services, see Chapter 15, section 220.1.2 B and b) for instructions specific to PT, OT, and SLP services in the CORF, see Chapter 12, section 10.

100-4, Chapter-5, 20

HCPCS Coding Requirement

A. Uniform Coding

Section 1834(k)(5) of the Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The current Healthcare Common Procedure Coding System/ Current Procedural Terminology is used for the reporting of these services. The uniform coding requirement in the Act is specific to payment for all CORF services and outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology - that is provided and billed to Medicare contractors. The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the non facility rate.

Effective for claims submitted on or after April 1, 1998, providers that had not previously reported HCPCS/CPT® for

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outpatient rehabilitation and CORF services began using HCPCS to report these services. This requirement does not apply to outpatient rehabilitation services provided by:

- Critical access hospitals, which are paid on a cost basis, not MPFS;
- RHCs, and FQHCs for which therapy is included in the all-inclusive rate; or
- Providers that do not furnish therapy services.

The following "providers of services" must bill the A/B MAC (A) for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF);
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC).
- Comprehensive outpatient rehabilitation facilities (CORFs); and
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient physical therapy facilities in this instruction).

Note 1. The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

Note 2. For HHAs, HCPCS/CPT® coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a home health plan of care.

The following practitioners must bill the A/B MAC (B) for outpatient rehabilitation therapy services using HCPCS/CPT® codes:

- Physical therapists in private practice (PTPPs),
- Occupational therapists in private practice (OTPPs),
- Speech-language pathologists in private practice (SLPPs),
- Physicians, including MDs, DOs, podiatrists and optometrists, and
- Certain nonphysician practitioners (NPPs), acting within their State scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Providers billing to intermediaries shall report:

- The date the therapy plan of care was either established or last reviewed (see §220.1.3B) in Occurrence Code 17, 29, or 30.
- The first day of treatment in Occurrence Code 35, 44, or 45.

B. Applicable Outpatient Rehabilitation HCPCS Codes

The CMS identifies the codes listed at:

https://www.cms.gov/medicare/billing/therapyservices?redirect=/therapyservices/05_annual_therapy_update.asp#TopOfPage as therapy services, regardless of the presence of a financial limitation. Therapy services include only physical therapy, occupational therapy and speech-language pathology services. Therapist means only a physical therapist, occupational therapist or speech language pathologist. Therapy modifiers are GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology.

When in effect, any financial limitation will also apply to services represented unless otherwise noted on the therapy page on the CMS Web site.

C. Additional HCPCS Codes

Some HCPCS/CPT® codes that are not on the list of therapy services should not be billed with a modifier. For example, outpatient non-rehabilitation HCPCS codes G0237, G0238, and G0239 should be billed without therapy modifiers. These HCPCS codes describe services for the improvement of respiratory function and may represent either "incident to" services or respiratory therapy services that may be appropriately billed in the CORF setting. When the services described by these G-codes are provided by physical therapists (PTs) or occupational therapists (OTs) treating respiratory conditions, they are considered therapy services and must meet the other conditions for physical and occupational therapy. The PT or OT would use the appropriate HCPCS/CPT® code(s) in the 97000 - 97799 series and the corresponding therapy modifier, GP or GO, must be used.

Another example of codes that are not on the list of therapy services and should not be billed with a therapy modifier includes the following HCPCS codes: 95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904, and 95934. These services represent diagnostic services - not therapy services; they must be appropriately billed and shall not include therapy modifiers.

Other codes not on the therapy code list, and not paid under another fee schedule, are appropriately billed with therapy modifiers when the services are furnished by therapists or provided under a therapy plan of care and where the services are covered and appropriately delivered (e.g., the therapist is qualified to provide the service). One example of non-listed codes where a therapy modifier is indicated regards the provision of services described in the CPT® code series, 29000 through 29590, for the application of casts and strapping. Some of these codes previously appeared on the therapy code list, but were deleted because we determined that they represented services that are most often performed outside a therapy plan of care. However, when these services are provided by therapists or as an integral part of a therapy plan of care, the CPT® code must be accompanied with the appropriate therapy modifier.

NOTE: The above lists of HCPCS/CPT® codes are intended to facilitate the contractor's ability to pay claims under the MPFS. It is not intended to be an exhaustive list of covered services, imply applicability to provider settings, and does not assure coverage of these services.

100-4, Chapter-5, 20.4

Coding Guidance for Certain CPT® Codes - All Claims

The following provides guidance about the use of codes 96105, 97026, 97150, 97545, 97546, and G0128.

- CPT® Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1- hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical

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necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the entire time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the worker's compensation program, thus CMS does not expect to see them reported for Medicare patients except under very unusual circumstances. Further, CMS would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

- CPT® Code 97026

Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Further coverage guidelines can be found in the National Coverage Determination Manual (Pub. 100-03), section 270.6.

Contractors shall deny claims with CPT® 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if the claim contains any of the following diagnosis codes:

ICD-9-CM

250.60 - 250.63

354.4, 354.5, 354.9

355.1 - 355.4

355.6 - 355.9

356.0, 356.2-356.4, 356.8-356.9

357.0 - 357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00 -707.07, 707.09-707.15, 707.19

870.0 - 879.9

880.00 - 887.7

890.0 - 897.7

998.31 - 998.32

ICD-10-CM

See Addendum A Chapter 5, Section 20.4 (at end of this chapter) for the list of ICD 10- CM diagnosis codes that require denial with the above HCPCD codes.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 50

RARC: N/A

MSN: 21.11

Advanced Beneficiary Notice (ABN):

Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHA), and hospital outpatient departments are liable if the service is performed, unless the beneficiary signs an ABN.

Similarly, DME suppliers and HHA are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

100-4, Chapter-5, 100.4

Outpatient Mental Health Treatment Limitation

The Outpatient Mental Health Treatment Limitation (the limitation) is not applicable to CORF services because CORFs do not provide services to treat mental, psychoneurotic and personality disorders that are subject to the limitation in section 1833(c) of the Act. For dates of service on or after October 1, 2012, HCPCS code G0409 is the only code allowed for social work and psychological services furnished in a CORF. This service is not subject to the limitation because it is not a psychiatric mental health treatment service.

For additional information on the limitation, see Publication 100-01, Chapter 3, section 30 and Publication 100-02, Chapter 12, sections 50-50.5.

100-4, Chapter-8, 60.2.1.1

Separately Billable ESRD Drugs

Effective January 1, 2011, section 153b of the MIPPA requires that all drugs and biologicals that are used in the treatment of ESRD be provided and billed by the ESRD facility. When a drug or biological is billed by providers other than the ESRD facility and the drug or biological furnished is designated as a drug or biological that is included in the ESRD PPS (renal dialysis service), the claim will be rejected or denied. In the event that a drug or biological generally used in the treatment of ESRD was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may report the drug on the claim with modifier AY and receive separate payment. For claims with dates of service on or after July 1, 2013, when these drugs are administered through the dialysate the provider must append the modifier JE (Administered via Dialysate).

All drugs reported on the renal dialysis facility claim are considered included in the ESRD PPS, unless they are covered by an exception as discussed below. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore no separate payment is made to ESRD facilities. However, CMS has determined that some of these drugs warrant separate payment when they are used to treat conditions other than ESRD.

Exceptions to "Always ESRD Related" Drugs:

The following drugs have been approved for separate payment consideration when billed with the AY modifier attesting to the drug not being used for the treatment of ESRD. The ESRD facility is required to indicate (in accordance with ICD coding guidelines) the diagnosis code for which the drug is indicated.

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- Vancomycin, effective January 1, 2012
- Daptomycin, effective January 1, 2013

Items and services subject to the consolidated billing requirements for the ESRD

PPS can be found on the CMS website at:

http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage

Other drugs and biologicals are separately payable to the dialysis facility if the drug was not used for the treatment of ESRD. The facility must include the modifier AY to indicate it was not for the treatment of ESRD.

Drugs are assigned HCPCS codes. If no HCPCS code is listed for a drug (e.g., a new drug) the facility bills using HCPCS code J3490, "Unclassified Drugs," and submits documentation identifying the drug. To establish a code for the drug, the A/B MAC (A) checks HCPCS to verify that there is no acceptable HCPCS code for billing and if a code is not found checks with the local A/B MAC (B), which may have a code and price that is appropriate. If no code is found the drug is processed under HCPCS code J3490. See Chapter 17 for a complete description of drug pricing.

100-4, Chapter-8, 60.4

Erythropoietin Stimulating Agents (ESAs)

Coverage rules for ESAs are explained in the Medicare Benefit Policy Manual, Publication 100-02, Chapter 11.

ESAs and their administration supplies and staff are included in the payment for the ESRD PPS effective January 1, 2011. Providers must continue to report ESAs on the claim. ESAs are eligible for outlier payment consideration. The Medicare allowed payment (MAP) amounts for the outlier policy include the ESA rate provided on the Average Sale Price (ASP) list.

100-4, Chapter-8, 60.4.1

ESA Claims Monitoring Policy

Effective for services provided on or after April 1, 2006, Medicare has implemented a national claims monitoring policy for ESAs administered in Medicare renal dialysis facilities. This policy does not apply to claims for ESAs for patients who receive their dialysis at home and self-administer their ESA.

While Medicare is not changing its coverage policy on erythropoietin use to maintain a target hematocrit level between 30% and 36%, we believe the variability in response to ESAs warrants postponing requiring monitoring until the hematocrit reaches higher levels. For dates of services April 1, 2006, and later, the Centers for Medicare & Medicaid Services (CMS) claims monitoring policy applies when the hematocrit level exceeds 39.0% or the hemoglobin level exceeds 13.0g/dL. This does not preclude the contractors from performing medical review at lower levels.

Effective for services provided on or after April 1, 2006, for claims reporting hematocrit or hemoglobin levels exceeding the monitoring threshold, the dose shall be reduced by 25% over the preceding month. Providers may report that a dose reduction did occur in response to the reported elevated hematocrit or hemoglobin level by adding a GS modifier on the claim. The definition of the GS modifier is defined as: "Dosage of ESA has been reduced and maintained in response to hematocrit or hemoglobin level." Thus, for claims reporting a hematocrit level or hemoglobin level exceeding the monitoring threshold without the GS modifier, CMS will reduce the covered dosage reported on the claim by 25%. The excess dosage is considered to be not reasonable and necessary. Providers are reminded that the patient's medical records should reflect hematocrit/hemoglobin levels and any dosage reduction reported on the claim during the same time period for which the claim is submitted.

Effective for dates of service provided on and after January 1, 2008, requests for payments or claims for ESAs for ESRD patients receiving dialysis in renal dialysis facilities reporting a hematocrit level exceeding 39.0% (or hemoglobin exceeding 13.0g/dL) shall also include modifier ED **or** EE. Claims reporting neither modifier or both modifiers will be returned to the provider for correction.

The definition of modifier ED is "The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) 3 or more consecutive billing cycles immediately prior to and including the current billing cycle." The definition of modifier EE is "The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) less than 3 consecutive billing cycles immediately prior to and including the current billing cycle." The GS modifier continues to be defined as stated above.

Providers may continue to report the GS modifier when the reported hematocrit or hemoglobin levels exceed the monitoring threshold for less than 3 months and a dose reduction has occurred. When both modifiers GS and EE are included, no reduction in the covered dose will occur. Claims reporting a hematocrit or hemoglobin level exceeding the monitoring threshold and the ED modifier shall have an automatic 50% reduction in the covered dose applied, even if the claim also reports the GS modifier.

Below is a chart illustrating the resultant claim actions under all possible reporting scenarios:

Hct Exceeds 39.0% or Hgb Exceeds 13.0g/dL	ED Modifier? (Hct >39% or Hgb >13g/dL ≥3 cycles)	EE Modifier? (Hct >39% or Hgb >13g/dL <3 cycles)	GS Modifier? (Dosage reduced and maintained)	Claim Action
No	N/A	N/A	N/A	Do not reduce reported dose.
Yes	No	No	No	Return to provider for correction. Claim must report either modifier ED or EE.
Yes	No	No	Yes	Return to provider for correction. Claim must report either modifier ED or EE.
Yes	No	Yes	Yes	Do not reduce reported dose.
Yes	No	Yes	No	Reduce reported dose 25%.
Yes	Yes	No	Yes	Reduce reported dose 50%.
Yes	Yes	No	No	Reduce reported dose 50%.

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In some cases, physicians may believe there is medical justification to maintain a hematocrit above 39.0% or hemoglobin above 13.0g/dL. Beneficiaries, physicians, and/or renal facilities may submit additional medical documentation to justify this belief under the routine appeal process. You may reinstate any covered dosage reduction amounts under this first level appeal process when you believe the documentation supports a higher hematocrit/hemoglobin level.

Providers are reminded that, in accordance with FDA labeling, CMS expects that as the hematocrit approaches 36.0% (hemoglobin 12.0g/dL), a dosage reduction occurs. Providers are expected to maintain hematocrit levels between 30.0 to 36.0% (hemoglobin 10.0-12.0g/dL). Hematocrit levels that remain below 30.0% (hemoglobin levels below 10.0g/dL)) despite dosage increases, should have causative factors evaluated. The patient's medical record should reflect the clinical reason for dose changes and hematocrit levels outside the range of 30.0-36.0% (hemoglobin levels 10.0-12.0g/dL). Medicare contractors may review medical records to assure appropriate dose reductions are applied and maintained and hematological target ranges are maintained.

These hematocrit requirements apply only to ESAs furnished as an ESRD benefit under §1881(b) of the Social Security Act.

Effective January 1, 2020, the EMP is discontinued under the ESRD PPS. Prescribing practitioners should continue to prescribe ESAs in accordance with ESA dosing guidelines and ESRD facilities should continue to report what they furnish.

The type of bill 72X will no longer be subject to dose reductions or ESA dose limitations.

ESRD facilities are not required to report the following modifiers:

1. GS - Dosage of erythropoietin stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level
2. ED - Hematocrit level has exceeded 39% (or hemoglobin level has exceeded 13.0 g/dl) for 3 or more consecutive billing cycles immediately prior to and including the current cycle
3. EE - Hematocrit level has not exceeded 39% (or hemoglobin level has not exceeded 13.0 g/dl) for 3 or more consecutive billing cycles immediately prior to and including the current cycle

Medically Unlikely Edits (MUE)

For dates of service on and after January 1, 2008, the MUE for claims billing for Epogen® is reduced to 400,000 units from 500,000. The MUE for claims for Aranesp® is reduced to 1200 mcg from 1500 mcg.

It is likely that claims reporting doses exceeding the threshold reflect typographical errors and will be returned to providers for correction.

Effective January 1, 2020 the medically unlikely edits for ESAs exceeding the threshold limits above are discontinued under the ESRD PPS.

100-4, Chapter-8, 60.4.6.3

Payment Amount for Darbepoetin Alfa (Aranesp)

Payment for ESRD-related Aranesp is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.

100-4, Chapter-8, 60.6

Vaccines Furnished to ESRD Patients

The Medicare program covers Hepatitis B, influenza virus and Pneumococcal pneumonia virus (PPV) vaccines and their administration when furnished to eligible beneficiaries in accordance with coverage rules. Payment may be made for both the vaccine and the administration. The costs associated with the syringe and supplies are included in the administration fee: HCPCS code A4657 should not be billed for these vaccines.

Vaccines and their administration are reported using separate codes. See Chapter 18 of this manual for the payment and codes required for billing vaccines and the administration of the vaccine.

Vaccines remain separately payable under the ESRD PPS.

100-4, Chapter-11, 40.1.3.1

Care Plan Oversight

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

For a physician or NP employed by or under arrangement with a hospice agency, CPO functions are incorporated and are part of the hospice per diem payment and as such may not be separately billed.

For information on separately billable CPO services by the attending physician, or nurse practitioner, or physician assistant see Chapter 12, §180 of this manual.

100-4, Chapter-12, 30.4

Cardiovascular System (Codes 92950-93799)

A. Echocardiography Contrast Agents

Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code A9700 (Supply of Injectable Contrast Material for Use in Echocardiography, per study). The type of service code is 9. This code will be A/B MAC (B) priced.

B. Electronic Analyses of Implantable Cardioverter-defibrillators and Pacemakers

The CPT® codes 93731, 93734, 93741 and 93743 are used to report electronic analyses of single or dual chamber pacemakers and single or dual chamber implantable cardioverter-defibrillators. In the office, a physician uses a device called a programmer to obtain information about the status and performance of the device and to evaluate the patient's cardiac rhythm and response to the implanted device.

Advances in information technology now enable physicians to evaluate patients with implanted cardiac devices without requiring the patient to be present in the physician's office. Using a manufacturer's specific monitor/transmitter, a patient can send complete device data and specific cardiac data to a distant receiving station or secure Internet server. The electronic analysis of cardiac device data that is remotely obtained provides immediate and long-term data on the device and clinical data on the patient's cardiac functioning equivalent to that obtained during an in-office evaluation. Physicians

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should report the electronic analysis of an implanted cardiac device using remotely obtained data as described above with CPT® code 93731, 93734, 93741 or 93743, depending on the type of cardiac device implanted in the patient.

100-4, Chapter-12, 30.6.15.4

Power Mobility Devices (PMDs) (Code G0372)

Section 302(a)(2)(E)(iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sets forth revised conditions for Medicare payment of Power Mobility Devices (PMDs). This section of the MMA states that payment for motorized or power wheelchairs may not be made unless a physician (as defined in §1861(r)(1) of the Act), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in §1861(aa)(5)) has conducted a face-to-face examination of the beneficiary and written a prescription for the PMD.

Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient. Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, code G0372 (physician service required to establish and document the need for a power mobility device)has been established to recognize additional physician services and resources required to establish and document the need for the PMD.

The G code indicates that all of the information necessary to document the PMD prescription is included in the medical record, and the prescription and supporting documentation is delivered to the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources required to establish and document the need for the PMD and will be added to the Medicare physician fee schedule.

100-4, Chapter-12,80.1

Coverage of Physicians' Services Provided in Comprehensive Outpatient Rehabilitation Facility

B3-2220

Rehabilitation services furnished by comprehensive outpatient rehabilitation facilities (CORFs) are covered by Medicare Part B.

Under §1832(a)(2)(E), §1861(cc)(2), (go to http://www.ssa.gov/OP_Home/ssact/title18/1800.htm and select the applicable title) and related provisions of the Act, a CORF is recognized as a provider of services on the basis of its reasonable costs. Except for diagnostic and therapeutic services provided by physicians to individual patients, payment is made to the CORF by intermediaries (acting in the role of the A/B MAC (B).)

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. Instead they are services that the physician must bill to the Part B carrier. If covered services, payment is made according to the Medicare Physician Fee Schedule. When physician's diagnostic and therapeutic services are furnished in a CORF, the claim must be annotated to show the CORF as the place of treatment.

Services considered administrative services provided by the physician associated with the CORF are considered CORF services reimbursable to the CORF by the FI. Administrative services include consultation with and medical supervision of nonphysician staff, establishing and reviewing the plan of treatment, and other medical and facility administration activities.

100-4, Chapter-12, 100.1.1

Evaluation and Management (E/M) Services

A. General Documentation Requirements

Evaluation and Management (E/M) Services – For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT®) book and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

B. E/M Service Documentation Provided By Students

Any contribution and participation of students to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

C. Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. Effective January 1, 2022, teaching physicians may use only medical decision making (MDM) for purposes of E/M visit level selection when billing the Medicare program under the physician fee schedule for office/outpatient E/M visits under this primary care exception. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary care exception: HCPCS code G0402 (Initial preventive physical examination; face-to-face visit services

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limited to new beneficiary during the first 12 months of Medicare enrollment).

Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS codes G0438 (Annual wellness visit, including personal preventive plan service, first visit) and G0439 (Annual wellness visit, including personal preventive plan service, subsequent visit).

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in §100.1 applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's A/B MAC (A). This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the A/B MAC (A) that the entity meets the requirements of a written agreement between the hospital and the entity set forth at 42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a)(6).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than 6 months in a GME approved residency program.

Teaching physicians submitting claims under this exception must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the residents;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the residents during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and,
- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

The patient medical record must document the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary. The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

100-4, Chapter-12, 180

Care Plan Oversight Services

The Medicare Benefit Policy Manual, Chapter 15, contains requirements for coverage for medical and other health services including those of physicians and non-physician practitioners.

Care plan oversight (CPO)is the physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency or Medicare approved hospice. CPO services require complex or multidisciplinary care modalities involving:

- Regular physician development and/or revision of care plans;
- Review of subsequent reports of patient status;
- Review of related laboratory and other studies;
- Communication with other health professionals not employed in the same practice who are involved in the patient's care;
- Integration of new information into the medical treatment plan; and/or
- Adjustment of medical therapy.

The CPO services require recurrent physician supervision of a patient involving 30 or more minutes of the physician's time per month. Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to:

- Time associated with discussions with the patient, his or her family or friends to adjust medication or treatment;
- Time spent by staff getting or filing charts;
- Travel time; and/or
- Physician's time spent telephoning prescriptions into the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO services were billed. The physician who bills for CPO must be the same physician who signs the plan of care.

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Nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of State law, may bill for care plan oversight. These non-physician practitioners must have been providing ongoing care for the beneficiary through evaluation and management services. These non-physician practitioners may not bill for CPO if they have been involved only with the delivery of the Medicare-covered home health or hospice service.

A. Home Health CPO

Non-physician practitioners can perform CPO only if the physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for CPO and either:

- The physician and NPP are part of the same group practice; or
- If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or
- If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

Billing may be made for care plan oversight services furnished by an NPP when:

- The NPP providing the care plan oversight has seen and examined the patient;
- The NPP providing care plan oversight is not functioning as a consultant whose participation is limited to a single medical condition rather than multidisciplinary coordination of care; and
- The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care. NPPs may not certify the beneficiary for home health care.

NPPs may not certify the beneficiary for home health care.

B. Hospice CPO

The attending physician or nurse practitioner (who has been designated as the attending physician) may bill for hospice CPO when they are acting as an "attending physician". An "attending physician" is one who has been identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care. They are not employed nor paid by the hospice. The care plan oversight services are billed using Form CMS-1500 or electronic equivalent. For additional information on hospice CPO, see Chapter 11, §40.1.3.1 of this manual.

100-4, Chapter-12, 180.1

Care Plan Oversight Billing Requirements

A. Codes for Which Separate Payment May Be Made

Effective January 1, 1995, separate payment may be made for CPO oversight services for 30 minutes or more if the requirements specified in the Medicare Benefits Policy Manual, Chapter 15 are met.

Providers billing for CPO must submit the claim with no other services billed on that claim and may bill only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service.

Physicians may bill and be paid separately for CPO services only if all the criteria in the Medicare Benefit Policy Manual, Chapter 15 are met.

B. Physician Certification and Recertification of Home Health Plans of Care

Effective 2001, two new HCPCS codes for the certification and recertification and development of plans of care for Medicare-covered home health services were created.

See the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-01, Chapter 4, "Physician Certification and Recertification of Services," §10-60, and the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, "Home Health Services", §30.

The home health agency certification code can be billed only when the patient has not received Medicare-covered home health services for at least 60 days. The home health agency recertification code is used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period. The home health agency recertification code will be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.

C. Provider Number of Home Health Agency (HHA) or Hospice

For claims for CPO submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the 6-character Medicare provider number of the HHA or hospice providing Medicare-covered services to the beneficiary for the period during which CPO services was furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the HHA or hospice Medicare provider numbers.

Additionally, physicians should provide their UPIN to the HHA or hospice furnishing services to their patient.

NOTE: There is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice provider number required for a care plan oversight claim. For this reason, the requirement to include the HHA or hospice provider number on a care plan oversight claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for care plan oversight claims.

100-4, Chapter-12, 190.3

List of Medicare Telehealth Services

The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. The various services and corresponding current procedure terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes are listed on the CMS website at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/.

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT® codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT® code or appropriate hospital or

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nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

100-4, Chapter-12, 190.3.1

Telehealth Consultation Services, Emergency Department or Initial Inpatient versus Inpatient Evaluation and Management (E/M) Visits

A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified nonphysician practitioner (NPP) at the request of another physician or appropriate source.

Section 1834(m) of the Social Security Act includes "professional consultations" in the definition of telehealth services. Inpatient or emergency department consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site.

The use of a telecommunications system may substitute for an in-person encounter for emergency department or initial and follow-up inpatient consultations.

Medicare A/B MACs (B) pay for reasonable and medically necessary inpatient or emergency department telehealth consultation services furnished to beneficiaries in hospitals or SNFs when all of the following criteria for the use of a consultation code are met:

- An inpatient or emergency department consultation service is distinguished from other inpatient or emergency department evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices;
- A request for an inpatient or emergency department telehealth consultation from an appropriate source and the need for an inpatient or emergency department telehealth consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and
- After the inpatient or emergency department telehealth consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

The intent of an inpatient or emergency department telehealth consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.

Unlike inpatient or emergency department telehealth consultations, the majority of subsequent inpatient hospital, emergency department and nursing facility care services require in-person visits to facilitate the comprehensive, coordinated, and personal care that medically volatile, acutely ill patients require on an ongoing basis.

Subsequent hospital care services are limited to one telehealth visit every 3 days. Subsequent nursing facility care services are limited to one telehealth visit every 30 days.

Beginning with dates of service on and after January 1, 2021, the limit for nursing facility care services is one telehealth visit every 14 days.

100-4, Chapter-12, 190.3.2

Telehealth Consultation Services, Emergency Department or Initial Inpatient Defined

Emergency department or initial inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the emergency department or initial inpatient consultation via telehealth cannot be the physician of record or the attending physician, and the emergency department or initial inpatient telehealth consultation would be distinct from the care provided by the physician of record or the attending physician. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Emergency department or initial inpatient telehealth consultations are subject to the criteria for emergency department or initial inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.

Payment for emergency department or initial inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional E/M service could be billed for work related to an emergency department or initial inpatient telehealth consultation.

Emergency department or initial inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward, would bill HCPCS code G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth).
- Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity, would bill HCPCS code G0426 (Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth).
- Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity, would bill HCPCS code G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth).

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Although emergency department or initial inpatient telehealth consultations are specific to telehealth, these services must be billed with POS 02 to identify the telehealth technology used to provide the service.

100-4, Chapter-12, 190.3.3

Follow-Up Inpatient Telehealth Consultations Defined

Follow-up inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth to follow-up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in-person or via telehealth.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs.

The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by the physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation. Follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3.1 of this chapter.

Payment for follow-up inpatient telehealth consultations includes all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim labwork) and communicating with other professionals or family members. Intra-service activities must include at least two of the three key elements described below for each procedure code. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional evaluation and management service could be billed for work related to a follow-up inpatient telehealth consultation.

Follow-up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS code G0406 (Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth).
- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS code G0407(Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth).
- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS code G0408 (Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth).

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with either the -GT or –GQ modifier to identify the telehealth technology used to provide the service.

100-4, Chapter-12, 190.3.4

Payment for ESRD-Related Services as a Telehealth Service

The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-face "hands on" to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient's plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary's plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit, including a clinical examination of the vascular access site, must be conducted face-to-face "hands on" by a physician, clinical nurse specialist, nurse practitioner or physician's assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary's prescription is indicated, due to such changes as the estimate of the patient's dry weight.

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100-4, Chapter-12, 190.3.5

Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services

(Rev. 3476, Issued: 03-11-16, Effective: 01-01-15, Effective: 04-11-16)

Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3 of this chapter.

100-4, Chapter-12, 190.3.6

Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service

Individual and group DSMT services may be paid as a Medicare telehealth service. Before 03-11-2016, this manual provision required that 1 hour of the 10 hour DSMT benefit's initial training must be furnished in-person to allow for effective injection training. Because injection training is not always clinically indicated, we are revising this provision to permit all 10 hours of the initial training and the two (2) hours of annual follow-up training to be furnished via telehealth in those cases when injection training is not applicable. The in-person injection training, when provided, may be furnished through either individual or group DSMT services. By reporting place of service (POS) 02 or the – GT or –GQ modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner attests that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year following the initial DSMT service or any calendar year's 2 hours of follow-up training.

As specified in 42 CFR 410.141(e) and stated in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 300.2, individual and group DSMT services may be furnished by a physician, other individual, or entity that furnishes other items or services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by a national accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 190.6 of this chapter, Medicare telehealth services, including individual and group DSMT services furnished as a telehealth service, could only be furnished by a physician, PA, NP, CNS, CNM , clinical psychologist, clinical social worker, or registered dietitian or nutrition professional, as applicable.

100-4, Chapter-12, 210

Outpatient Mental Health Treatment Limitation

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. This limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 –December 31, 2011, the limitation percentage is 68.75%.
  (Medicare pays 55% and the patient pays 45%).
- January 1, 2012 –December 31, 2012, the limitation percentage is 75%.
  (Medicare pays 60% and the patient pays 40%).
- January 1, 2013 –December 31, 2013, the limitation percentage is 81.25%.
  (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 –onward, the limitation percentage is 100%.
  (Medicare pays 80% and the patient pays 20%).

For additional details concerning computation of the limitation, please see the examples under section 210.1 E.

100-4, Chapter-12, 210.1

Application of the Limitation

A. Status of Patient

The limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to mental health services furnished to a person in a physician's office, in the patient's home, in a skilled nursing facility, as an outpatient, and so forth. The term "hospital" in this context means an institution, which is primarily engaged in providing to inpatients, by or under the supervision of a physician(s):

- Diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons;
- Rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill patients.

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B. Disorders Subject to the Limitation

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric diagnoses described in the International Classification of Diseases, 9th Revision (ICD-9), under the code range 290-319.

When the treatment services rendered are both for a psychiatric diagnosis as defined in the ICD-9 and one or more nonpsychiatric conditions, separate the expenses for the psychiatric aspects of treatment from the expenses for the nonpsychiatric aspects of treatment. However, in any case in which the psychiatric treatment component is not readily distinguishable from the nonpsychiatric treatment component, all of the expenses are allocated to whichever component constitutes the primary diagnosis.

1. Diagnosis Clearly Meets Definition –If the primary diagnosis reported for a particular service is the same as or equivalent to a condition described in the ICD-9 under the code range 290-319 that represents mental, psychoneurotic and personality disorders, the expense for the service is subject to the limitation except as described in subsection D.
2. Diagnosis Does Not Clearly Meet Definition -When it is not clear whether the primary diagnosis reported meets the definition of mental, psychoneurotic, and personality disorders, it may be necessary to contact the practitioner to clarify the diagnosis. In deciding whether contact is necessary in a given case, give consideration to such factors as the type of services rendered, the diagnosis, and the individual's previous utilization history.

C. Services Subject to the Limitation

A/B MACs (B) must apply the limitation to claims for professional services that represent mental health treatment furnished to individuals who are not hospital inpatients by physicians, clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists and physician assistants. Items and supplies furnished by physicians or other mental health practitioners in connection with treatment are also subject to the limitation.

Generally, A/B MACs (B) must apply the limitation only to treatment services. However, diagnostic psychological and neuropsychological testing services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the limitation.

D. Services Not Subject to the Limitation

1. Diagnosis of Alzheimer's Disease or Related Disorder -When the primary diagnosis reported for a particular service is Alzheimer's Disease or an Alzheimer's related disorder, A/B MACs (B) must look to the nature of the service that has been rendered in determining whether it is subject to the limitation. Alzheimer's disease is coded 331.0 in the "International Classification of Diseases, 9th Revision", which is outside the code range 290-319 that represents mental, psychoneurotic and personality disorders. Additionally, Alzheimer's related disorders are identified by contractors under ICD-9 codes that are within the 290-319 code range (290.XX or others as contractors determine appropriate) or outside the 290-319 code range as determined appropriate by contractors. When the primary treatment rendered to a patient with a diagnosis of Alzheimer's disease or a related disorder is psychotherapy, it is subject to the limitation. However, typically, treatment provided to a patient with a diagnosis of Alzheimer's Disease or a related disorder represents medical management of the patient's condition (such as described under CPT® code 90862 or any successor code) and is not subject to the limitation. CPT® code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
2. Brief Office Visits for Monitoring or Changing Drug Prescriptions -Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders are not subject to the limitation. These visits are reported using HCPCS code M0064 or any successor code (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders). Claims where the diagnosis reported is a mental, psychoneurotic, or personality disorder (other than a diagnosis specified in subsection A) are subject to the limitation except for the procedure identified by HCPCS code M0064 or any successor code.
3. Diagnostic Services - A/B MACs (B) do not apply the limitation to psychiatric diagnostic evaluations and diagnostic psychological and neuropsychological tests performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric diagnostic evaluations billed under CPT® codes 90801 or 90802 (or any successor codes) and, psychological and neuropsychological tests billed under CPT® code range 96101-96118 (or any successor code range).

   An initial visit to a practitioner for professional services often combines diagnostic evaluation and the start of therapy. Such a visit is neither solely diagnostic nor solely therapeutic. Therefore, A/B MACs (B) must deem the initial visit to be diagnostic so that the limitation does not apply. Separating diagnostic and therapeutic components of a visit is not administratively feasible; unless the practitioner already has separately identified them on the bill.

   Determining the entire visit to be therapeutic is not justifiable since some diagnostic work must be done before even a tentative diagnosis can be made and certainly before therapy can be instituted. Moreover, the patient should not be disadvantaged because therapeutic as well as diagnostic services were provided in the initial visit. In the rare cases where a practitioner's diagnostic services take more than one visit, A/B MACs (B) must not apply the limitation to the additional visits. However, it is expected such cases are few. Therefore, when a practitioner bills for more than one visit for professional diagnostic services, A/B MACs (B) may find it necessary to request documentation to justify the reason for more than one diagnostic visit.
4. Partial Hospitalization Services Not Directly Provided by a Physician or a Practitioner - The limitation does not apply to partial hospitalization services that are not directly provided by a physician, clinical psychologist, nurse practitioner, clinical nurse specialist or a physician assistant. Partial hospitalization services are billed by hospital outpatient departments and community mental health centers (CMHCs) to A/B MACs (A). However, services furnished by physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants to partial hospitalization patients are billed separately from the partial hospitalization program of services. Accordingly, these professional's mental health services to partial hospitalization patients are paid under the physician fee schedule by A/B MACs (B) and

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may be subject to the limitation. (See chapter 4, section 260.1C).

5. Intensive Outpatient Services Not Directly Provided by a Physician or a Practitioner - The limitation does not apply to intensive outpatient services that are not directly provided by a physician, clinical psychologist, nurse practitioner, clinical nurse specialist, or a physician assistant. Intensive outpatient services are billed by hospital outpatient departments, community mental health centers (CMHCs), RHCs, FQHCs, and OTPs to A/B MACs (A). However, services furnished by physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants to intensive outpatient patients are billed separately from the intensive outpatient program of services. Accordingly, these professional's mental health services to intensive outpatient patients are paid under the physician fee schedule by A/B MACs (B) and may be subject to the limitation. (See chapter 4, section 261.1C).

E. Computation of Limitation

A/B MACs (B) determine the Medicare approved payment amount for services subject to the limitation. They:

- Multiply the approved amount by the limitation percentage amount;
- Subtract any unsatisfied deductible; and,
- Multiply the remainder by 0.8 to obtain the amount of Medicare payment.

The beneficiary is responsible for the difference between the amount paid by Medicare and the full Medicare approved amount.

The following examples illustrate the application of the limitation in various circumstances as it is gradually reduced under section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA). Please note that although the calendar year 2009 Part B deductible of $135 is used under these examples, the actual deductible amount for calendar year 2010 and future years is unknown and will be subject to change.

Example #1: In 2010, a clinical psychologist submits a claim for $200 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $180. Since clinical psychologists must accept assignment, the patient is not liable for the $20 in excess charges. The patient previously satisfied the $135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68 ¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as follows:

1. Actual charges	$200.00
2. Medicare-approved amount	$180.00
3. Medicare incurred expenses (0.6875 x line 2	$123.75
4. Unmet deductible	$0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	$123.75
6. Medicare payment (0.80 x line 5)	$99.00
7. Patient liability (line 2 minus line 6)	$81.00

Example #2: In 2012, a clinical social worker submits a claim for $135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $120. Since clinical social workers must accept assignment, the patient is not liable for the $15 in excess charges. The limitation reduces the amount of incurred expenses to 75 percent of the approved amount. The patient previously satisfied $70 of the $135 annual Part B deductible, leaving $65 unmet. The Medicare payment and patient liability are computed as follows:

1. Actual charges	$135.00
2. Medicare-approved amount	$120.00
3. Medicare incurred expenses (0.75 x line 2)	$90.00
4. Unmet deductible	$65.00
5. Remainder after subtracting deductible (line 3 minus line 4)	$25.00
6. Medicare payment (0.80 x line 5)	$20.00
7. Patient liability (line 2 minus line 6)	$100.00

Example #3: In calendar year 2013, a physician who does not accept assignment submits a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare-approved amount is $750. Because the physician does not accept assignment, the patient is liable for the $30 in excess charges. The patient has not satisfied any of the $135 Part B annual deductible. The Medicare payment and patient liability are computed as follows:

1. Actual charges	$780.00
2. Medicare-approved amount	$750.00
3. Medicare incurred expenses (0.8125 x line 2)	$609.38
4. Unmet deductible	$135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	$474.38
6. Medicare payment (0.80 x line 5)	$379.50
7. Patient liability (line 1 minus line 6)	$400.50

Example #4: A patient's Part B expenses during calendar year 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the $135 Part B deductible. The physician accepts assignment and submits a claim for $780. The Medicare-approved amount is $750. Since the limitation will be completely phased out as of January 1, 2014, the entire $750 Medicare-approved amount is recognized as the total incurred expenses because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient. The Medicare payment and patient liability are computed as follows:

1. Actual charges	$780.00
2. Medicare-approved amount	$750.00
3. Medicare incurred expenses (1.00 x line 2)	$750.00
4. Unmet deductible	$135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	$615.00
6. Medicare payment (0.80 x line 5)	$492.00
Beneficiary liability (line 2 minus line 6)	$258.00

100-4, Chapter-13, 40

Magnetic Resonance Imaging (MRI) Procedures

Effective September 28, 2009

The Centers for Medicare & Medicaid Services (CMS) finds that the non-coverage of magnetic resonance imaging (MRI) for blood flow determination is no longer supported by the available evidence. CMS is removing the phrase "blood flow measurement" and local Medicare contractors will have the discretion to cover (or not cover).

Consult Publication (Pub.) 100-03, National Coverage Determinations (NCD) Manual, chapter 1, section 220.2, for specific coverage and non-coverage indications associated with MRI and MRA (Magnetic Resonance Angiography).

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Prior to January 1, 2007

A/B MACs (B) do not make additional payments for three or more MRI sequences. The relative value units (RVUs) reflect payment levels for two sequences.

The technical component (TC) RVUs for MRI procedures that specify "with contrast" include payment for paramagnetic contrast media. Carriers do not make separate payment under code A4647.

A diagnostic technique has been developed under which an MRI of the brain or spine is first performed without contrast material, then another MRI is performed with a standard (0.1mmol/kg) dose of contrast material and, based on the need to achieve a better image, a third MRI is performed with an additional double dosage (0.2mmol/kg) of contrast material. When the high-dose contrast technique is utilized, A/B MACs (B):

- Do not pay separately for the contrast material used in the second MRI procedure;
- Pay for the contrast material given for the third MRI procedure through supply code Q9952, the replacement code for A4643, when billed with Current Procedural Terminology (CPT®) codes 70553, 72156, 72157, and 72158;
- Do not pay for the third MRI procedure. For example, in the case of an MRI of the brain, if CPT® code 70553 (without contrast material, followed by with contrast material(s) and further sequences) is billed, make no payment for CPT® code 70551 (without contrast material(s)), the additional procedure given for the purpose of administering the double dosage, furnished during the same session. Medicare does not pay for the third procedure (as distinguished from the contrast material) because the CPT® definition of code 70553 includes all further sequences; and
- Do not apply the payment criteria for low osmolar contrast media in §30.1.2 to billings for code Q9952, the replacement code for A4643.

Effective January 1, 2007

With the implementation for calendar year 2007 of a bottom-up methodology, which utilizes the direct inputs to determine the practice expense (PE) relative value units (RVUs), the cost of the contrast media is not included in the PE RVUs. Therefore, a separate payment for the contrast media used in various imaging procedures is paid. In addition to the CPT® code representing the imaging procedure, separately bill the appropriate HCPCS "Q" code (Q9945 –Q9954; Q9958-Q9964) for the contrast medium utilized in performing the service.

Effective February 24, 2011

Medicare will allow for coverage of MRI for beneficiaries with implanted PMs or cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study as described in section 220.C.1 of the NCD manual.

Effective July 7, 2011

Medicare will allow for coverage of MRI for beneficiaries with implanted pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment as described in section 220.2.C.1 of the NCD Manual.

100-4, Chapter-13, 40.1.2

HCPCS Coding Requirements

Providers must report HCPCS codes when submitting claims for MRA of the chest, abdomen, head, neck or peripheral vessels of lower extremities. The following HCPCS codes should be used to report these services:

MRA of head	70544, 70544-26, 70544-TC
MRA of head	70545, 70545-26, 70545-TC
MRA of head	70546, 70546-26, 70546-TC
MRA of neck	70547, 70547-26, 70547-TC
MRA of neck	70548, 70548-26, 70548-TC
MRA of neck	70549, 70549-26, 70549-TC
MRA of chest	71555, 71555-26, 71555-TC
MRA of pelvis	72198, 72198-26, 72198-TC
MRA of abdomen (dates of service on or after July 1, 2003) –see below.	74185, 74185-26, 74185-TC
MRA of peripheral lower extremities	73725, 73725-26, 73725-TC vessels of

Hospitals subject to OPPS should report the following C codes in place of the above HCPCS codes as follows:

- MRA of chest 71555: C8909 – C8911
- MRA of abdomen 74185: C8900 – C8902
- MRA of peripheral vessels of lower extremities 73725: C8912 – C8914

For claims with dates of service on or after July 1, 2003, coverage under this benefit has been expanded for the use of MRA for diagnosing pathology in the renal or aortoiliac arteries. The following HCPCS code should be used to report this expanded coverage of MRA:

- MRA, pelvis, with or without contrast material(s) 72198, 72198-26, 72198-TC

Hospitals subject to OPPS report the following C codes in place of HCPCS code 72198:

- MRA, pelvis, with or without contrast material(s) 72198: C8918 - C8920

NOTE: Information regarding the claim form locator that corresponds to the HCPCS code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.

100-4, Chapter-13, 60

Positron Emission Tomography (PET) Scans – General Information

Positron emission tomography (PET) is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images which are obtained by detecting radioactivity from a radioactive tracer substance (radiopharmaceutical) that emits a radioactive tracer substance (radiopharmaceutical FDG) such as 2 –[F-18] flouro-D-glucose FDG, that is administered intravenously to the patient.

The Medicare National Coverage Determinations (NCD) Manual, chapter 1, §220.6, contains additional coverage instructions to indicate the conditions under which a PET scan is performed.

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A. Definitions

For all uses of PET, excluding Rubidium 82 for perfusion of the heart, myocardial viability and refractory seizures, the following definitions apply:

Diagnosis: PET is covered only in clinical situations in which the PET results may assist in avoiding an invasive diagnostic procedure, or in which the PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET scans following a tissue diagnosis are generally performed for the purpose of staging, rather than diagnosis. Therefore, the use of PET in the diagnosis of lymphoma, esophageal and colorectal cancers, as well as in melanoma, should be rare. PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific signs and symptoms of disease).

Staging: PET is covered in clinical situations in which (1) (a) the stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound) or, (b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient and, (2) clinical management of the patient would differ depending on the stage of the cancer identified.

NOTE: Effective for services on or after April 3, 2009, the terms "diagnosis" and "staging" will be replaced with "Initial Treatment Strategy." For further information on this new term, refer to Pub. 100-03, NCD Manual, section 220.6.17.

Restaging: PET will be covered for restaging: (1) after the completion of treatment for the purpose of detecting residual disease, (2) for detecting suspected recurrence, or metastasis, (3) to determine the extent of a known recurrence, or (4) if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is to determine the extent of a known recurrence, or if study information is insufficient for the clinical management of the patient. Restaging applies to testing after a course of treatment is completed and is covered subject to the conditions above.

Monitoring: Use of PET to monitor tumor response to treatment during the planned course of therapy (i.e., when a change in therapy is anticipated).

NOTE: Effective for services on or after April 3, 2009, the terms "restaging" and "monitoring" will be replaced with "Subsequent Treatment Strategy." For further information on this new term, refer to Pub. 100-03, NCD Manual, section 220.6.17.

B. Limitations

For staging and restaging: PET is covered in either/or both of the following circumstances:

- The stage of the cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound); and/or
- The clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence, or to determine the extent of a known recurrence. Use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient.

The PET is not covered for other diagnostic uses, and is not covered for screening (testing of patients without specific symptoms). Use of PET to monitor tumor response during the planned course of therapy (i.e., when no change in therapy is being contemplated) is not covered.

100-4, Chapter-13, 60.3

PET Scan Qualifying Conditions and HCPCS Code Chart

Below is a summary of all covered PET scan conditions, with effective dates.

NOTE: The G codes below except those a # can be used to bill for PET Scan services through January 27, 2005. Effective for dates of service on or after January 28, 2005, providers must bill for PET Scan services using the appropriate CPT® codes. See section 60.3.1. The G codes with a # can continue to be used for billing after January 28, 2005 and these remain non-covered by Medicare. (***NOTE:*** PET Scanners must be FDA-approved.)

Conditions	Coverage Effective Date	****HCPCS/ CPT®
*Myocardial perfusion imaging (following previous PET G0030-G0047) single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0030
*Myocardial perfusion imaging (following previous PET G0030-G0047) multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0031
*Myocardial perfusion imaging (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0032
*Myocardial perfusion imaging (following rest SPECT 78464); multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0033
*Myocardial perfusion (following stress SPECT 78465); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0034
*Myocardial Perfusion Imaging (following stress SPECT 78465); multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0035
*Myocardial Perfusion Imaging (following coronary angiography 93510-93529); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0036
*Myocardial Perfusion Imaging, (following coronary angiography), 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0037
*Myocardial Perfusion Imaging (following stress planar myocardial perfusion, 78460); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0038

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Conditions	Coverage Effective Date	****HCPCS/ CPT®
*Myocardial Perfusion Imaging (following stress planar myocardial perfusion, 78460); multiple studies, rest or stress (exercise and/ or pharmacologic)	3/14/95	G0039
*Myocardial Perfusion Imaging (following stress echocardiogram 93350); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0040
*Myocardial Perfusion Imaging (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0041
*Myocardial Perfusion Imaging (following stress nuclear ventriculogram 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0042
*Myocardial Perfusion Imaging (following stress nuclear ventriculogram 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0043
*Myocardial Perfusion Imaging (following stress ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)	3/14/95	G0044
*Myocardial perfusion (following stress ECG, 93000), multiple studies; rest or stress (exercise and/or pharmacologic)	3/14/95	G0045
*Myocardial perfusion (following stress ECG, 93015), single study; rest or stress (exercise and/or pharmacologic)	3/14/95	G0046
*Myocardial perfusion (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)	3/14/95	G0047
PET imaging regional or whole body; single pulmonary nodule	1/1/98	G0125
Lung cancer, non-small cell (PET imaging whole body) Diagnosis, Initial Staging, Restaging	7/1/01	G0210 G0211 G0212
Colorectal cancer (PET imaging whole body) Diagnosis, Initial Staging, Restaging	7/1/01	G0213 G0214 G0215
Melanoma (PET imaging whole body) Diagnosis, Initial Staging, Restaging	7/1/01	G0216 G0217 G0218
Melanoma for non-covered indications	7/1/01	#G0219
Lymphoma (PET imaging whole body) Diagnosis, Initial Staging, Restaging	7/1/01	G0220 G0221 G0222
Head and neck cancer; excluding thyroid and CNS cancers (PET imaging whole body or regional) Diagnosis, Initial Staging, Restaging	7/1/01	G0223 G0224 G0225
Esophageal cancer (PET imaging whole body) Diagnosis, Initial Staging, Restaging	7/1/01	G0226 G0227 G0228
Metabolic brain imaging for pre-surgical evaluation of refractory seizures	7/1/01	G0229
Metabolic assessment for myocardial viability following inconclusive SPECT study	7/1/01	G0230
Recurrence of colorectal or colorectal metastatic cancer (PET whole body, gamma cameras only)	1/1/02	G0231
Staging and characterization of lymphoma (PET whole body, gamma cameras only)	1/1/02	G0232
Recurrence of melanoma or melanoma metastatic cancer (PET whole body, gamma cameras only)	1/1/02	G0233
Regional or whole body, for solitary pulmonary nodule following CT, or for initial staging of non-small cell lung cancer (gamma cameras only)	1/1/02	G0234
Non-Covered Service PET imaging, any site not otherwise specified	1/28/05	#G0235
Non-Covered Service Initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes), not covered (full- and partial-ring PET scanners only)	10/1/02	#G0252
Breast cancer, staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after or prior to course of treatment (full- and partial-ring PET scanners only)	10/1/02	G0253
Breast cancer, evaluation of responses to treatment, performed during course of treatment (full- and partial-ring PET scanners only)	10/1/02	G0254
Myocardial imaging, positron emission tomography (PET), metabolic evaluation)	10/1/02	78459
Restaging or previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan (full- and partial-ring PET scanner only)	10/1/03	G0296
Tracer Rubidium**82 (Supply of Radiopharmaceutical Diagnostic Imaging Agent) (This is only billed through Outpatient Perspective Payment System, OPPS.) (Carriers must use HCPCS Code A4641).	10/1/03	Q3000
Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13	01/1/04	A9526
PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia	09/15/04	Appropriate CPT® Code from section 60.3.1
PET Cervical Cancer Staging as adjunct to conventional imaging, other staging, diagnosis, restaging, monitoring	1/28/05	Appropriate CPT® Code from section 60.3.1

***NOTE:** A/B MACs (B) must report A4641 for the tracer Rubidium 82 when used with PET scan codes G0030 through G0047 for services performed on or before January 27, 2005.

****NOTE:** Not FDG PET

*****NOTE:** For dates of service October 1, 2003, through December 31, 2003, use temporary code Q4078 for billing this radiopharmaceutical.

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100-4, Chapter-13, 60.3.1

Appropriate CPT® Codes Effective for PET Scans for Services Performed on or After January 28, 2005

NOTE: All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See section 60.3.2 below for applicable tracer codes.

CPT® Code	Description
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study, single study; with concurrently acquired computed tomography transmission scan
78430	Myocardial imaging, positron emission tomography (PET), perfusion study; single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
78431	Myocardial imaging, positron emission tomography (PET), perfusion study; multiple studies at rest and stress, with concurrently acquired computed tomography transmission scan
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study, dual radiotracer;
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study, dual radiotracer; with concurrently acquired computed tomography transmission scan
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78811	Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid-thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

100-4, Chapter-13, 60.3.2

Tracer Codes Required for Positron Emission Tomography (PET) Scans

An applicable tracer/radiopharmaceutical code, along with an applicable Current Procedural Technology (CPT®) code, is necessary for claims processing of any Positron Emission Tomography (PET) scan services. While there are a number of PET tracers already billable for a diverse number of medical indications, there have been, and may be in the future, additional PET indications that might require a new PET tracer. Under those circumstances, the process to request/approve/implement a new code could be time-intensive. To help alleviate inordinate spans of time between when a national coverage determination is made, or when the Food and Drug Administration (FDA) approves a particular radiopharmaceutical for an oncologic indication already approved by the Centers for Medicare & Medicaid Services (CMS), and when it can be fully implemented via valid claims processing, CMS has created two new PET radiopharmaceutical unclassified tracer codes that can be used temporarily. This time period would be pending the creation/approval/implementation of permanent CPT® codes that would later specifically define their function by CMS in official instructions.

Effective with dates of service on or after January 1, 2018, the following Healthcare Common Procedure Coding System (HCPCS) codes shall be used ONLY AS NECESSARY FOR AN INTERIM PERIOD OF TIME under the circumstances explained here. Specifically, there are two circumstances that would warrant use of the below codes: (1) After FDA approval of a PET oncologic indication, or, (2) after CMS approves coverage of a new PET indication, and ONLY if either of those situations requires the use of a dedicated PET radiopharmaceutical/tracer that is currently non-existent. Once permanent replacement codes are officially implemented by CMS, use of the temporary code for that particular indication will simultaneously be discontinued.

NOTE: The following two codes were effective as of January 1, 2017, with the January 2017 quarterly HCPCS update.

A9597 - Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified

A9598 - Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified

Effective for claims with dates of service on and after January 1, 2018, when PET tracer code A9597 or A9598 are present on a claim, that claim must also include:

-an appropriate PET HCPCS code, either 78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, or 78816,

-if tumor-related, either the -PI or -PS modifier as appropriate,

-if clinical trial, registry, or study-related outside of NCD220.6.17, PET for Solid Tumors, clinical trial modifier –Q0,

-if clinical trial, registry, or study-related, all claims require the 8-digit clinical trial number,

-if Part A OP and clinical trial, registry, or study-related outside of NCD220.6.17, PET for Solid Tumors, also include condition code 30 and ICD-10 diagnosis Z00.6.

Effective for claims with dates of service on and after January 1, 2018, A/Medicare Administrative Contractors (MACs) shall line-item deny, and B/MACs shall line-item reject, PET claims

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for A9597 or A9598 that don't include the elements noted above as appropriate.

Contractors shall use the following messaging when line-item denying (Part A) or line item rejecting (Part B) PET claims containing HCPCS A9597 or A9598:

Remittance Advice Remark Codes (RARC) N386

Claim Adjustment Reason Code (CARC) 50, 96, and/or 119.

Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

(The above new verbiage will supersede any existing verbiage in chapter 13, section 60.3.2.)

100-4, Chapter-13, 60.13

Billing Requirements for PET Scans for Specific Indications of Cervical Cancer for Services Performed on or After January 28, 2005

Contractors shall accept claims for these services with the appropriate CPT® code listed in section 60.3.1. Refer to Pub. 100-03, section 220.6.17, for complete coverage guidelines for this new PET oncology indication. The implementation date for these CPT® codes will be April 18, 2005. Also see section 60.17, of this chapter for further claims processing instructions for cervical cancer indications.

100-4, Chapter-13, 60.14

Billing Requirements for PET Scans for Non-Covered Indications

For services performed on or after January 28, 2005, contractors shall accept claims with the following HCPCS code for non-covered PET indications:

-G0235: PET imaging, any site not otherwise specified Short Descriptor: PET not otherwise specified Type of Service:4

NOTE: This code is for a non-covered service.

100-4, Chapter-13, 60.15

Billing Requirements for CMS - Approved Clinical Trials and Coverage With Evidence Development Claims for PET Scans for Neurodegenerative Diseases, Previously Specified Cancer Indications, and All Other Cancer Indications Not Previously Specified

A/B MACs (A and B)

Effective for services on or after January 28, 2005, contractors shall accept and pay for claims for Positron Emission Tomography (PET) scans for lung cancer, esophageal cancer, colorectal cancer, lymphoma, melanoma, head & neck cancer, breast cancer, thyroid cancer, soft tissue sarcoma, brain cancer, ovarian cancer, pancreatic cancer, small cell lung cancer, and testicular cancer, as well as for neurodegenerative diseases and all other cancer indications not previously mentioned in this chapter, if these scans were performed as part of a Centers for Medicare & Medicaid (CMS)-approved clinical trial. (See Pub. 100-03, National Coverage Determinations (NCD) Manual, sections 220.6.13 and 220.6.17.)

Contractors shall also be aware that PET scans for all cancers not previously specified at Pub. 100-03, NCD Manual, section 220.6.17, remain nationally non-covered unless performed in conjunction with a CMS-approved clinical trial.

Effective for dates of service on or after June 11, 2013, Medicare has ended the coverage with evidence development (CED) requirement for FDG (2-[F18] fluoro-2-deoxy-Dglucose) PET and PET/computed tomography (CT) and PET/magnetic resonance imaging (MRI) for all oncologic indications contained in section 220.6.17 of the NCD Manual. Modifier -Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) or -Q1 (routine clinical service provided in a clinical research study that is in an approved clinical research study) is no longer mandatory for these services when performed on or after June 11, 2013.

A/B MACs (B) Only

A/B MACs (B) shall pay claims for PET scans for beneficiaries participating in a CMS approved clinical trial submitted with an appropriate current procedural terminology (CPT®) code from section 60.3.1 of this chapter and modifier Q0/Q1 for services performed on or after January 1, 2008, through June 10, 2013. (***NOTE:*** Modifier QR (Item or service provided in a Medicare specified study) and QA (FDA investigational device exemption) were replaced by modifier Q0 effective January 1, 2008.) Modifier QV (item or service provided as routine care in a Medicare qualifying clinical trial) was replaced by modifier Q1 effective January 1, 2008.) Beginning with services performed on or after June 11, 2013, modifier Q0/Q1 is no longer required for PET FDG services.

A/B MACs (A) Only

In order to pay claims for PET scans on behalf of beneficiaries participating in a CMS approved clinical trial, A/B MACs (A) require providers to submit claims with, if ICD-9- CM is applicable, ICD-9 code V70.7; if ICD-10-CM is applicable, ICD-10 code Z00.6 in the primary/secondary diagnosis position using the ASC X12 837 institutional claim format or on Form CMS-1450, with the appropriate principal diagnosis code and an appropriate CPT® code from section 60.3.1. Effective for PET scan claims for dates of service on or after January 28, 2005, through December 31, 2007, A/B MACs (A) shall accept claims with the QR, QV, or QA modifier on other than inpatient claims. Effective for services on or after January 1, 2008, through June 10, 2013, modifier Q0 replaced the QR and QA modifier, modifier Q1 replaced the QV modifier. Modifier Q0/Q1 is no longer required for services performed on or after June 11, 2013.

100-4, Chapter-13, 60.16

Billing and Coverage Changes for PET Scans Effective for Services on or After April 3, 2009

A. Summary of Changes

Effective for services on or after April 3, 2009, Medicare will not cover the use of FDG PET imaging to determine initial treatment strategy in patients with adenocarcinoma of the prostate.

Medicare will also not cover FDG PET imaging for subsequent treatment strategy for tumor types other than breast, cervical, colorectal, esophagus, head and neck (non-CNS/thyroid), lymphoma, melanoma, myeloma, non-small cell lung, and ovarian, unless the FDG PET is provided under the coverage

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with evidence development (CED) paradigm (billed with modifier -Q0/-Q1, see section 60.15 of this chapter).

Medicare will cover FDG PET imaging for initial treatment strategy for myeloma.

Effective for services performed on or after June 11, 2013, Medicare has ended the CED requirement for FDG PET and PET/CT and PET/MRI for all oncologic indications contained in section 220.6.17 of the NCD Manual. Effective for services on or after June 11, 2013, the Q0/Q1 modifier is no longer required.

Beginning with services performed on or after June 11, 2013, contractors shall pay for up to three (3) FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy (modifier PS) after completion of initial anti-cancer therapy (modifier PI) for the exact same cancer diagnosis.

Coverage of any additional FDG PET scans (that is, beyond 3) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-tumor therapy for the same cancer diagnosis will be determined by the A/B MACs (A or B). Claims will include the KX modifier indicating the coverage criteria is met for coverage of four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis under this NCD.

A different cancer diagnosis whether submitted with a PI or a PS modifier will begin the count of one initial and three subsequent FDG PET scans not requiring the KX modifier and four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis requiring the KX modifier.

NOTE: The presence or absence of an initial treatment strategy claim in a beneficiary's record does not impact the frequency criteria for subsequent treatment strategy claims for the same cancer diagnosis.

NOTE: Providers please refer to the following link for a list of appropriate diagnosis codes, http://cms.gov/medicare/coverage/determinationprocess/downloads/petforsolidtumorsonc ologicdxcodesattachment_NCD220_6_17.pdf

For further information regarding the changes in coverage, refer to Pub.100-03, NCD Manual, section 220.6.17.

B. Modifiers for PET Scans

Effective for claims with dates of service on or after April 3, 2009, the following modifiers have been created for use to inform for the **initial treatment strategy** of biopsy-proven or strongly suspected tumors or **subsequent treatment strategy** of cancerous tumors:

PI Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.

Short descriptor: PET tumor init tx strat

PS Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treatment physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

Short descriptor: PS - PET tumor subsq tx strategy

C. Billing for A/B MACs (A and B)

Effective for claims with dates of service on or after April 3, 2009, contractors shall accept FDG PET claims billed to inform **initial treatment strategy** with the following CPT® codes **AND** modifier PI: 78608, 78811, 78812, 78813, 78814, 78815, 78816.

Effective for claims with dates of service on or after April 3, 2009, contractors shall accept FDG PET claims with modifier PS for the **subsequent treatment strategy** for solid tumors using a CPT® code above **AND** a cancer diagnosis code.

Contractors shall also accept FDG PET claims billed to **inform initial treatment strategy or subsequent treatment strategy** when performed under CED with one of the PET or PET/CT CPT® codes above **AND** modifier PI **OR** modifier PS **AND** a cancer diagnosis code **AND** modifier Q0/Q1. Effective for services performed on or after June 11, 2013, the CED requirement has ended and modifier Q0/Q1, along with condition code 30 (institutional claims only), or ICD-9 code V70.7, (both institutional and practitioner claims) are no longer required.

D. Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for dates of service on or after April 3, 2009, contractors shall **return as unprocessable/return to provider** claims that do not include the PI modifier with one of the PET/PET/CT CPT® codes listed in subsection C. above when billing for the **initial treatment strategy** for solid tumors in accordance with Pub.100-03, NCD Manual, section 220.6.17.

In addition, contractors shall **return as unprocessable/return to provider** claims that do not include the PS modifier with one of the CPT® codes listed in subsection C. above when billing for the **subsequent treatment strategy** for solid tumors in accordance with Pub.100-03, NCD Manual, section 220.6.17.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4

RARC: MA130

MSN: N/A

Effective for claims with dates of service on or after April 3, 2009, through June 10, 2013, contractors shall **return as unprocessable/return to provider** FDG PET claims billed to **inform initial treatment strategy or subsequent treatment strategy** when performed under CED without one of the PET/PET/CT CPT® codes listed in subsection C. above **AND** modifier PI **OR** modifier PS **AND** a cancer diagnosis code **AND** modifier Q0/Q1.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4

RARC: MA130

MSN: N/A

Effective April 3, 2009, contractors shall deny claims with ICD-9/ICD-10 diagnosis code 185/C61 for FDG PET

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imaging for the initial treatment strategy of patients with adenocarcinoma of the prostate.

For dates of service prior to June 11, 2013, contractors shall also **deny** claims for FDG PET imaging for **subsequent treatment strategy** for tumor types other than breast, cervical, colorectal, esophagus, head and neck (non-CNS/ thyroid), lymphoma, melanoma, myeloma, non-small cell lung, and ovarian, unless the FDG PET is provided under CED (submitted with the Q0/Q1 modifier) and use the following messages:

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO

CARC: 50

RARC: N/A

MSN: 15.4

Effective for dates of service on or after June 11, 2013, contractors shall use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the KX modifier is not included, identified by CPT® codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier PS, HCPCS A9552, and the same cancer diagnosis code.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR (if claim is received with a GA modifier) otherwise CO

CARC: 96

RARC: N435

MSN: 23.17

100-4, Chapter-13, 60.17

Billing and Coverage Changes for PET Scans for Cervical Cancer Effective for Services on or After November 10, 2009

A. Billing Changes for A/B MACs (A and B)

Effective for claims with dates of service on or after November 10, 2009, contractors shall accept FDG PET oncologic claims billed to inform initial treatment strategy; specifically for staging in beneficiaries who have biopsy-proven cervical cancer when the beneficiary's treating physician determines the FDG PET study is needed to determine the location and/or extent of the tumor as specified in Pub. 100-03, section 220.6.17.

EXCEPTION: CMS continues to non-cover FDG PET for initial diagnosis of cervical cancer related to initial treatment strategy.

NOTE: Effective for claims with dates of service on and after November 10, 2009, the – Q0 modifier is no longer necessary for FDG PET for cervical cancer.

B. Medicare Summary Notices, Remittance Advice Remark Codes, and Claim

Adjustment Reason Codes

Additionally, contractors shall return as unprocessable / return to provider for FDG PET for cervical cancer for initial treatment strategy billed without the following: one of the PET/PET/CT CPT® codes listed in 60.16 C above **AND** modifier PI **AND** a cervical cancer diagnosis code.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4

RARC: MA130

MSN: N/A

100-4, Chapter-13, 60.18

Billing and Coverage Changes for PET (NaF-18) Scans to Identify Bone Metastasis of Cancer Effective for Claims With Dates of Services on or After February 26, 2010

A. Billing Changes for A/B MACs (A and B)

Effective for claims with dates of service on and after February 26, 2010, contractors shall pay for NaF-18 PET oncologic claims to inform of initial treatment strategy (PI) or subsequent treatment strategy (PS) for suspected or biopsy proven bone metastasis **ONLY** in the context of a clinical study and as specified in Pub. 100-03, section 220.6. All other claims for NaF-18 PET oncology claims remain non-covered.

B. Medicare Summary Notices, Remittance Advice Remark Codes, and Claim Adjustment Reason Codes

Effective for claims with dates of service on or after February 26, 2010, contractors shall return as unprocessable NaF-18 PET oncologic claims billed with **modifier TC or globally (for A/B MACs (A) modifier TC or globally does not apply)** and HCPCS A9580 to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that do not include ALL of the following:

- PI or PS modifier AND
- PET or PET/CT CPT® code (78811, 78812, 78813, 78814, 78815, 78816) AND
- Cancer diagnosis code AND
- Q0 modifier - Investigational clinical service provided in a clinical research study, are present on the claim.

NOTE: For institutional claims, continue to include ICD-10 diagnosis code Z00.6 and condition code 30 to denote a clinical study.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two

Group Code: CO

CARC: 4

RARC: MA130

MSN: N/A

Effective for claims with dates of service on or after February 26, 2010, contractors shall accept PET oncologic claims billed with **modifier 26** and modifier KX to inform the initial treatment

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strategy or subsequent treatment strategy for bone metastasis that include the following:

- PI or PS modifier AND
- PET or PET/CT CPT® code (78811, 78812, 78813, 78814, 78815, 78816) AND
- Cancer diagnosis code AND
- Q0 modifier - Investigational clinical service provided in a clinical research study, are present on the claim.

NOTE: If modifier KX is present on the professional component service, Contractors shall process the service as PET NaF-18 rather than PET with FDG.

Contractors shall also return as unprocessable NaF-18 PET oncologic professional component claims (i.e., claims billed with modifiers 26 and KX) to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis billed with HCPCS A9580.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 4

RARC: MA130

MSN: N/A

NOTE: Effective for claims with dates of service on or after 12/15/2017, HCPCS code A9580 (NaF-18) is nationally non-covered.

100-4, Chapter-13, 140

Bone Mass Measurements (BMMs)

Sections 1861(s)(15)and (rr)(1)of the Social Security Act (the Act) (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardize Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This coverage is effective for claims with dates of service furnished on or after July 1, l998.

Effective for dates of service on and after January 1, 2007, the CY 2007 Physician Fee Schedule final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry as it is not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act. Finally, it required that in the case of monitoring and confirmatory baseline BMMs, they be performed with a dual-energy X-ray absorptiometry (axial) test.

Conditions of Coverage for BMMs are located in Pub.100-02, Medicare Benefit Policy Manual, chapter 15.

100-4, Chapter-14, 40.3

Payment for Intraocular Lens (IOL)

Prior to January 1, 2008, payment for facility services furnished by an ASC for IOL insertion during or subsequent to cataract surgery includes an allowance for the lens. The procedures that include insertion of an IOL are:

Payment Group 6: CPT®-4 Codes 66985 and 66986

Payment Group 8: CPT®-4 Codes 66982, 66983 and 66984

Physicians or suppliers are not paid for an IOL furnished to a beneficiary in an ASC after July 1, 1988. Separate claims for IOLs furnished to ASC patients beginning March 12, 1990 are denied. Also, effective March 12, 1990, procedures 66983 and 66984 are treated as single procedures for payment purposes.

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare ASC payment for the associated surgical procedure. Consequently, no separate payment for the IOL is made, except for a payment adjustment for NTIOLs established according to the process outlined in 42 CFR 416.185. ASCs should not report separate charges for conventional IOLs because their payment is included in the Medicare payment for the associated surgical procedure. The ASC payment system logic that excluded $150 for IOLs for purposes of the multiple surgery reduction in cases of cataract surgery prior to January 1, 2008 no longer applies, effective for dates of service on or after January 1, 2008.

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare pays an additional $50 for specified Category 3 NTIOLs that are provided in association with a covered ASC surgical procedure. The list of Category 3 NTIOLS is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ASCPayment/NTIOLs.html

ASCs should use HCPCS code Q1003 to bill for a Category 3 NTIOL. HCPCS code Q1003, along with one of the approved surgical procedure codes (CPT® codes 66982, 66983, 66984, 66985, 66986) are to be used on all NTIOL Category 3 claims associated with reduced spherical aberration from February 27, 2006, through February 26, 2011. The payment adjustment for the NTIOL is subject to beneficiary coinsurance but is not wage-adjusted.

Any subsequent IOL recognized by CMS as having the same characteristics as the first NTIOL recognized by CMS for a payment adjustment as a Category III NTIOL (those of reduced spherical aberration) will receive the same adjustment for the remainder of the 5- year period established by the first recognized IOL.

100-4, Chapter-14, 40.8

Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008

Contractors pay ASCs a reduced amount for certain specified procedures when a specified device is furnished without cost or for which either a partial or full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include modifier –FB on the procedure code when a specified device is furnished without cost or for which full credit is received. If the ASC receives a partial credit of 50 percent or more of the cost of a specified device, the ASC is required to include modifier –FC on the procedure code if the procedure is on the list of specified procedures to which the -FC reduction applies. A single procedure code should not be submitted with both modifiers –FB and -FC. The pricing determination related to modifiers –FB and -FC is made prior to the application of multiple procedure payment reductions. Contractors adjust beneficiary coinsurance to reflect the reduced payment amount. Tables listing the procedures and devices to which the payment adjustments apply, and the full and partial adjustment amounts, are available on the CMS Web site.

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In order to report that the receipt of a partial credit of 50 percent or more of the cost of a device, ASCs have the option of either: 1) Submitting the claim for the procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgement of credit for a specified device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or 2) holding the claim for the procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with modifier –FC appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the device. If choosing the first billing option, to request a claims adjustment once the credit determination is made, ASCs should keep in mind that the initial Medicare payment for the procedure involving the device is conditional and subject to adjustment.

100-4, Chapter-14, 40.9

Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively.

Effective for dates of service on and after January 1, 2008, when inserting an approved A-C IOL in an ASC concurrent with cataract extraction, HCPCS code V2787 (Astigmatism-correcting function of intraocular lens) should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens.

Additionally, note that HCPCS code V2788 (Presbyopia-correcting function of intraocular lens) is no longer valid to report non-covered charges associated with the A-C IOL. However, this code continues to be valid to report non-covered charges for a P-C IOL. The payment for the conventional lens portion of the A-C IOL and P-C IOL continues to be bundled with the ASC procedure payment.

Effective for services on and after January 1, 2010, ASCs are to bill for insertion of a Category 3 new technology intraocular lens (NTIOL) that is also an approved A-C IOL or P-C IOL, concurrent with cataract extraction, using three separate codes. ASCs shall use HCPCS code V2787 or V2788, as appropriate, to report charges associated with the non-covered functionality of the A-C IOL or P-C IOL, the appropriate HCPCS code 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage); 66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)); or 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)), to report the covered cataract extraction and insertion procedure; and Q1003 (New technology, intraocular lens, category 3 (reduced spherical aberration) as defined in Federal Register notice, Vol. 65, dated May 3, 2000) to report the covered NTIOL aspect of the lens on claims for insertion of an A-C IOL or P-C IOL that is also designated as an NTIOL. Listings of the CMS-approved Category 3 NTIOLs, A-C IOLs, and P-C IOLs are available on the CMS Website.

100-4, Chapter-14, 60.1

Applicable Messages for NTIOLs

Contractors shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in 40.3.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 16

RARC: M67

MSN: N/A

Contractors shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 58

RARC: N/A

MSN: 16.2

Contractors shall deny payment for Q1003 if billed by an entity other than a Medicare approved ASC.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 170

RARC: N/A

MSN: 33.1

Contractors shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 27

RARC: N/A

MSN: 21.11

A/B MACs (B) shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC.

The contractor shall use the following remittance advice messages and associated codes when denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 58

RARC: N/A

MSN: 16.2

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100-4, Chapter-15, 10.4

Additional Introductory Guidelines

Since April 1, 2002 (the beginning of the transition to the full implementation of the ambulance fee schedule), payment for a medically necessary ambulance service is based on the level of service provided, not on the vehicle used.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building. See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 10.3.3 - Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service for further details. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing, section 10.5 - Hospital Inpatient Bundling for additional information on hospital inpatient bundling of ambulance services. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 - Inpatient Hospital Billing for the definitions of an inpatient for the various inpatient facility types. All Prospective Payment Systems (PPS) have a different criteria for determining when ambulance services are payable (i.e., during an interrupted stay, on date of admission and date of discharge).

NOTE: The cost of oxygen and its administration in connection with and as part of the ambulance service is covered. Under the ambulance FS, oxygen and other items and services provided as part of the transport are included in the FS base payment rate and are NOT separately payable.

The A/B MAC (A) is responsible for the processing of claims for ambulance services furnished by a hospital based ambulance or for ambulance services provided by a supplier if provided under arrangements for an inpatient. The A/B MAC (B) is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. See section 10.2 below for further clarification of the definition of Providers and Suppliers of ambulance services.

Effective December 21, 2000, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH are paid on a reasonable cost basis, but only if the CAH or entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH or entity. Beginning February 24, 1999, ambulance transports to or from a non-hospital-based dialysis facility, origin and destination modifier "J," satisfy the program's origin and destination requirements for coverage.

Ambulance supplier services furnished under arrangements with a provider, e.g., hospital or SNF are typically not billed by the supplier to its A/B MAC (B), but are billed by the provider to its A/B MAC (A). The A/B MAC (A) is responsible for determining whether the conditions described below are met. In cases where all or part of the ambulance services are billed to the A/B MAC (B), the A/B MAC (B) has this responsibility, and the A/B MAC (A) shall contact the A/B MAC (B) to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the A/B MAC (A) should accept the A/B MAC (B)'s determination without pursuing its own investigation.

Where a provider furnishes ambulance services under arrangements with a supplier of ambulance services, such services can be covered only if the supplier's vehicles and crew meet the certification requirements applicable for independent ambulance suppliers.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, if ambulance claims submitted with a code(s) that is/are not separately billable the payment for the code(s) is included in the base rate.

Contractors shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO

CARC: 97

RARC: N390

MSN: 1.6

This is true whether the primary transportation service is allowed or denied. When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

Payment for ambulance services may be made only on an assignment related basis.

Prospective payment systems, including the Ambulance Fee Schedule, are exempt from Inherent Reasonableness provisions.

100-4, Chapter-15, 20.1.4

Components of the Ambulance Fee Schedule

The mileage rates provided in this section are the base rates that are adjusted by the yearly ambulance inflation factor (AIF). The payment amount under the fee schedule is determined as follows:

- **For ground ambulance services,** the fee schedule amount includes:
  1. A money amount that serves as a nationally uniform base rate, called a "conversion factor" (CF), for all ground ambulance services;
  2. A relative value unit (RVU) assigned to each type of ground ambulance service;
  3. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (geographic practice cost index (GPCI));

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4. A nationally uniform loaded mileage rate;
5. An additional amount for certain mileage for a rural point-of-pickup; and
6. For specified temporary periods, certain additional payment amounts as described in section 20.1.4A, below.

- **For air ambulance services**, the fee schedule amount includes:
  1. A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
  2. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (GPCI);
  3. A nationally uniform loaded mileage rate for each type of air service; and
  4. A rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup

A. Ground Ambulance Services

1. Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF is updated annually by the ambulance inflation factor and for other reasons as necessary.

2. Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, e.g., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

The RVUs are as follows:

Service Level	RVU
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

3. Geographic Adjustment Factor (GAF)

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services. The GAF for the ambulance FS uses the non-facility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the ambulance FS are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance (POP) establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the POP establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70 percent of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the ground mileage rate.

4. Mileage

In the context of all payment instructions, the term "mileage" refers to loaded mileage. The ambulance FS provides a separate payment amount for mileage. The mileage rate per statute mile applies for all types of ground ambulance services, except Paramedic Intercept, and is provided to all Medicare contractors electronically by CMS as part of the ambulance FS. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

5. Adjustment for Certain Ground Mileage for Rural Points of Pickup (POP)

The payment rate is greater for certain mileage where the POP is in a rural area to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period.

If the POP is a rural ZIP Code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. For loaded miles 1-17, the rural adjustment for ground mileage is 1.5 times the rural mileage allowance.

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).

The following chart summarizes the above information:

Service	Dates of Service	Bonus	Calculation
Loaded miles 1-17, Rural POP	Beginning 4/1/02	50%	FS Rural mileage * 1.5
Loaded miles 18-50, Rural POP	4/1/02 – 12/31/03	25%	FS Rural mileage * 1.25
All loaded miles (Urban or Rural POP) 51+	7/1/04 – 12/31/08	25%	FS Urban or Rural mileage * 1.25

The POP, as identified by ZIP Code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the ZIP Code of the POP establishes whether a rural adjustment applies to such second (or subsequent) transport.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service (USPS) ZIP Code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or in New England, a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith modification." (The Goldsmith modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical

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features that they are more rural than urban in character and lack easy geographic access to health services.)

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;
- It is located outside of an MSA or NECMA; or
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.

See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 –Ambulance Services, section 30.1.1 –Ground Ambulance Services for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable FS amount for mileage. Thus, when rural mileage is involved, the contractor compares the calculated FS rural mileage payment rate to the provider's/supplier's actual charge for mileage and pays the lesser amount.

The CMS furnishes the ambulance FS files to claims processing contractors electronically. A version of the Ambulance Fee Schedule is also posted to the CMS website (http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp) for public consumption. To clarify whether a particular ZIP Code is rural or urban, please refer to the most recent version of the Medicare supplied ZIP Code file.

6. Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground ambulance transports is subject to a minimum amount. This minimum amount depends upon the area of the country in which the service is furnished. The country is divided into 9 census divisions and each of the census divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national rate and the regional rate in accordance with the following schedule:

Year	National FS Percentage	Regional FS Percentage
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 – CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. Note that this provision affects only the FS portion of the blended transition payment rate. This floor amount is calculated by CMS centrally and is incorporated into the FS amount that appears in the FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare B/MAC or A/MAC in order to implement this provision.

7. Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports

For services furnished during the period July 1, 2004 through December 31, 2010, the base rate portion of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by a percentage amount determined by CMS. Section 3105 (c) and 10311 (c) of the Affordable Care Act amended section 1834 (1) (13) (A) of the Act to extend this rural bonus for an additional year through December 31, 2010. This increase applies if the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. CMS will determine this bonus amount and the designated POP rural ZIP Codes in which the bonus applies. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a "B" indicator on the national ZIP Code file. Contractors must apply the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP Codes.

Subsequently, section of 106 (c) of the MMEA again amended section 1843 (l) (13) (A) of the Act to extend the rural bonus an additional year, through December 31, 2011.

8. Adjustments for FS Payment Rates for Ground Ambulance Transports

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006 as well as July 1, 2008 through December 31, 2010. For ground ambulance transport services furnished where the POP is urban, the rates are increased by 1 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. For ground ambulance transport services furnished where the POP is rural, the rates are increased by 2 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010. Subsequently, section 106 (a) of the Medicare and Medicaid Extenders Act of 2010 (MMEA) again amended section 1834 (1) (12) (A) of the Act to extend the payment increases for an additional year, through December 31, 2011. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that became effective on July 1, 2004 as well as the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 changes that became effective July 1, 2008 and were extended by the Patient Protection and Affordable Care Act of 2010 and the Medicare and Medicaid Extenders Act of 2010 (MMEA).

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Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA, MIPPA and MMEA

Service	Effective Dates	Payment Increase*
All rural miles	7/1/04 - 12/31/06	2%
All rural miles	7/1/08 – 12/31/11	3%
Rural miles 51+	7/1/04 - 12/31/08	25% **
All urban miles	7/1/04 - 12/31/06	1%
All urban miles	7/1/08 – 12/31/11	2%
Urban miles 51+	7/1/04 - 12/31/08	25% **
All rural base rates	7/1/04 - 12/31/06	2%
All rural base rates	7/1/08 – 12/31/11	3%
Rural base rates (lowest quartile)	7/1/04 - 12/31/11	22.6 %**
All urban base rates	7/1/04 - 12/31/06	1%
All urban base rates	7/1/08 – 12/31/11	2%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

NOTES: *All payments are percentage increases and all are cumulative.

**Contractor systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file.

B. Air Ambulance Services

1. Base Rates

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services.

2. Geographic Adjustment Factor (GAF)

The GAF, as described above for ground ambulance services, is also used for air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50 percent of each of the base rates (fixed and rotary wing).

3. Mileage

The FS for air ambulance services provides a separate payment for mileage.

4. Adjustment for Services Furnished in Rural Areas

The payment rates for air ambulance services where the POP is in a rural area are greater than in an urban area. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted FS amount, e.g., the applicable air service base rate multiplied by the GAF plus the mileage amount or, in other words, 1.5 times both the applicable air service base rate and the total mileage amount.

The basis for a rural adjustment for air ambulance services is determined in the same manner as for ground services. That is, whether the POP is within a rural ZIP Code as described above for ground services.

100-4, Chapter-15, 20.2

Payment for Mileage Charges

Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to his/her arrival at destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes his basic charge for ambulance services and his rate for loaded mileage. Suppliers should be notified that separate charges for unloaded mileage will be denied.

Instructions on billing mileage are found in §30.

100-4, Chapter-15, 20.3

Air Ambulance

Refer to IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 - Ambulance Services, section 10.4 – Air Ambulance Services, and section 30.1.2 – Definitions of Air Ambulance Services for additional information on the coverage and definitions of air ambulance services. Under certain circumstances, transportation by airplane or helicopter may qualify as covered ambulance services. If the conditions of coverage are met, payment may be made for the air ambulance services.

Air ambulance services are paid at different rates according to two air ambulance categories:

- **AIR** ambulance service, conventional air services, transport, one way, **fixed wing** (FW) (HCPCS code A0430)
- **AIR** ambulance service, conventional air services, transport, one way, **rotary wing** (RW) (HCPCS code A0431)

Covered air ambulance mileage services are paid when the appropriate HCPCS code is reported on the claim:

- HCPCS code A0435 identifies FIXED WING AIR MILEAGE
- HCPCS code A0436 identifies ROTARY WING AIR MILEAGE

Effective for claims with dates of service on or after January 1, 2011, air mileage must be reported in fractional numbers of loaded statute miles flown. Contractors must ensure that the appropriate air transport code is used with the appropriate mileage code.

Air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician's office, or a patient's home may not be paid air ambulance. The destination is identified by the use of an appropriate modifier As defined in Section 30(A) of this chapter.

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing. Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions;
- Hazardous weather; or
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 –Intermediary MR Guidelines for Specific Services contains instructions for Medical Review of Air Ambulance Services.

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100-4, Chapter-15, 20.6

Payment for Non-Emergency Trips to/from ESRD Facilities

Section 637 of the American Taxpayer Relief Act of 2012 requires that, effective for transports occurring on and after October 1, 2013, fee schedule payments for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment be reduced by 10%. The payment reduction affects transports (base rate and mileage) to and from hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. Non-emergency BLS ground transports are identified by Healthcare Common Procedure Code System (HCPCS) code A0428. Ambulance transports to and from renal dialysis treatment are identified by modifier codes "G" (hospital-based ESRD) and "J" (freestanding ESRD facility) in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier. (See Section 30 (A) for information regarding modifiers specific to ambulance.)

Effective for claims with dates of service on and after October 1, 2013, the 10% reduction will be calculated and applied to HCPCS code A0428 when billed with modifier code "G" or "J". The reduction will also be applied to any mileage billed in association with a non-emergency transport of a beneficiary with ESRD to and from renal dialysis treatment. BLS mileage is identified by HCPCS code A0425.

The 10% reduction will be taken after calculation of the normal fee schedule payment amount, including any add-on or bonus payments, and will apply to transports in rural and urban areas as well as areas designated as "super rural".

Payment for emergency transports is not affected by this reduction. Payment for non-emergency BLS transports to other destinations is also not affected. This reduction does not affect or change the Ambulance Fee Schedule.

NOTE: The 10% reduction applies to beneficiaries with ESRD that are receiving non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, contractors have discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.

Section 53108 of the Bipartisan Budget Act of 2018 increased the amount of the reduction described above to 23% for transports occurring on and after October 1, 2018.

100-4, Chapter-15, 30.1.2

Coding Instructions for Paper and Electronic Claim Forms

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Except as otherwise noted, beginning with dates of service on or after January 1, 2001, the following coding instructions must be used.

Origin

Electronic billers should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup). Beginning with the early implementation of version 5010 of the ASC X12 837 professional claim format on January 1, 2011, electronic billers are required to submit, in addition to the loaded ambulance trip's origin information (e.g., the ZIP Code of the point of pickup), the loaded ambulance trip's destination information (e.g., the ZIP code of the point of drop-off). Refer to the appropriate Implementation Guide to determine how to report the destination information. Only the ZIP Code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off. However, the point of drop-off is an additional reporting requirement on version 5010 of the ASC X12 837 professional claim format.

Where the CMS-1500 Form is used the ZIP code is reported in item 23. Since the ZIP Code is used for pricing, more than one ambulance service may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP Code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP Codes.

Claims without a ZIP Code in item 23 on the CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 16

RARC: N53

MSN: N/A

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

Mileage

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

Beginning with dates of service on or after January 1, 2011, mileage billed must be reported as fractional units in the following situations:

- Where billing is by ASC X12 claims transaction (professional or institutional), and
- Where billing is by CMS-1500 paper form.

Electronic billers should see the appropriate Implementation Guide to determine where to report the fractional units. Item 24G of the Form CMS-1500 paper claim is used.

Fractional units are not required on Form CMS-1450.

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For trips totaling up to 100 covered miles suppliers must round the total miles up to the nearest tenth of a mile and report the resulting number with the appropriate HCPCS code for ambulance mileage. The decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling up to 100 covered miles and greater, suppliers must report mileage rounded up to the next whole number mile without the use of a decimal (e.g., 998.5 miles should be reported as 999).

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

For mileage HCPCS billed on the ASC X12 837 professional transaction or the CMS-1500 paper form only, contractors shall automatically default to "0.1" units when the total mileage units are missing.

Multiple Patients on One Trip

Ambulance suppliers submitting a claim using the ASC X12 professional format or the CMS1500 paper form for an ambulance transport with more than one patient onboard must use the "GM" modifier ("Multiple Patients on One Ambulance Trip") for each service line item. In addition, suppliers are required to submit documentation to A/B MACs (Part B) to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the Medicare beneficiary identifiers for each Medicare beneficiary. A/B/MACs (Part B) shall calculate payment amounts based on policy instructions found in Pub.100-02, Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.

Ambulance claims submitted on or after January 1, 2011, in version 5010 of the ASC X12 837 professional claim format require the presence of a diagnosis code and the absence of diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. The presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the presence (or absence) of a diagnosis code, but a diagnosis code is required on the ASC X12 837 professional claim format.

100-4, Chapter-15, 30.2.4

Non-covered Charges on Institutional Ambulance Claims

Medicare law contains a restriction that miles beyond the closest available facility cannot be billed to Medicare. Non-covered miles beyond the closest facility are billed with HCPCS procedure code A0888 ("non-covered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility"). These non-covered line items can be billed on claims also containing covered charges. Ambulance claims may use the –GY modifier on line items for such non-covered mileage, and liability for the service will be assigned correctly to the beneficiary.

The method of billing all miles for the same trip, with covered and non-covered portions, on the same claim is preferable in this scenario. However, billing the non-covered mileage using condition code 21 claims is also permitted, if desired, as long as all line items on the claims are non-covered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories but excepting some points in Canada and Mexico in some cases, mileage is also statutorily excluded from Medicare coverage. Such billings are more likely to be submitted on entirely non-covered claims using condition code 21. This scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

Another scenario in which billing non-covered mileage to Medicare may occur is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. The –QL modifier should be used on the base rate line in this scenario, in place of origin and destination modifiers, and the line is submitted with covered charges. The –QL modifier should also be used on the accompanying mileage line, if submitted, with non-covered charges. Submitting this non-covered mileage line is optional for providers.

Non-covered charges may also apply is if there is a subsidy of mileage charges that are never charged to Medicare. Because there are no charges for Medicare to share in, the only billing option is to submit non-covered charges, if the provider bills Medicare at all (it is not required in such cases). These non-covered charges are unallowable, and should not be considered in settlement of cost reports. However, there is a difference in billing if such charges are subsidized, but otherwise would normally be charged to Medicare as the primary payer. In this latter case, CMS examination of existing rules relating to grants policy since October 1983, supported by Federal regulations (42CFR 405.423), generally requires providers to reduce their costs by the amount of grants and gifts restricted to pay for such costs. Thereafter, section 405.423 was deleted from the regulations.

Thus, providers were no longer required to reduce their costs for restricted grants and gifts, and charges tied to such grants/gifts/subsidies should be submitted as covered charges. This is in keeping with Congress's intent to encourage hospital philanthropy, allowing the provider receiving the subsidy to use it, and also requiring Medicare to share in the unreduced cost. Treatment of subsidized charges as non-covered Medicare charges serves to reduce Medicare payment on the Medicare cost report contrary to the 1983 change in policy.

Medicare requires the use of the –TQ modifier so that CMS can track the instances of the subsidy scenario for non-covered charges. The –TQ should be used whether the subsidizing entity is governmental or voluntary. The -TQ modifier is not required in the case of covered charges submitted when a subsidy has been made, but charges are still normally made to Medicare as the primary payer.

If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider covered charges occurring in the subsidy case, since Medicare had previous billing instructions that stated all charges in the case of a subsidy, not just charges when the entity providing the subsidy never charges another entity/primary payer, should be submitted as non-covered charges, they may contact their A/B MAC (A) about reopening the reports in question for which the time period in 42 CFR 405.1885 has not expired. A/B MACs (A) have the discretion to determine if the amount in question warrants reopening. The CMS does not expect many such cases to occur.

Billing requirements for all these situations, including the use of modifiers, are presented in the chart below:

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Mileage Scenario	HCPCS	Modifiers*	Liability	Billing	Remit. Requirements	MSN Message
STATUTE: Miles beyond closest facility, OR **Pick up point outside of U.S.	A0888 on line item for the non-covered mileage	-QM or –QN, origin/ destination modifier, and –GY unless condition code 21 claim used	Beneficiary	Bill mileage line item with A0888 –GY and other modifiers as needed to establish liability, line item will be denied; OR bill service on condition code 21 claim, no –GY required, claim will be denied	Group code PR, reason code 96	16.10 "Medicare does not pay for this item or service"; OR, "Medicare no paga por este artículo o servicio"
Beneficiary dies after ambulance is called	Most appropriate ambulance HCPCS mileage code (i.e., ground, air)	–QL unless condition code –21 claim	Provider	Bill mileage line item with –QL as non-covered, line item will be denied	Group Code CO, reason code 96	16.58 "The provider billed this charge as non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."
Subsidy or government owned Ambulance, Medicare NEVER billed***	A0888 on line item for the non-covered mileage	-QM or –QN, origin/ destination modifier, and -TQ must be used for policy purposes	Provider	Bill mileage line item with A0888, and modifiers as non-covered, line item will be denied	Group Code CO, reason code 96	16.58 "The provider billed this charge as non-covered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

*Current ambulance billing requirements state that either the –QM or –QN modifier must be used on services. The –QM is used when the "ambulance service is provided under arrangement by a provider of services," and the –QN when the "ambulance service is provided directly by a provider of services." Line items using either the –QM or–QN modifiers are not subject to the FISS edit associated with FISS reason code 31322 so that these lines items will process to completion. Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination, and are not non-covered by definition.

** This is the one scenario where the base rate is not paid in addition to mileage, and there are certain exceptions in Canada and Mexico where mileage is covered as described in existing ambulance instructions.

***If Medicare would normally have been billed, submit mileage charges as covered charges despite subsidies.

Medicare systems may return claims to the provider if they do not comply with the requirements in the table.

100-4, Chapter-15, 40

Medical Conditions List and Instructions

See http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html for a medical conditions list and instructions to assist ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service.

In addition to reporting one of the medical conditions on the claim, one of the transportation indicators may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim. Information on the appropriate use of transportation indicators is also available at http://www.cms.gov/Center/ProviderType/Ambulances-Services-Center.html.

100-4, Chapter-16, 60.1.4

Coding Requirements for Specimen Collection

The following HCPCS codes and terminology must be used:

- 36415 - Collection of venous blood by venipuncture.
- G0471 - Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)
- P9615 - Catheterization for collection of specimen(s).

The allowed amount for specimen collection in each of the above circumstances is included in the laboratory fee schedule distributed annually by CMS.

100-4, Chapter-16, 60.2

Travel Allowance

Section 1833(h)(3)(B) of the Act states that the Secretary shall provide for and establish a fee in addition to the payment

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amounts for CDLTs on the CLFS to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample.

Travel Allowance Eligibility

CMS pays a travel allowance when the specimen collection fee is paid. Requirements regarding payment for specimen collection are described in Section 60.1 above and CFR § 414.523(a)(1). These requirements must be met for the travel allowance to be payable.

Travel for simple pickup of specimens or for specimen collection that does not require the services of trained technicians should not be considered in the calculation of the travel allowance. This means that the travel allowance amount may be paid only if a specimen collection fee is also payable; for example, no travel allowance would be paid if a trained technician merely performs a messenger service to pick up a specimen drawn by other technicians.

The travel allowance may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital), such that travel allowance may only be paid when a trained technician draws a specimen from a patient who either is in an inpatient facility that is not a hospital or is a homebound patient.

Only one travel allowance payment may be made for specimen collection for a Medicare beneficiary based on the beneficiary's location, and only when a Medicare beneficiary requires the collection of a specimen necessary for performance of CDLTs.

Only Medicare patients should be considered in the calculation and payment of the travel allowance, as the statutory language states "the location of an individual," that is, the location of a Medicare beneficiary receiving specimen collection services. Non-Medicare patients should not be included in any portion of the calculation of the travel allowance.

Travel Allowance Eligible Miles

For the purposes of travel allowance for specimen collection, eligible miles are those miles traveled that may be included in the calculation to determine the travel allowance amount.

Eligible miles begin at the laboratory or the starting point of the trained technician's travel for specimen collection and end at the laboratory or the ending point of the trained technician's travel for specimen collection. A trained technician's travel for specimen collection from Medicare beneficiaries may begin at a laboratory or at a location other than the laboratory. Therefore, eligible miles begin at the laboratory or the starting point of the trained technician's travel for specimen collection. Additionally, a trained technician's travel for specimen collection from Medicare beneficiaries may end at a laboratory or at a location other than the laboratory. Therefore, eligible miles end at the laboratory or the ending point of the trained technician's travel for specimen collection.

Eligible miles do not include miles traveled for any purpose unrelated to specimen collection, such as collecting specimens from non-Medicare beneficiaries or for personal reasons. Therefore, any miles traveled to a location where no specimens are collected, such as to the location of a non-Medicare beneficiary for specimen collection, to a Medicare beneficiary where no specimen collection occurs, or for personal purposes, are excluded from the calculation of eligible miles.

Effective January 1, 2022, CMS has made permanent the option for laboratories to maintain electronic documentation of miles traveled for the purposes of covering the transportation and personnel expenses for trained technicians to travel to the location of an individual to collect a specimen sample. This option for laboratories to maintain electronic documentation applies to specimen collection for any CDLT. Laboratories may utilize electronic and/or other documentation in order to demonstrate miles traveled for the purposes of specimen collection. Laboratories need to be able to produce electronic documentation in a form and manner that can be shared with MACs and should continue to consult with their local MACs regarding the format and process for submission of this information if necessary.

Travel Allowance Mileage Rate

The Act requires the travel allowance to cover both the "transportation" and "personnel expenses" for trained personnel to travel to the location of an individual to collect a sample. The travel allowance mileage rate reflects both of these components.

The "transportation" component of the travel allowance mileage rate equals the IRS standard mileage rate. The IRS updates and issues standard mileage rates on a periodic basis, generally annually and are used to calculate the deductible costs of operating an automobile for business, charitable, medical, or moving for the purpose of calculating Federal taxes.

The "personnel expenses" component of the travel allowance mileage rate where the trained technician's personnel expenses is based on a wages-per-mile amount. Effective January 1, 2023, CMS uses wage data in the Bureau of Labor Statistics BLS-defined category of phlebotomist to establish the personnel expense component of the travel allowance mileage rate. Specifically, CMS uses the latest available published figure for the median hourly wage amount for phlebotomists, which is published by the BLS, for the purposes of annually updating the travel allowance amount for specimen collection.

CMS calculates a per-mile amount to derive the approximate number of miles traveled by the trained technician each hour by using an average driving speed. The average miles per-hour driving speed is multiplied by the trained technician's estimated wages, as described above, and the result would be an amount that represents wages per mile, which is the personnel expenses associated with travel for specimen collection. CMS uses an average driving speed of 40 miles per hour, as most of the travel related to specimen collection would be performed in local and residential areas.

To establish the personnel expenses component of the travel allowance mileage rate, which is a per-mile amount, CMS divides the most recent median hourly wage for phlebotomists, as published by the BLS, by 40, to represent an average miles-per-hour.

The total travel allowance mileage rate, which includes both the "transportation" and "personnel expenses" for trained personnel to travel to the location of an individual to collect a sample, is equal to the IRS standard mileage rate plus an amount to cover expenses for a trained technician which is equal to the most recent median hourly wage for phlebotomists, as published by the BLS, divided by 40 to represent an average miles per-hour driving speed.

Updates to the Travel Allowance Mileage Rate

Updates to the travel allowance mileage rate are issued through subregulatory guidance, specifically the existing CMS change request process, on an annual basis. Updates will be made to the travel allowance mileage rate based upon the

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most recently published IRS standard mileage rate, as well as the most recently published wage rate for phlebotomist as published by the BLS. The revised travel allowance mileage rate will be effective for the January update of the clinical laboratory fee schedule file.

The travel allowance mileage rate for CY2024 is $1.13:

- The IRS standard mileage rate, which is $0.67; plus,
- The most recent median hourly wage for phlebotomists, as published by the BLS, which is $18.53, divided by 40 to represent an average miles-per-hour driving speed, which is $0.46.
- Yielding a total travel allowance mileage rate for CY2024 of $1.133, rounded up to $1.13.

Travel Allowance Bases: Flat-Rate and Per-Mile

CMS pays a travel allowance on the following bases:

1) flat-rate travel allowance; and

2) per-mile travel allowance.

Flat-Rate Travel Allowance

The flat-rate travel allowance basis applies when the trained technician travels 20 eligible miles or less to and from one location for specimen collection from one or more Medicare beneficiaries.

Laboratories bill Medicare using HCPCS code P9604 to receive payment for the flat-rate travel allowance amount, prorated by the number of beneficiaries for whom a specimen collection fee is paid.

Per-Mile Travel Allowance

The per-mile travel allowance basis applies in two circumstances:

1) When the round-trip travel to one location is greater than 20 eligible miles for specimen collection from one or more beneficiaries; or,

2) When travel is to more than one location, regardless of the number of miles traveled.

Laboratories bill Medicare using HCPCS code P9603 to receive payment for the per mile travel allowance amount, prorated by the number of beneficiaries for whom a specimen collection fee is paid.

Travel Allowance Amount Calculation

Calculation: Flat-rate Travel Allowance Basis

For flat-rate travel allowance basis, the travel allowance amount calculation is the travel allowance mileage rate multiplied by ten (10) and divided by the number of beneficiaries for whom a specimen collection fee is paid.

Dividing by the number of beneficiaries for whom a specimen collection fee is paid ensures that the flat-rate travel allowance amount is apportioned to each beneficiary receiving specimen collection services and that payment is calculated in an operationally feasible manner, as a laboratory must submit a claim for each beneficiary to receive payment for travel allowance. This method allows for a fixed payment amount to be straightforwardly apportioned to the number of beneficiaries for whom a specimen collection fee is paid in a single location.

Example: Flat-rate Travel Allowance Calculation

For an example of the flat-rate travel allowance calculation, consider a situation in which a trained technician travels 7 miles from the laboratory to a nursing home to collect blood specimens collected through venipuncture from five patients, four of whom are Medicare beneficiaries.

The trained technician collects three specimens from Medicare beneficiaries, collects one specimen from the non-Medicare patient, and simply picks up a previously collected specimen from one Medicare beneficiary. The trained technician then drives 7 miles back to the laboratory to deliver the specimens without making any other stops. The trained technician has provided specimen collection services to three Medicare beneficiaries. One Medicare beneficiary did not require specimen collection services, and therefore, a specimen collection fee would not be payable.

In this example, the laboratory would use the flat-rate travel allowance basis because the trained technician traveled a total of 14 miles. To calculate the travel allowance mileage rate, the laboratory would divide flat-rate travel allowance amount of $11.30 by the number of beneficiaries for whom a specimen collection fee is paid (three beneficiaries), which equals $3.77. To bill for the travel allowance, the laboratory would submit one claim for each beneficiary for whom a specimen collection fee is paid by billing HCPCS code P9604.

Calculation: Per-mile Travel Allowance Basis

The calculation for the per-mile travel allowance amount is equal the number of eligible miles multiplied by the travel allowance mileage rate, divided by the number of beneficiaries for whom a specimen collection fee is paid.

To calculate the per-mile travel allowance amount, the laboratory would first calculate the total number of eligible miles that the trained technician traveled – this would be the total number of miles traveled by the trained technician to locations where one or more Medicare beneficiaries received specimen collection services and back to the laboratory where the technician returns the specimen(s) for testing.

The eligible miles would be multiplied by the travel allowance mileage rate as described above, then divided by the number of beneficiaries for whom a specimen collection fee is paid. This quotient yields a prorated travel allowance amount for each beneficiary. The laboratory receives payment for the total number of eligible miles traveled for specimen collection, apportioned equally to each Medicare beneficiary for whom a specimen collection fee is paid. The laboratory then submits a claim billing HCPCS code P9603 for payment of the per-mile travel allowance amount for each beneficiary for whom a specimen collection fee is paid.

Examples: Per-mile Travel Allowance Amount Calculation

Example 1: For an example of the per-mile travel allowance amount calculation, consider a trained technician traveling 45 miles from a laboratory in a city to a rural SNF, collecting blood specimens through venipuncture from 6 Medicare beneficiaries, and then driving 45 miles to return to the laboratory.

In this example, the laboratory would use the per-mile travel allowance basis because the trained technician traveled more than 20 eligible miles to one location for specimen collection.

To calculate the per-mile travel allowance amount, the laboratory would sum the eligible miles traveled to the location of Medicare beneficiaries receiving specimen collection services, which, in this case is 45 miles from the laboratory to the SNF and 45 miles from the SNF returning to the laboratory, for a total of 90 eligible miles.

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The eligible miles would then be multiplied by the travel allowance mileage rate of $1.13, yielding a total of $101.70. This total amount would then be prorated by dividing by the number of Medicare beneficiaries for whom a specimen collection fee is paid (6), yielding a per-beneficiary amount of $16.95 ($101.70/6 = $16.95). To bill for the travel allowance, the laboratory would submit one claim for each beneficiary in the amount of $16.95 HCPCS code P9603.

Example 2: In another example, a trained technician travels 40 miles from a laboratory to the location of a Medicare beneficiary to collect a blood specimen through venipuncture, then travels 10 miles to the location of a non-Medicare patient to collect a blood specimen through venipuncture, then travels 20 miles to the location of two Medicare beneficiaries to collect urine specimens by catheterization, and then travels 20 miles to return to the laboratory.

In this example, the laboratory would use the per-mile travel allowance basis because the trained technician traveled to more than one location for specimen collection.

To calculate the per-mile travel allowance amount, the laboratory would sum the eligible miles, which would include the miles traveled from the laboratory to the locations of Medicare beneficiaries to collect specimens plus the miles back to the laboratory for specimen drop-off. Eligible miles would not include the 10 miles traveled to the location of the non-Medicare patient to collect a specimen, but would include the 40 miles traveled from the laboratory to the location of the first Medicare beneficiary, the 20 miles to the location of the two Medicare beneficiaries, and the return trip to the laboratory of 20 miles, for a total of 80 eligible miles.

The eligible miles would then be multiplied by the travel allowance mileage rate of $1.13, yielding a total of $90.40. This total would then be prorated by dividing by three (3) Medicare beneficiaries for whom a specimen collection fee is paid, yielding an amount of $30.13. The laboratory would then submit a claim using HCPCS code P9603 for travel allowance for each of the Medicare beneficiaries in the amount of $30.13. The laboratory would receive payment for the eligible miles traveled by the trained technician, apportioned equally to each Medicare beneficiary for whom a specimen collection fee is paid.

Neither the annual deductible nor the 20 percent coinsurance for Medicare apply to the travel allowance amount for CDLTs.

100-4, Chapter-16, 70.8

Certificate of Waiver

Effective September 1, 1992, all laboratory testing sites (except as provided in 42CFR 493.3(b)) must have either a CLIA certificate of waiver, certificate for provider-performed microscopy procedures, certificate of registration, certificate of compliance, or certificate of accreditation to legally perform clinical laboratory testing on specimens from individuals in the United States.

The Food and Drug Administration approves CLIA waived tests on a flow basis. The CMS identifies CLIA waived tests by providing an updated list of waived tests to the A/B MACs (A) and (B) on a quarterly basis via a Recurring Update Notification. To be recognized as a waived test, some CLIA waived tests have unique HCPCS procedure codes and some must have a QW modifier included with the HCPCS code.

Information regarding CLIA test complexity categorization can be found by searching the U.S. Food and Drug Administration website (www.fda.gov).

100-4, Chapter-17, 80.4.1

Clotting Factor Furnishing Fee

The Medicare Modernization Act section 303(e)(1) added section 1842(o)(5)(C) of the Social Security Act which requires that, beginning January 1, 2005, a furnishing fee will be paid for items and services associated with clotting factor.

Beginning January 1, 2005, a clotting factor furnishing fee is separately payable to entities that furnish clotting factor unless the costs associated with furnishing the clotting factor is paid through another payment system.

The clotting factor furnishing fee is updated each calendar year based on the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The clotting factor furnishing fees applicable for dates of service in each calendar year (CY) are listed below:

CY 2005 - 0.140 per unit

CY 2006 - 0.146 per unit

CY 2007 - 0.152 per unit

CY 2008 - 0.158 per unit

CY 2009 - 0.164 per unit

CY 2010 - 0.170 per unit

CY 2011 - 0.176 per unit

CY 2012 - 0.181 per unit

CY 2013 - 0.188 per unit

CY 2014 - 0.192 per unit

CY 2015 - 0.197 per unit

CY 2016 - $0.202 per unit

CY 2017 - $0.209 per unit

CY 2018 - $0.215 per unit

CY 2019 - $0.220 per unit

CY 2020 - $0.226 per unit

CY 2021 - $0.238 per unit

CY 2022 - $0.239 per unit

CY 2023 - $0.250 per unit

CY 2024 - $0.250 per unit

Annual updates to the clotting factor furnishing fee are subsequently communicated by a Recurring Update Notification.

CMS includes this clotting factor furnishing fee in the nationally published payment limit for clotting factor billing codes. When the clotting factor is not included on the Average Sales Price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, the contractor must make payment for the clotting factor as well as make payment for the furnishing fee.

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100-4, Chapter-17, 90.3

Hospital Outpatient Payment Under OPPS for New, Unclassified Drugs and Biologicals After FDA Approval But Before Assignment of a Product-Specific Drug or Biological HCPCS Code

Section 621(a) of the MMA amends Section 1833(t) of the Social Security Act by adding paragraph (15), Payment for New Drugs and Biologicals Until HCPCS Code Assigned. Under this provision, payment for an outpatient drug or biological that is furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned shall be paid an amount equal to 95 percent of average wholesale price (AWP). This provision applies only to payments under the hospital outpatient prospective payment system (OPPS).

Beginning January 1, 2004, hospital outpatient departments may bill for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a product-specific HCPCS code has not been assigned. Beginning on or after the date of FDA approval, hospitals may bill for the drug or biological using HCPCS code C9399, Unclassified drug or biological.

Hospitals report in the ASC X12 837 institutional claim format in specific locations, or in the "Remarks" section of Form CMS-1450):

- the National Drug Code (NDC),
- the quantity of the drug that was administered, expressed in the unit of measure applicable to the drug or biological, and
- the date the drug was furnished to the beneficiary.

Contractors shall manually price the drug or biological at 95 percent of AWP. They shall pay hospitals 80 percent of the calculated price and shall bill beneficiaries 20 percent of the calculated price, after the deductible is met. Drugs and biologicals that are manually priced at 95 percent of AWP are not eligible for outlier payment.

HCPCS code C9399 is only to be reported for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which there is no HCPCS code that describes the drug.

100-4, Chapter-18, 10.1.2

Influenza Virus Vaccine

Effective for services furnished on or after May 1, 1993, the influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a flu season. Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. Since there is no yearly limit, contractors A/B MACs (A) and (B) determine whether such services are reasonable and allow payment if appropriate.

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.4.2 for additional coverage requirements for influenza virus vaccine.

100-4, Chapter-18, 10.2.1

Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes

Vaccines and their administration are reported using separate codes. The following codes are for reporting the vaccines only.

HCPCS	Definition
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
90653	Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use
90654	Influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 – 64;
90655	Influenza virus vaccine, split virus, preservative free, for children 6- 35 months of age, for intramuscular use;
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use;
90657	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use;
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90672	Influenza virus vaccine, live, quadrivalent, for intranasal use
90673	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90685	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use

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90694 Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for us in individuals 2 years or older, for subcutaneous or intramuscular use;

90739 Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use

90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;

90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;

90744 Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;

90746 Hepatitis B vaccine, adult dosage, for intramuscular use; and

90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.

90756 Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use

90759 Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use

Note: COVID-19 vaccine and administration HCPCS are temporarily posted at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-dmonoclonal-antibodies.

Note: For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-BDrugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html

The following codes are for reporting administration of the vaccines only. The administration of the vaccines is billed using:

HCPCS Definition

G0008 Administration of influenza virus vaccine; G0009 Administration of pneumococcal vaccine; and

*G0010 Administration of Hepatitis B vaccine.

*90471 Immunization administration. (For OPPS hospitals billing for the Hepatitis B vaccine administration)

*90472 Each additional vaccine. (For OPPS hospitals billing for the Hepatitis B vaccine administration)

* NOTE: Beginning January 1, 2011, providers should report G0010 for billing under the OPPS rather than 90471 or 90472 to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccine.

NOTE: COVID-19 vaccine and administration HCPCS are temporarily posted at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/COVID-19-vaccines-andmonoclonal-antibodies.

The following diagnosis code must be reported. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim, the applicable following diagnosis code may be used.

ICD-10-CM Diagnosis Code	Description
Z23	Encounter for Immunization

NOTE: ICD-10-CM diagnosis code Z23 is to be used for all encounters for preventive vaccine immunizations, including COVID-19 immunizations.

All claims must have the appropriate diagnosis code, procedure, and admin code to process correctly.

100-4, Chapter-18, 10.2.2.1

Payment for Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus Vaccines and Their Administration on Institutional Claims

Payment for Vaccines

Payment for these vaccines is as follows:
Payment for the administration of Hepatitis B vaccine is as follows:

Facility	Type of Bill	Payment
Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs)	012x, 013x	Reasonable cost
IHS Hospitals	012x, 013x, 083x	95% of AWP
IHS CAHs	085x	95% of AWP
CAHs		
Method I and Method II	085x	Reasonable cost
Skilled Nursing Facilities	022x, 023x	Reasonable cost
Home Health Agencies	034x	Reasonable cost
Hospices	081x, 082x	95% of AWP
Comprehensive Outpatient Rehabilitation Facilities	075x	95% of the AWP
Independent Renal Dialysis Facilities	072x	95% of the AWP
Hospital-based Renal Dialysis Facilities	072x	Reasonable cost

Payment for Vaccine Administration

Payment for the administration of influenza virus and pneumococcal vaccines is as follows:

Facility	Type of Bill	Payment
Hospitals, other than IHS Hospitals and CAHs	012x, 013x	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS
IHS Hospitals	012x, 013x, 083x	MPFS
IHS CAHs	085x	MPFS
CAHs Method I and II	085x	Reasonable cost

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Facility	Type of Bill	Payment
Skilled Nursing Facilities	022x, 023x	MPFS
Home Health Agencies	034x	OPPS
Hospices	081x, 082x	MPFS
Comprehensive Outpatient Rehabilitation Facilities	075x	MPFS
Independent RDFs	072x	MPFS
Hospital-based RDFs	072x	Reasonable cost
Hospitals other than IHS hospitals and CAHs	012x, 013x	Outpatient Prospective Payment System (OPPS) for hospitals subject to OPPS Reasonable cost for hospitals not subject to OPPS
IHS Hospitals	012x, 013x, 083x	MPFS
CAHs Method I and II	085x	Reasonable cost
IHS CAHs	085x	MPFS
Skilled Nursing Facilities	022x, 023x	MPFS
Home Health Agencies	034x	OPPS
Hospices	081x, 082x	MPFS
Comprehensive Outpatient Rehabilitation Facilities	075x	MPFS
Independent RDFs	072x	MPFS
Hospital-based RDFs	072x	Reasonable cost

100-4, Chapter-18, 10.2.5.2

MAC (Part B) Payment Requirements

Implementation:05-16-22) Payment for Medicare covered preventive vaccines, including the recently developed COVID-19 vaccines, follows the same standard rules that are applicable to any injectable drug or biological.

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers of Medicare covered preventive vaccines, must accept assignment for the vaccine.

Prior to March 1, 2003, the administration of pneumococcal, influenza virus, and hepatitis B vaccines, (HCPCS codes G0008, G0009, and G0010), though not reimbursed directly through the MPFS, were paid at the same rate as HCPCS code 90782 on the MPFS for the year that corresponded to the date of service of the claim.

For dates of service on or after March 1, 2003 through December 31, 2021, payment rates for HCPCS G0008, G0009, and G0010 were paid at the same rate as similar services on the MPFS determined through notice-and-comment rulemaking. These payment amounts were determined on an annual basis and MACs were notified accordingly.

Beginning January 1, 2022, the national payment rate for HCPCS G0008, G0009, and G0010 is $30. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for HCPCS G0008, G0009, and G0010 are available of the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-BDrugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

Beginning January 1, 2022 and through the end of the calendar year in which the PHE for COVID19 ends, the national payment rate for the administration of COVID-19 vaccines is $40. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for the administration of COVID-19 vaccines are available of the CMS website: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19vaccines-and-monoclonal-antibodies

Effective January 1 of the year following the year in which the PHE for COVID-19 ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type "Mass Immunization Roster Biller," submits roster bills, or participates in the centralized billing program.

MACs (Part B) may not apply the limiting charge provision for pneumococcal, influenza virus , hepatitis B, or COVID-19 vaccines and their administration in accordance with §§1833(a)(1) and 1833(a)(10)(A) of the Social Security Act (the Act.)

The vaccine and administration of the pneumococcal and influenza virus, and COVID-19 vaccine is covered in §1861(s)(10)(A) of the Act; §1861(s)(10)(B) includes the hepatitis B vaccine and administration rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent Health Professional Shortage Area (HPSA) incentive payment or the 5 percent Physician Scarcity Area (PSA) incentive payment.

No Legal Obligation to Pay

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 16.) Thus, for example, Medicare may not pay for influenza virus vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128(b)(6)(A) of the Act.) When an employer offers free vaccinations to its employees, it must also offer the free vaccination to an employee who is also a Medicare beneficiary. It does not have to offer free vaccinations to its non-Medicare employees.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as PHCs) may bill Medicare for pneumococcal, hepatitis B, influenza virus, and COVID-19

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vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries. Government entities may NOT bill Medicare for vaccine products during a public health emergency when vaccines are provided at no charge to Medicare and non-Medicare beneficiaries.

100-4, Chapter-18, 10.3.1.1

Centralized Billing for Influenza Virus and Pneumococcal Vaccines to A/B MACs (B)

The CMS currently authorizes providers to centrally bill for influenza, pneumococcal, and COVID-19 vaccination claims. That is to say, they bill all of the claims for those vaccinations to one MAC, rather than to each of the MACs that service the location where the services are rendered.

Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunization Roster Biller," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

The contractor assigned to process the claims for centralized billing will be chosen at the discretion of The Centers for Medicare & Medicaid Services (CMS) based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. Currently the specialty contractor for centralized billing is Novitas (JH).

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different MACs processing claims. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the vaccinations are given and the MAC will verify this through the enrollment process.

As previously stated, centralized billers must send all claims for influenza, pneumococcal, and COVID-19 vaccinations to a single MAC for payment, regardless of the jurisdiction in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) Payment is made based on the payment locality where the service was provided. Centralized billing is only available for claims for the influenza, pneumococcal, and COVID-19 vaccines and their administration. The general coverage and coding rules still apply to these claims.

This section applies only to those individuals and entities that provide mass immunization services for influenza, pneumococcal, and COVID-19 virus vaccinations that have been authorized by CMS to centrally bill. All other providers, including those individuals and entities that provide mass immunization services that are not authorized to centrally bill, must continue to submit claims to their regular MAC (Part B) per the instructions in §10.3.1 of this chapter.

The claims processing instructions in this section apply only to claims submitted to the designated processing MAC. However, all MACs (Part B) must follow the instructions in §10.3.1.1.J, below, "Provider Education Instructions for All MACs (Part B)."

A. Request for Approval

Centralized Billing for Influenza, Pneumococcal and COVID-19 Virus Vaccinations

A. Information for Providers Interested in Applying for Centralized Billing

In order to qualify as a centralized biller, a provider must be operating in at least three payment localities for which there are three different MACs processing claims.

Individuals and corporations who wish to enroll as a CMS centralized biller must send their request in writing to Novitas, (the current specialty contractor) at the address at the end of this section.

Providers must include the following information in their application to become a centralized biller.

1. Providers must indicate that they agree to the following:
   a. Centralized billers providing the vaccine and administration must be properly licensed in the States in which the vaccinations are given.
   b. Centralized biller must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza, pneumococcal and COVID-19 vaccinations, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.
   c. Centralized billers must understand that beginning December 11, 2021 the payment rate for the administration of the COVID-19 vaccine is $40 and $30 for the other preventive vaccinations. These payment amounts are geographically adjusted by locality. Therefore, the centralized biller must be willing to accept that payments received may vary based on the geographic locality where the service was performed.
   d. Centralized billers must understand that the payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals.
   e. Centralized billers must agree to submit their claims in a CMS approved electronic media claims standard format. Paper claims will not be accepted.
   f. In addition to the elements required by regular roster billing, centralized billers must complete the service facility location in order for the MAC to be able to pay correctly by geographic locality. Centralized billers should contact the processing contractor for specific information.
   g. Centralized billers must obtain certain information for each beneficiary including name, Medicare Beneficiary Identifier, date of birth, sex, and signature. Novitas must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the correct MBI as Novitas will not be able to process incomplete or incorrect claims.
   h. Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary. Beneficiaries are sometimes confused when they receive an

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MSN from a MAC other than the MAC that normally processes their claims, which results in unnecessary beneficiary inquiries to the MAC. Therefore, centralized billers must notify every beneficiary receiving an influenza, pneumococcal or COVID-19 virus vaccination that the claim will be processed by Novitas. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

i. Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. Novitas can provide this information.

j. Though centralized billers may already have a National Provider Identifier (NPI) number, for purposes of centralized billing, they must also enroll with Novitas. This can be done by completing the Form CMS-855 (Provider Enrollment Application) that can be obtained from Novitas.

k. If the request for centralized billing is approved, for influenza and pneumococcal, and COVID-19 vaccinations, that approval is ongoing. It is the responsibility of the approved centralized billers to contact Novitas to make updates to their provider enrollment data on file (i.e. clinic locations, name change, and change to ownership are a few examples) . Claims submitted without approval will be denied.

l. If a centralized biller is applying to provide COVID-19 vaccinations only, that approval will be ongoing. It is the responsibility of the approved centralized billers to contact Novitas to make updates to their provider enrollment data on file (i.e. clinic locations, name change, and change to ownership are a few examples). Claims submitted without approval will be denied.

2. Applicants for centralized billing should also include responses to the following:
   a. A list of the States in which vaccination clinics will be held;
   b. Contact information for a designated contact for the centralized billing program.

Applications for centralized billing must be sent to the specialty MAC for centralized billing at:

Novitas Solutions, Inc.

Provider Enrollment Services

Attention: Centralized Billing Program

P.O. Box 3095

Mechanicsburg, PA 17055-1813

All applicants must meet the criteria for centralized billing at the time they apply for approval. Failure to provide a response to each statement will result in the request not being processed. Novitas will reach out to the applicant to attempt to complete any missing data. Should they be unable to resolve the matter via outreach efforts, Novitas shall return the application with details explaining why the submission could not be processed.

B. Review of Applications

Novitas will review the information provided by applicants for completeness. Novitas will approve or deny the applicant's request for participation based on the information provided. Applicants who are approved shall continue to the next steps of enrollment through Novitas' provider enrollment department.

Novitas will send a letter of disapproval to applicants who are determined ineligible to participate in the Medicare centralized billing program. The letter will clearly explain why the request was denied.

Submitting a request for participation does not automatically provide approval to set up vaccination clinics, vaccinate beneficiaries, and bill Medicare for reimbursement. All new participants must complete the approval process, including submission of a CMS-855 Application for enrollment with Novitas and receive a final approval before they vaccinate Medicare beneficiaries and bill Medicare for reimbursement.

If a provider's request is approved for centralized billing for influenza, pneumococcal and COVID-19 vaccinations, the approval shall be ongoing. Approved providers will no longer be required to reapply on an annual basis. Centralized billers shall contact Novitas with any changes to their enrollment and/or that states in which they operate.

C. Enrollment

COVID-19 Mass Immunizer Centralized Biller Enrollment

For more information on enrolling as a COVID-19 mass immunizer centralized biller go to: **https://www.cms.gov/medicare/covid-19/enrollment-administering-covid-19-vaccine-shots**

D. Electronic Submission of Claims on Roster Bills

All centralized billers must agree to submit their claims on roster bills in an electronic media claims format. The processing contractor must provide instructions on acceptable roster billing formats to the approved centralized billers. Paper claims will not be accepted.

E. Required Information on Roster Bills for Centralized Billing

In addition to the roster billing instructions found in §10.3.1 of this chapter, centralized billers must provide on the claim the ZIP code of where the service was rendered (to determine the payment locality for the claim), and the provider of service/supplier's billing name, address, ZIP code, and telephone number. In addition, the NPI of the billing provider or group must be appropriately reported.

F. Payment Rates and Mandatory Assignment

The payment rates for the administration of the vaccinations are based on the Medicare Physician Fee Schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments vary based on the geographic locality where the service was performed.

The HCPCS codes G0008 and G0009 for the administration of the vaccines are not paid on the MPFS. However, prior to March 1, 2003, they must be paid at the same rate as HCPCS code 90782, which is on the MPFS. The designated contractor must pay per the correct MPFS file for each calendar year based on the date of service of the claim. Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 are to be reimbursed at the same rate as HCPCS code 90471.

Effective for claims with dates of service January 1, 2020 through December 31, 2021, the payment rates for G0008, G0009, and G0010, rather than being linked to the MPFS payment rate for 90471, they were to be paid at the same rate as they had been in 2019.

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Beginning January 1, 2022, the national payment rate for HCPCS G0008, G0009, and G0010 is $30. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality adjusted payment rates for HCPCS G0008, G0009, and G0010 are available of the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-BDrugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

Beginning January 1, 2022 and through the end of the calendar year in which the PHE for COVID-19 ends, the national payment rate for the administration of COVID-19 vaccines is $40. This payment amount is adjusted based on the Geographic Practice Cost Indices used in the MPFS. Locality-adjusted payment rates for the administration of COVID-19 vaccines are available of the CMS website: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonalantibodies

Effective January 1 of the year following the year in which the PHE for COVID-19 ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

In order to pay claims correctly for centralized billers, the designated contractor must have the correct name and address, including ZIP code, of where the service was provided.

The following remittance advice and Medicare Summary Notice (MSN) messages apply:

Claim adjustment reason code 16, "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code, **Remittance advice remark code MA114,** "Missing/incomplete/invalid information on where the services were furnished."

MSN 9.4 - "This item or service was denied because information required to make payment was incorrect."

The payment rates for the vaccines must be determined by the standard method used by Medicare for reimbursement of drugs and biologicals. (See chapter 17 for procedures for determining the payment rates for vaccines.)

Effective for claims with dates of service on or after February 1, 2001, §114, of the Benefits Improvement and Protection Act of 2000 mandated that all drugs and biologicals be paid based on mandatory assignment. Therefore, all providers Medicare covered preventive must accept assignment for the vaccine. In addition, as a requirement for both centralized billing and roster billing, providers must agree to accept assignment for the administration of the vaccines as well. This means that they must agree to accept the amount that Medicare pays for the vaccine and the administration. Also, since there is no coinsurance or deductible for the influenza, pneumococcal, and COVID-19 vaccine benefits, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination.

G. Common Working File Information

To identify these claims and to enable central office data collection on the project, special processing number 39 has been assigned. The number should be entered on the HUBC claim record to CWF in the field titled Demonstration Number.

H. Provider Education Instructions for the Designated Processing Part B MAC

The designated Part B MAC must fully educate the centralized billers on the processes for centralized billing as well as for roster billing. General information on influenza, pneumococcal, and COVID-19 vaccine coverage and billing instructions is available on the CMS Web site for providers.

I. Provider Education Instructions for All MACs (Part B)

By XXXX of every year, all MACs (Part B) must publish in their bulletins and put on their Web sites the following notification to providers. Questions from interested providers should be forwarded to Novitas, the designated processing Part B MAC for the centralized billing workload at the address below. MACs (Part B) must enter the name of the assigned processing contractor where noted before sending.

NOTIFICATION TO PROVIDERS

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and pneumococcal pneumonia virus (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in influenza and pneumococcal centralized billing must contact Novitas, to begin centrally billing for influenza and pneumococcal vaccines.

Applications to become a mass immunizer centralized biller for the COVID-19 vaccine is an ongoing enrollment. Individuals and entities can submit a request to become a centralized mass immunizer at any time. For more information on enrolling as a COVID-19 mass immunizer centralized biller go to: https://www.cms.gov/medicare/covid-19/enrollment-administering-covid-19-vaccine-shots.

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

CRITERIA FOR CENTRALIZED BILLING

- To qualify for centralized billing, an individual or entity providing mass vaccination services for influenza virus, pneumococcal, and COVID-19 vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.
- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for

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an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore.

NOTE: The practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per § 1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is [Fill in name of contractor.]
- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.
- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an approved electronic format. Paper claims will not be accepted.
- Centralized billers must obtain certain information for each beneficiary including name, MBI number, date of birth, sex, and signature. [The designated Part B MAC] must be contacted prior to submitting claims for verification of billing requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the contractor will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that a Medicare Summary Notice (MSN) can be sent to the beneficiary by the Part B MAC. Beneficiaries are sometimes confused when they receive an MSN from a Part B MAC other than the MAC that normally processes their claims which results in unnecessary beneficiary inquiries. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing Part B MAC. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. [The designated Part B MAC] can provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from [The designated Part B MAC]. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from [The designated Part B MAC].

NOTE: Influenza/Pneumococcal Mass Immunizer Centralized Billers DO NOT need to enroll separately as a COVID-19 Mass Immunizer Centralized Biller to administer COVID-19 vaccine shots.

- If an individual or entity's request for centralized billing of influenza, pneumococcal, and/or COVID-19 vaccines is approved, the approval is ongoing. Claims will not be processed for any influenza, pneumococcal, or COVID-19 centralized biller without approval from the designated Part B MAC.
- Each year the centralized biller must contact the designated Part B MAC to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.
- The information in items 1 through 8 below must be included with the individual or entity's annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;
2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations;
3. Estimates for the number of beneficiaries who will receive COVID-19 vaccinations (if applicable);
4. The approximate dates for when the vaccinations will be given;
5. A list of the states in which influenza, pneumococcal, and COVID-19 vaccination clinics will be held;
6. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse);
7. Whether the nurses who will administer the influenza, and pneumococcal, and COVID-19 vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza, pneumococcal, and COVID-19 vaccinations;
8. Names and addresses of all entities operating under the corporation's application (not clinic locations);
9. Contact information for designated contact person for centralized billing program.

100-4, Chapter-18, 10.4.1

CWF Edits on MAC (Part A) Claims

In order to prevent duplicate payment by the same MAC (Part A), CWF edits by line item on the MAC (Part A) number, the Medicare Beneficiary Identifier (MBI) number, and the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and the pneumococcal procedure codes 90670, 90671, 90677, or 90732, and the administration code, G0008 or G0009.

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF rejects.
2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a

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claim with the same MBI number, same MAC (Part A) number, same date of service, and the same HCPCS code, the second claim submitted to CWF rejects when all four items match.

3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same MBI number, same MAC (Part A) number, same date of service, and same procedure code, CWF rejects the second claim submitted when all four items match.

CWF returns to the MAC (Part A) a reject code "7262" for this edit. MACs (Part A) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

100-4, Chapter-18, 10.4.2

CWF Edits on MAC (Part B) Claims

In order to prevent duplicate payment by the same MAC (Part B), CWF will edit by line item on the MAC (Part B) number, the MBI number, the date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal procedure codes 90670, 90671, 90677, or 90732; and the administration code G0008 or G0009.

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656,90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and any one of those HCPCS codes, the second claim submitted to CWF will reject.
2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject when all four items match.
3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with the same MBI number, same MAC (Part B) number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return to the MAC (Part B) a specific reject code for these edits. MACs (Part B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

In order to prevent duplicate payment by the centralized billing contractor and local MAC (Part B), CWF will edit by line item for MAC (Part B) number, same MBI number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal virus procedure codes 90670, 90671, 90677, or 90732; and the administration code G0008 or G0009.

If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with a different MAC (Part B) number, but same MBI number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, different MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.

If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different MAC (Part B) number, but the same MBI number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for these edits. MACs (Part B) must deny the second claim. The reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

MSN: 7.2 – "This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them."

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

EDITS FOR CLAIMS SUBMITTED TO THE CENTRALIZED BILLING PROCESSING MAC (PART B) AND THE LOCAL MAC (PART B)

In order to prevent duplicate payment by the centralized billing contractor and local MAC (Part B), CWF will edit by line item for MAC (Part B) number, same MBI number, same date of service, the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal virus procedure codes 90670, 90671, 90677, or 90732; and the administration code G0008 or G0009.

1. If CWF receives a claim with either HCPCS codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756 and it already has on record a claim with a different MAC (Part B) number, but same MBI number, same date of service, and any one of those same HCPCS codes, the second claim submitted to CWF will reject.
2. If CWF receives a claim with HCPCS codes 90670, 90671, 90677, or 90732 and it already has on record a claim with the same MBI number, different MAC (Part B) number, same date of service, and the same HCPCS code, the second claim submitted to CWF will reject.
3. If CWF receives a claim with HCPCS administration codes G0008 or G0009 and it already has on record a claim with a different MAC (Part B) number, but the same MBI number, same date of service, and same procedure code, CWF will reject the second claim submitted.

CWF will return a specific reject code for these edits. MACs (Part B) must deny the second claim. The reject code should automatically trigger the following Medicare Summary Notice (MSN) and Remittance Advice (RA) messages.

MSN: 7.2 – "This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them."

Claim Adjustment Reason Code 18 – Exact duplicate claim/service

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100-4, Chapter-18, 10.4.3

CWF Crossover Edits for A/B MAC (B) Claims

When CWF receives a claim from the MAC (Part B), it will review Part B outpatient claims history to verify that a duplicate claim has not already been posted.

CWF will edit on the beneficiary MBI number; the date of service; the influenza virus procedure codes 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90694, or 90756; the pneumococcal procedure codes 90670,90671, 90677, or 90732; and the administration code G0008 or G0009.

CWF will return a specific reject code for this edit. MACs (B) must deny the second claim and use the same messages they currently use for the denial of duplicate claims.

100-4, Chapter-18, 20

Mammography Services (Screening and Diagnostic)

A. Screening Mammography

Beginning January 1, 1991, Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiologic procedures for early detection of breast cancer and include a physician's interpretation of the results. A doctor's prescription or referral is not necessary for the procedure to be covered. Whether payment can be made is determined by a woman's age and statutory frequency parameter. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.3 for additional coverage information for a screening mammography.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39 and waives the Part B deductible. Coverage applies as follows:

Age Groups	Screening Period
Under age 35	No payment allowed for screening mammography.
35-39	Baseline (pay for only one screening mammography performed on a woman between her 35th and 40th birthday)
Over age 39	Annual (11 full months have elapsed following the month of last screening

NOTE: Count months between screening mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination in January 2005, begin counting the next month (February 2005) until 11 months have elapsed. Payment can be made for another screening mammography in January 2006.

B. Diagnostic Mammography

A diagnostic mammography is a radiological mammogram and is a covered diagnostic test under the following conditions:

- A patient has distinct signs and symptoms for which a mammogram is indicated;
- A patient has a history of breast cancer; or
- A patient is asymptomatic, but based on the patient's history and other factors the physician considers significant, the physician's judgment is that a mammogram is appropriate.
- Beginning January 1, 2005, Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, §644, Public Law 108-173 has changed the way Medicare pays for diagnostic mammography. Medicare will pay based on the MPFS in lieu of OPPS or the lower of the actual change.

100-4, Chapter-18, 60.1

Payment

Payment is under the Medicare Physician Fee Schedule (MPFS) except as follows:

- FOBTs [CPT® 82270* (HCPCS G0107*) and HCPCS G0328] are paid under the clinical laboratory fee schedule (CLFS) except reasonable cost is paid to all non-outpatient prospective payment system (OPPS) hospitals, including Critical Access Hospitals (CAHs), but not Indian Health Service (IHS) hospitals billing on type of bill (TOB) 83X. IHS hospitals billing on TOB 83X are paid the Ambulatory Surgery Center (ASC) payment amount. Other IHS hospitals (billing on TOB 13X) are paid the Office of Management and Budget (OMB)-approved all-inclusive rate (AIR), or the facility specific per visit amount as applicable. Deductible and coinsurance do not apply for these tests. See section A below for payment to Maryland waiver hospitals on TOB 13X. Payment to all hospitals for non-patient laboratory specimens on TOB 14X will be based on the CLFS, including CAHs and Maryland waiver hospitals.
- For claims with dates of service on or after January 1, 2015 through December 31, 2015, the Cologuard™ multitarget sDNA test (HCPCS G0464) is paid under the CLFS.

  NOTE: For claims with dates of service October 9, 2014 thru December 31, 2014, HCPCS code G0464 is paid under local contractor pricing.

- For claims with dates of service on or after January 1, 2016, CPT® code 81528 replaces G0464 is paid under on the CLFS.
- Flexible sigmoidoscopy (code G0104) is paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs; or current payment methodologies for hospitals not subject to OPPS.
- For claims with dates of service on or after January 19, 2021, Blood-based Biomarker test (HCPCS G0327) is paid under the CLFS.
- Colonoscopies (HCPCS G0105 and G0121) and barium enemas (HCPCS G0106 and G0120) are paid under OPPS for hospital outpatient departments and on a reasonable cost basis for CAHs or current payment methodologies for hospitals not subject to OPPS. Also colonoscopies may be performed in an ASC and when done in an ASC, the ASC rate applies. The ASC rate is the same for diagnostic and screening colonoscopies. The ASC rate is paid to IHS hospitals when the service is billed on TOB 83X.

The following screening codes must be paid at rates consistent with the rates of the diagnostic codes indicated. Coinsurance and deductible apply to diagnostic codes.

HCPCS Screening Code	HCPCS Diagnostic Code
G0104	45330
G0105 and G0121	45378
G0106 and G0120	74280

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A. Special Payment Instructions for TOB 13X Maryland Waiver Hospitals

For hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission, screening colorectal services HCPCS G0104, G0105, G0106, 82270* (G0107*), G0120, G0121, G0328, G0464 and 81528 are paid according to the terms of the waiver, that is 94% of submitted charges minus any unmet existing deductible, co-insurance and non-covered charges. Maryland Hospitals bill TOB 13X for outpatient colorectal cancer screenings.

B. Special Payment Instructions for Non-Patient Laboratory Specimen (TOB 14X) for All Hospitals

Payment for colorectal cancer screenings (CPT® 82270* (HCPCS G0107*), HCPCS G0328, and G0464 (Effective January 1, 2016, HCPCS G0464 is discontinued and replaced with CPT® 81528) to a hospital for a non-patient laboratory specimen (TOB 14X), is the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and Maryland Waiver hospitals). Part B deductible and coinsurance do not apply.

- ****NOTE:*** For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS G0107. Effective January 1, 2007, HCPCS G0107 was discontinued and replaced with CPT® 82270.

100-4, Chapter-18, 80

Initial Preventive Physical Examination (IPPE)

(***NOTE:*** For billing and payment requirements for the Annual Wellness Visit, see chapter 18, section 140, of this chapter.)

Background: Sections 1861(s)(2)(w) and 1861(ww) of the Social Security Act (and implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11)) authorize coverage under Part B for a one-time initial preventive physical examination (IPPE) for new Medicare beneficiaries that meet certain eligibility requirements.

Coverage: As described in implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11), the IPPE may be performed by a doctor of medicine or osteopathy as defined in section 1861 (r)(1) of the Social Security Act (the Act) or by a qualified nonphysician practitioner (NPP) (physician assistant, nurse practitioner, or clinical nurse specialist), not later than 12 months after the date the individual's first coverage begins under Medicare Part B. (See section 80.3 for a list of bill types of facilities that can bill A/B MACs for this service.)

The IPPE includes:

1. review of the individual's medical and social history with attention to modifiable risk factors for disease detection,
2. review of the individual's potential (risk factors) for depression or other mood disorders,
3. review of the individual's functional ability and level of safety;
4. an examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history;
5. end-of-life planning, upon agreement of the individual.
6. education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and
7. education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B.

Medicare will pay for only one IPPE per beneficiary per lifetime. The Common Working File (CWF) will edit for this benefit.

The IPPE does not include other preventive services that are currently separately covered and paid under Medicare Part B. (That is: pneumococcal, influenza and Hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, diabetes screening tests, screening ultrasound for abdominal aortic aneurysms, an electrocardiogram, and additional preventive services covered under Medicare Part B through the Medicare national coverage determination process.)

For the physician/practitioner billing correct coding and payment policy, refer to chapter 12, section 30.6.1.1, of this manual.

100-4, Chapter-18, 80.1

Healthcare Common Procedure Coding System (HCPCS/CPT®) Coding for the IPPE

The HCPCS codes listed below were developed for the IPPE benefit effective January 1, 2005, for individuals whose initial enrollment is on or after January 1, 2005.

G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment

Short Descriptor: Initial Preventive Exam

G0366: Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0367: tracing only, without interpretation and report, performed as a component of the initial preventive examination

Short Descriptor: EKG tracing for initial prev

G0368: interpretation and report only, performed as a component of the initial preventive examination

Short Descriptor: EKG interpret & report preve

The following new HCPCS codes were developed for the IPPE benefit effective January 1, 2009, and replaced codes G0344, G0366, G0367, and G0368 shown above beginning with dates of service on or after January 1, 2009:

G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Short Descriptor: Initial Preventive exam

G0403: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

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G0404: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

Short Descriptor: EKG tracing for initial prev

G0405: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

Short Descriptor: EKG interpret & report preve

100-4, Chapter-18, 80.2

A/B MAC) (B) Billing Requirements

Effective for dates of service on and after January 1, 2005, through December 31, 2008, A/B MACs (B) shall recognize the HCPCS codes G0344, G0366, G0367, and G0368 shown above in §80.1 for an IPPE. The type of service (TOS) for each of these codes is as follows:

G0344: TOS = 1

G0366: TOS = 5

G0367: TOS = 5

G0368: TOS = 5

A/B MACs (B) shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 6 months after the date the individual's first coverage begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005.

Effective for dates of service on and after January 1, 2009, A/B MACs (B) shall recognize the HCPCS codes G0402, G0403, G0404, and G0405 shown above in §80.1 for an IPPE. The TOS for each of these codes is as follows:

G0402: TOS = 1

G0403: TOS = 5

G0404: TOS = 5

G0405: TOS = 5

Under the MIPPA of 2008, A/B MACs (B) shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 12 months after the date the individual's first coverage begins under Medicare Part B only if that coverage period begins on or after January 1, 2009.

A/B MACs (B) shall allow payment for a medically necessary Evaluation and Management (E/M) service at the same visit as the IPPE when it is clinically appropriate. Physicians and qualified nonphysician practitioners shall use CPT® codes 99201-99215 to report an E/M with CPT® modifier 25 to indicate that the E/M is a significant, separately identifiable service from the IPPE code reported (G0344 or G0402, whichever applies based on the date the IPPE is performed). Refer to chapter 12, §30.6.1.1, of this manual for the physician/practitioner billing correct coding and payment policy regarding E/M services.

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified NPP during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring physician or qualified NPP needs to make sure that the performing physician or entity bills the appropriate G code for the screening EKG, and not a CPT® code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service.** Effective for dates of service on and after January 1, 2009, the screening EKG is optional and is no longer a mandated service of an IPPE if performed as a result of a referral from an IPPE.

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, report the appropriate EKG CPT® code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

Physicians or qualified nonphysician practitioners shall bill the A/B MACs (B) the appropriate HCPCS codes for IPPE. The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). See §1.3 of this chapter for waiver of cost sharing requirements of coinsurance, copayment and deductible for furnished preventive services available in Medicare.

100-4, Chapter-18, 80.3.3

Outpatient Prospective Payment System (OPPS) Hospital Billing

Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier -25 when billing the IPPE G0344 along with the technical component of the EKG, G0367, on the same claim. The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404. This is due to an OPPS Outpatient Code Editor (OCE) which contains an edit that requires a modifier -25 on any evaluation and management (E/M) HCPCS code if there is also a status "S" or "T" HCPCS procedure code on the claim.

100-4, Chapter-18, 80.4

Coinsurance and Deductible

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. Coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the Affordable Care Act, effective for the IPPE provided on or after January 1, 2011, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived.

100-4, Chapter-18, 130.1

Healthcare Common Procedure Coding System (HCPCS) for HIV Screening Tests

Effective for claims with dates of service on and after December 8, 2009, implemented with the April 5, 2010, IOCE, the following HCPCS codes are to be billed for HIV screening:

- G0432- Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening,
- G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and,
- G0435 -Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

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100-4, Chapter-18, 130.2

Billing Requirements

Medicare Administrative Contractors (MACs) shall recognize the above HCPCS codes for HIV screening in accordance with Publication 100-03, Medicare National Coverage Determinations Manual, section 210.7.

Effective for claims with dates of service on and after December 8, 2009, MACs shall pay for voluntary HIV screening as follows:

- A maximum of once annually for beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered), and,
- A maximum of three times per term of pregnancy for pregnant Medicare beneficiaries beginning with the date of the first test when ordered by the woman's clinician.

Claims that are submitted for HIV screening shall be submitted in the following manner:

For beneficiaries reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 (Special screening for other specified viral disease) as primary, and V69.8 (Other problems related to lifestyle), as secondary.

For beneficiaries not reporting increased risk factors, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 only.

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, or G0435 with diagnosis code V73.89 as primary, and one of the following ICD-9 diagnosis codes: V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy), as secondary.

Effective for claims with dates of service on or after April 13, 2015, MACs shall also pay for voluntary, HIV screening as follows (replacing ICD-9 with ICD-10 beginning October 1, 2015):

For pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, G0435, G0475 or CPT®-80081 with primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4, along with one of the following ICD-9/ICD-10 diagnosis codes as secondary listed below, and allow no more than 3 HIV screening tests during each term of pregnancy beginning with the date of the 1st test:

ICD-9:	V22.0	Supervision of normal first pregnancy
ICD-10:	Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
	Z34.01	Encounter for supervision of normal first pregnancy, first trimester
	Z34.02	Encounter for supervision of normal first pregnancy, second trimester
	Z34.03	Encounter for supervision of normal first pregnancy, third trimester
ICD-9:	V22.1	Supervision of other normal pregnancy
ICD-10:	Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
	Z34.81	Encounter for supervision of other normal pregnancy, first trimester
	Z34.82	Encounter for supervision of other normal pregnancy, second trimester
	Z34.83	Encounter for supervision of other normal pregnancy, third trimester
	Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
	Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
	Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
	Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
ICD-9:	V23.9	Supervision of unspecified high-risk pregnancy
ICD-10:	O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester
	O09.92	Supervision of high risk pregnancy, unspecified, second trimester
		O09.93 Supervision of high risk pregnancy, unspecified, third trimester

For non-pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, G0435, or G0475 for beneficiaries between 15 and 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary regardless of risk factors. If primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present and the beneficiary is between 15 and 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

For non-pregnant Medicare beneficiaries, claims shall contain HCPCS code G0432, G0433, G0435, or G0475 for beneficiaries less than 15 and greater than 65 years of age one time per annum with ICD-9/ICD-10 diagnosis code V73.89/ Z11.4 as primary, and one of the following secondary ICD-9/ICD-10 diagnosis codes:

V69.8 (Other problems related to lifestyle)/Z72.89 (Other problems related to lifestyle)

Z72.51 (High risk heterosexual behavior)

Z72.52 (High risk homosexual behavior)

Z72.53 (High risk bisexual behavior)

If ICD-9/ICD-10 diagnosis code V73.89/Z11.4 is not present as primary and one of the ICD-9/ICD-10 secondary codes listed above is not present and the beneficiary is less than 15 or greater than 65 years of age, or the service is billed more than one time per annum, the detail line shall be denied.

100-4, Chapter-18, 130.3

Payment Method

Payment for HIV screening, HCPCS codes G0432, G0433, G0435, is under the Medicare Clinical Laboratory Fee Schedule (CLFS) for Types of Bill (TOB) 12X, 13X, 14X, 22X, and 23X beginning January 1, 2011. For TOB 85X payment is based on reasonable cost. Deductible and coinsurance do not apply. Between December 8, 2009, and April 4, 2010, these services can be billed with unlisted procedure code 87999.

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Between April 5, 2010, and January 1, 2011, HCPCS codes G0432, G0433, and G0435 will be contractor priced.

Payment for HIV screening, HCPCS code G0475, for institutional claims will be under the Medicare CLFS for TOB 12X, 13X, 14X, 22X, and 23X for claims on or after January 1, 2017. For TOB 85X payment is based on reasonable cost.

Effective for claims with date of service from April 13, 2015 through December 31, 2016, HCPCS code G0475 will be contractor priced. Beginning with date of service January 1, 2017 and after, HCPCS code G0475 will be priced and paid according to the CLFS.

HCPCS code G0475 will be included in the January 2017 CLFS, January 1, 2016 IOCE, the January 2016 OPPS and January 1, 2016 MPFSD. HCPCS code G0475 will be effective retroactive to April 13, 2015 in the IOCE & OPPS.

A/B MACs (B) shall only accept claims submitted with a G0475, G0432, G0433, or G0435 with a Place of Service (POS) Code equal to 81 Independent Lab, and 11, Office.

Deductible and coinsurance do not apply.

100-4, Chapter-18, 130.5

Diagnosis Code Reporting

A claim that is submitted for HIV screening shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims where increased risk factors are reported: ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary and ICD-9/ICD-10 diagnosis code V69.8/Z72.89, Z72.51, Z72.52, or Z72.53, as secondary.

b. For claims where increased risk factors are NOT reported: ICD-9/ICD-10 diagnosis code V73.89/Z11.4 as primary only.

c. For claims for pregnant Medicare beneficiaries, the following secondary diagnosis codes shall be submitted in addition to primary ICD-9/ICD-10 diagnosis code V73.89/Z11.4 to allow for more frequent screening than once per 12-month period:

ICD-9:	V22.0	Supervision of normal first pregnancy
ICD-10:	Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
	Z34.01	Encounter for supervision of normal first pregnancy, first trimester
	Z34.02	Encounter for supervision of normal first pregnancy, second trimester
	Z34.03	Encounter for supervision of normal first pregnancy, third trimester
ICD-9:	V22.1	Supervision of other normal pregnancy
ICD-10:	Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
	Z34.81	Encounter for supervision of other normal pregnancy, first trimester
	Z34.82	Encounter for supervision of other normal pregnancy, second trimester
	Z34.83	Encounter for supervision of other normal pregnancy, third trimester
	Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
	Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
	Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
	Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
ICD-9:	V23.9	Supervision of unspecified high-risk pregnancy
ICD-10:	O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester
	O09.92	Supervision of high risk pregnancy, unspecified, second trimester
	O09.93	Supervision of high risk pregnancy, unspecified, third trimester

100-4, Chapter-18, 140

Annual Wellness Visit (AWV)

Pursuant to section 4103 of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) amended section 411.15(a)(1) and 411.15(k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

The AWV will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B. CMS amended 42 CFR §§411.15(a)(1) and 411.15(k)(15) to allow payment on or after January 1, 2011, for an AWV (as established at 42 CFR 410.15) when performed by qualified health professionals.

Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional;
2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months.

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See Pub. 100-02,Medicare Benefit Policy Manual, chapter 15, section 280.5, for detailed policy regarding the AWV, including definitions of: (1) detection of cognitive impairment, (2) eligible beneficiary, (3) establishment of, or an update to, an individual's medical/family history, (4&5) first and subsequent AWVs providing PPPS, (6) health professional, and, (7) review of an individual's functional ability/level of safety.

100-4, Chapter-18, 140.1

Healthcare Common Procedure Coding System (HCPCS) Coding for the AWV

The HCPCS codes listed below were developed for the AWV benefit effective January 1, 2011, for individuals whose initial enrollment is on or after January 1, 2011.

G0438 -Annual wellness visit; includes a personalized prevention plan of service (PPPS); first visit

G0439 –Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit

100-4, Chapter-18, 140.5

Coinsurance and Deductible

Sections 4103 and 4104 of the Affordable Care Act provide for a waiver of Medicare coinsurance/copayment and Part B deductible requirements for the AWV effective for services furnished on or after January 1, 2011.

100-4, Chapter-18, 140.6

Common Working File (CWF) Edits

Effective for claims with dates of service on and after January 1,2011, CWF shall reject:

- AWV claims for G0438 when a previous (first) AWV, HCPCS code G0438, is paid in history regardless of when it occurred.
- AWV claims when a previous AWV, G0438 or G0439, is paid in history within the previous 12 months.
- Beginning January 1, 2011, AWV claims when a previous IPPE, HCPCS code G0402, is paid in history within the previous 12 months.
- AWV claims (G0438 and G0439) billed for a date of service within 12 months after the effective date of a beneficiary's first Medicare Part B coverage period.

The following change shall be effective for claims processed on or after April 1, 2013. Typically, when a preventive service is posted to a beneficiary's utilization history, separate entries are posted for a "professional" service (the professional claim for the delivery of the service itself) and a "technical" service (the institutional claims for a facility fee). However, in the case of AWV services, since there is no separate payment for a facility fee, the AWV claim will be posted as the "professional" service only, regardless of whether it is paid on a professional claim or an institutional claim.

100-4, Chapter-18, 150

Counseling to Prevent Tobacco Use

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT® codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively. See Chapter 32 section 12 for coverage and billing requirements for smoking cessation services.

Note: For claims effective 10/1/16. CPT® Codes 99406 or 99407 used for processing NCD210.4.1

***NOTE:* Instructions in sections 150 thru 150.4 are no longer valid.**

Effective for claims with dates of service on and after August 25, 2010, the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use services for outpatient and hospitalized Medicare beneficiaries:

1. Who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease;
2. Who are competent and alert at the time that counseling is provided; and,
3. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.

Conditions of Medicare Part A and Medicare Part B coverage for counseling to prevent tobacco use are located in the Medicare National Coverage Determinations (NCD) Manual, Publication 100-3, chapter1, section 210.4.1.

100-4, Chapter-18, 150.1

Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Coding

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT® codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively. See Chapter 32 section 12 for coverage and billing requirements for smoking cessation services.

The CMS has created two new CPT® codes for billing for tobacco cessation counseling services to prevent tobacco use for those individuals who use tobacco but do not have signs or symptoms of tobacco-related disease.

The two CPT® codes 99406 or 99407 that currently are used for smoking and tobacco-use cessation counseling for symptomatic individuals.

NOTE: The above G codes will not be active in A/B MAC (A), (B), and (HHH) systems until January 1, 2011. Therefore, A/B MAC (A), (B), and (HHH) shall advise non-outpatient perspective payment system (OPPS) providers to use unlisted code 99199 to bill for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010.

On January 3, 2011, A/B MAC (A), (B), and (HHH) systems will accept the new G codes for services performed on or after August 25, 2010.

Two new C codes have been created for facilities paid under OPPS when billing for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010:

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C9801 - Smoking and tobacco cessation counseling visit for the asymptomatic patient, intermediate, greater than 3 minutes, up to 10 minutes

Short descriptor: Tobacco-use counsel 3-10 min

C9802 - Smoking and tobacco cessation counseling visit for the asymptomatic patient, intensive, greater than 10 minutes

Short descriptor: Tobacco-use counsel >10min

Claims for smoking and tobacco use cessation counseling services 99406 or 99407 shall be submitted with the applicable diagnosis codes:

ICD-10-CM

ICD-10CM Code	Code Description
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
T65.211A	Toxic effect of chewing tobacco, accidental (unintentional), initial encounter
T65.212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65.213A	Toxic effect of chewing tobacco, assault, initial encounter
T65.214A	Toxic effect of chewing tobacco, undetermined, initial encounter
T65.221A	Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter
T65.222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65.223A	Toxic effect of tobacco cigarettes, assault, initial encounter
T65.224A	Toxic effect of tobacco cigarettes, undetermined, initial encounter
T65.291A	Toxic effect of other tobacco and nicotine, accidental (unintentional), initial encounter
T65.292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65.293A	Toxic effect of other tobacco and nicotine, assault, initial encounter
T65.294A	Toxic effect of other tobacco and nicotine, undetermined, initial encounter
Z87.891	Personal history of nicotine dependence

A/B MAC (A), (B), and (HHH) shall allow payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners shall use an appropriate HCPCS code to report an E/M service with modifier -25 to indicate that the E/M service is a separately identifiable service from 99406 or 99407.

100-4, Chapter-18, 150.2

A/B MACs (B) Billing Requirements

A/B MACs (B) shall pay for counseling to prevent tobacco use services billed with code G0436 or G0437 for dates of service on or after January 1, 2011. A/B MACs (B) shall pay for counseling services billed with code 99199 for dates of service performed on or after August 25, 2010 through December 31, 2010. The type of service (TOS) for each of the new codes is 1.

A/B MACs (B) pay for counseling services billed based on the Medicare Physician Fee Schedule (MPFS). Deductible and coinsurance apply for services performed on August 25, 2010, through December 31, 2010. For claims with dates of service on and after January 1, 2011, coinsurance and deductible do not apply on G0436 and G0437.

Physicians or qualified non-physician practitioners shall bill the A/B MACs (B) for counseling to prevent tobacco use services on Form CMS-1500 or an approved electronic format.

NOTE: The above G codes will not be active in MACs' systems until January 1, 2011. Therefore, MACs shall advise providers to use unlisted code 99199 to bill for counseling to prevent tobacco use services during the interim period of August 25, 2010, through December 31, 2010.

NOTE: Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT® codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively.

100-4, Chapter-18, 150.2.1

A/B MAC (A) and (HHH) Billing Requirements

The A/B MACs (A) and (HHH) shall pay for counseling to prevent tobacco use services with codes G0436 and G0437 for dates of service on or after January 1, 2011. A/B MACs (A) and (HHH) shall pay for counseling services billed with code 99199 for dates of service performed on or after August 25, 2010, through December 31, 2010. For facilities paid under OPPS, A/B MACs (A) shall pay for counseling services billed with codes C9801 and C9802 for dates of service performed on or after August 25, 2010, through December 31, 2010.

Claims for counseling to prevent tobacco use services should be submitted on Form CMS-1450 or its electronic equivalent.

The applicable bill types are 12X, 13X, 22X, 23X, 34X, 71X, 77X, and 85X.

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Payment for outpatient services is as follows:

Type of Facility	Method of Payment
Rural Health Centers (RHCs) TOB 71X/Federally Qualified Health Centers (FQHCs)TOB 77X	All-inclusive rate (AIR) for the encounter
Hospitals TOBs 12X and 13X	OPPS for hospitals subject to OPPS MPFS for hospitals not subject to OPPS
Indian Health Services (IHS) Hospitals TOB 13X	AIR for the encounter
Skilled Nursing Facilities (SNFs) TOBs 22X and 23X	Medicare Physician Fee Schedule (MPFS)
Home Health Agencies (HHAs) TOB 34X	MPFS
Critical Access Hospitals (CAHs) TOB 85X	Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS Data Base
IHS CAHs TOB 85X	Based on specific rate
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

Deductible and coinsurance apply for services performed on August 25, 2010, through December 31, 2010. For claims with dates of service on and after January 1, 2011, coinsurance and deductible do not apply for G0436 and G0437.

Effective September 30, 2016, HCPCS codes G0436 and G0437 are no longer valid. The services previously represented by G0436 and G0437 should be billed under existing CPT® codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater 10 minutes) respectively.

NOTE: Section 4104 of ACA provided for a waiver of Medicare coinsurance and Part B deductible for this service effective on or after 1/1/11. Copayment/coinsurance waived; Deductible waived for HCPCS G0436 & G0437 through 9/30/16, for CPT® codes 99406 & 99407 effective 10/1/16.

100-4, Chapter-18, 150.4

Common Working File (CWF)

The Common Working File (CWF) shall edit for the frequency of service limitations of counseling to prevent tobacco use sessions and smoking and tobacco-use cessation counseling services (99406, 99407) rendered to a beneficiary for a combined total of 8 sessions within a 12-month period. The beneficiary may receive another 8 sessions during a second or subsequent year after 11 full months have passed since the first Medicare covered counseling session was performed. To start the count for the second or subsequent 12-month period, begin with the month after the month in which the first Medicare covered counseling session was performed and count until 11 full months have elapsed.

By entering the beneficiary's health insurance claim number (HICN), providers have the capability to view the number of sessions a beneficiary has received for this service via inquiry through CWF.

100-4, Chapter-18, 160

Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)

For services furnished on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers intensive behavioral therapy (IBT) for cardiovascular disease (CVD). See National Coverage Determinations (NCD) Manual (Pub. 100-03) §210.11 for complete coverage guidelines.

100-4, Chapter-18, 160.1

Coding Requirements for IBT for CVD Furnished on or After November 8, 2011

The following is the applicable Healthcare Procedural Coding System (HCPCS) code for IBT for CVD:

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

A/B MACs (A) and (B) shall not apply deductibles or coinsurance to claim lines containing HCPCS code G0446.

100-4, Chapter-18, 160.2.1

Correct Place of Service (POS) Codes for IBT for CVD on Professional Claims

A/B MACs (B) shall pay for IBT CVD, G0446 only when services are provided at the following POS:

11- Physician's Office

22- Outpatient Hospital

49- Independent Clinic

72- Rural Health Clinic

Claims not submitted with one of the POS codes above will be denied.

The following messages shall be used when Medicare contractors deny professional claims for incorrect POS:

Claim Adjustment Reason Code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remittance Advice Remark Code (RARC) N428: "Not covered when performed in this place of service."

Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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100-4, Chapter-18, 160.2.2

Provider Specialty Edits for IBT for CVD on Professional Claims

A/B MACs (B) shall pay claims for HCPCS code G0446 only when services are submitted by the following provider specialty types found on the provider's enrollment record:

01= General Practice

08 = Family Practice

11= Internal Medicine

16 = Obstetrics/Gynecology

37= Pediatric Medicine

38 = Geriatric Medicine

42= Certified Nurse Midwife

50 = Nurse Practitioner

89 = Certified Clinical Nurse Specialist

97= Physician Assistant

A/B MACs (B) shall deny claim lines for HCPCS code G0446 performed by any other provider specialty type other than those listed above.

The following messages shall be used when A/B MACs (B) deny IBT for CVD claims billed with invalid provider specialty types:

CARC 185: "The rendering provider is not eligible to perform the service billed."

NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N95: "This provider type/provider specialty may not bill this service."

MSN 21.18: "This item or service is not covered when performed or ordered by this provider."

Spanish version: "Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

100-4, Chapter-18, 160.3

Correct Types of Bill (TOB) for IBT for CVD on Institutional Claims

Effective for claims with dates of service on and after November 8, 2011, the following types of bill (TOB) may be used for IBT for CVD: 13X, 71X, 77X, or 85X. All other TOB codes shall be denied.

The following messages shall be used when Medicare contractors deny claims for G0446 when submitted on a TOB other than those listed above:

CARC 170: Payment is denied when performed/billed by this type of provider. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N428: Not covered when performed in this place of service."

MSN 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

100-4, Chapter-18, 160.4

Frequency Edits for IBT for CVD Claims

A/B MACs (A) and (B) shall allow claims for G0446 no more than once in a 12-month period.

NOTE: 11 full months must elapse following the month in which the last G0446 IBT for CVD took place.

MAC shall deny claims IBT for CVD claims that exceed one (1) visit every 12 months.

A/B MACs (A) and (B) shall allow one professional service and one facility fee claim for each visit.

The following messages shall be used when Medicare A/B MACs (A) and (B) deny IBT for CVD claims that exceed the frequency limit:

CARC 119: "Benefit maximum for this time period or occurrence has been reached."

RARC N362: "The number of days or units of service exceeds our acceptable maximum."

MSN 20.5: "These services cannot be paid because your benefits are exhausted at this time."

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se hanagotado."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

100-4, Chapter-18, 170.1

Healthcare Common Procedure Coding System (HCPCS) Codes for Screening for STIs and HIBC to Prevent STIs

Effective for claims with dates of service on and after November 8, 2011, the claims processing instructions for payment of screening tests for STI will apply to the following HCPCS/CPT® codes:

- Chlamydia: 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800 (used for combined chlamydia and gonorrhea testing)
- Gonorrhea: 87590, 87591, 87850, 87800 (used for combined chlamydia and gonorrhea testing)
- Syphilis: 86592, 86593, 86780
- Hepatitis B: (Hepatitis B surface antigen): 87340, 87341

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Effective for claims with dates of service on and after November 8, 2011, implemented with the January 2, 2012, IOCE, the following HCPCS/CPT® code is to be billed for HIBC to prevent STIs

- G0445 –high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.

100-4, Chapter-18, 170.2

Diagnosis Code Reporting

A claim that is submitted for screening chlamydia, gonorrhea, syphilis, and/or Hepatitis B shall be submitted with one or more of the following diagnosis codes in the header and pointed to the line item:

a. For claims for screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant use the following ICD-10-CM diagnosis codes:
   - Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission;
   - And any of
     - Z72.89 - Other problems related to lifestyle, or
     - Z72.51 - High risk heterosexual behavior, or
     - Z72.52 - High risk homosexual behavior, or
     - Z72.53 - High risk bisexual behavior. (These diagnosis codes are used to indicate high/ increased risk for STIs).

b. For claims for screening for syphilis in men at increased risk use the following ICD-10-CM diagnosis codes:
   - Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission;
   - And any of
     - Z72.89 - Other problems related to lifestyle, or
     - Z72.51 - High risk heterosexual behavior, or
     - Z72.52 - High risk homosexual behavior, or
     - Z72.53 - High risk bisexual behavior. (These diagnosis codes are used to indicate high/ increased risk for STIs).

c. For claims for screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs use the following ICD-10-CM diagnosis codes, if applicable:
   - Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and one of:
     - Z72.89 - Other problems related to lifestyle, or
     - Z72.51 - High risk heterosexual behavior, or
     - Z72.52 - High risk homosexual behavior, or
     - Z72.53 - High risk bisexual behavior (These diagnosis codes are used to indicate high/ increased risk for STIs).

and also one of the following.

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

d. For claims for screening for syphilis in pregnant women use the following ICD-10-CM diagnosis codes:
   - Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; and one of

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

e. For claims for screening for syphilis in pregnant women at increased risk for STIs use the following ICD-10-CM diagnosis codes:

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- Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission; **and** any of:
  - Z72.89 - Other problems related to lifestyle, or
  - Z72.51 - High risk heterosexual behavior, or
  - Z72.52 - High risk homosexual behavior, or
  - Z72.53 - High risk bisexual behavior

and **also** one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

f. For claims for screening for hepatitis B in pregnant women use the following ICD-10-CM diagnosis codes:
   - Z11.59 - Encounter for screening for other viral diseases, **and** any of
   - Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester, or
   - Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester, or
   - Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester, or
   - O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester.

g. For claims for screening for hepatitis B in pregnant women at increased risk for STIs use the following ICD-10-CM diagnosis codes:
   - Z11.59 - Encounter for screening for other viral diseases, **and**
   - Z72.89 - Other problems related to lifestyle, **and**
   - any of
     - Z72.51 - High risk heterosexual behavior, or
     - Z72.52 - High risk homosexual behavior, or
     - Z72.53 - High risk bisexual behavior;
   - **and** also one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

100-4, Chapter-18, 170.3

Billing Requirements

- Effective for dates of service November 8, 2011, and later, A/B MACs (A) and (B) shall recognize HCPCS code G0445 for HIBC. Medicare shall cover up to two occurrences of G0445 when billed for IBC to prevent STIs. A claim that is submitted with HCPCS code G0445 for HIBC shall be submitted with ICD-9-CM diagnosis code V69.8 or ICD-10-CM diagnosis code Z72.89.
- A/B MACs (A) and (B) shall pay for screening for chlamydia, gonorrhea, and syphilis (as indicated by the presence of ICD-9-CM diagnosis code V74.5 or if ICD-10 is applicable, ICD-10-CM diagnosis code Z11.3); and/or Hepatitis B (as indicated by the presence of ICD-9-CM diagnosis code V73.89 or ICD-10-CM diagnosis code Z11.59) as follows:
- One annual occurrence of screening for chlamydia, gonorrhea, and syphilis (i.e., 1 per 12-month period) in women at increased risk who are not pregnant,
- One annual occurrence of screening for syphilis (i.e., 1 per 12-month period) in men at increased risk,
- Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening,
- One occurrence per pregnancy of screening for syphilis in pregnant women,
- Up to an additional two occurrences per pregnancy of screening for syphilis in pregnant women if the beneficiary is at continued increased risk for STIs,
- One occurrence per pregnancy of screening for Hepatitis B in pregnant women, and,

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- One additional occurrence per pregnancy of screening for Hepatitis B in pregnant women who are at continued increased risk for STIs.

100-4, Chapter-18, 170.4.1

Payment Method

Payment for HIBC is based on the all-inclusive payment rate for rural health clinics (TOBs 71X) and federally qualified health centers (TOB 77X). Hospital outpatient departments (TOB 13X) are paid based on the outpatient prospective payment system and CAHs (TOB 85X) are paid based on reasonable cost. CAHs electing the optional method of payment for outpatient services are paid based on 115% of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or submitted charge.

Effective for dates of service on and after November 8, 2011, deductible and coinsurance do not apply to claim lines with G0445.

HCPCS code G0445 may be paid on the same date of service as an annual wellness visit, evaluation and management (E&M) code, or during the global billing period for obstetrical care, but only one G0445 may be paid on any one date of service. If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs.

For Medicare Part B physician and non-practitioner claims, payment for HIBC to prevent STIs is based on the MPFS amount for G0445.

100-4, Chapter-18, 170.5

Specialty Codes and Place of Service (POS)

Medicare provides coverage for screening for chlamydia, gonorrhea, syphilis, and/or Hepatitis B and HIBC to prevent STIs only when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes:

- 01 –General Practice
- 08 –Family Practice
- 11 –Internal Medicine
- 16 –Obstetrics/Gynecology
- 37 –Pediatric Medicine
- 38 –Geriatric Medicine
- 42 –Certified Nurse Midwife
- 50 –Nurse Practitioner
- 89 –Certified Clinical Nurse Specialist
- 97 –Physician Assistant

Medicare provides coverage for HIBC to prevent STIs only when provided by a primary care practitioner (physician or non-physician) with any of the specialty codes identified above.

Medicare provides coverage for HIBC to prevent STIs only when the POS billed is 11, 22, 49, or 71.

100-4, Chapter-18, 180

Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

The United States Preventive Services Task Force (USPSTF) defines alcohol misuse as risky, hazardous, or harmful drinking which places an individual at risk for future problems with alcohol consumption. In the general adult population, alcohol consumption becomes risky or hazardous when consuming:

- Greater than 7 drinks per week or greater than 3 drinks per occasion for women and persons greater than 65 years old.
- Greater than 14 drinks per week or greater than 4 drinks per occasion for men 65 years old and younger.

100-4, Chapter-18, 180.1

Policy

Claims with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol misuse screening (HCPCS code G0442) consisting of 1 screening session, and for those that screen positive, upto 4 brief, face-to-face behavioral counseling sessions (HCPCS code G0443) per 12-month period for Medicare beneficiaries, including pregnant women.

Medicare beneficiaries that may be identified as having a need for behavioral counseling sessions include those:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Once a Medicare beneficiary has agreed to behavioral counseling sessions, the counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below.

1. ***Assess:*** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/ methods.
2. ***Advise:*** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. ***Agree:*** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. ***Assist:*** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

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5. ***Arrange:*** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

100-4, Chapter-18, 180.3

Professional Billing Requirements

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 -General Practice

08 -Family Practice

11 -Internal Medicine

16 -Obstetrics/Gynecology

37 -Pediatric Medicine

38 -Geriatric Medicine

42 –Certified Nurse-Midwife

50 -Nurse Practitioner

89 -Certified Clinical Nurse Specialist

97 -Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, only when submitted with one of the following place of service (POS) codes:

11 -Physician's Office

22 -Outpatient Hospital

49 -Independent Clinic

71 -State or local public health clinic or

Any claims that are not submitted with one of the POS codes noted above will be denied.

The alcohol screening/counseling services are payable with another encounter/visit on the same day. This does not apply for IPPE.

100-4, Chapter-18, 180.4

Claim Adjustment Reason Codes, Remittance Advice Remark Codes, Group Codes, and Medicare Summary Notice Messages

A/B MACs (A) and (B) shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for alcohol misuse screening and alcohol misuse behavioral counseling sessions:

- For RHC and FQHC claims that contain screening for alcohol misuse HCPCS code G0442 and alcohol misuse counseling HCPCS code G0443 with another encounter/visit with the same line item date of service, use group code CO and reason code:
  - Claim Adjustment Reason Code (CARC) 97 –The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present
- Denying claims containing HCPCS code G0442 and HCPCS code G0443 submitted on a TOB other than 13X, 71X, 77X, and 85X:
  - Claim Adjustment Reason Code (CARC) 5 -The procedure code/bill type is inconsistent with the place of service. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present
  - Remittance Advice Remark Code (RARC) M77 – Missing/incomplete/invalid place of service
  - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
  - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Denying claims that contains more than one alcohol misuse behavioral counseling session G0443 on the same date of service.
  - Medicare Summary Notice (MSN) 15.6 –The information provided does not support the need for this many services or items within this period of time.
  - Claim Adjustment Reason Code (CARC) 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
  - Remittance Advice Remark Code (RARC) M86 – Service denied because payment already made for same/similar procedure within set time frame.
  - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
  - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Denying claims that are not submitted from the appropriate provider specialties:
  - Medicare Summary Notice (MSN) 21.18 –This item or service is not covered when performed or ordered by this provider.
  - Claim Adjustment Reason Code (CARC) 185 -The rendering provider is not eligible to perform the service billed. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
  - Remittance Advice Remark Code (RARC) N95 -This provider type/provider specialty may not bill this service.
  - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
  - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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- Denying claims without the appropriate POS code:
  - Medicare Summary Notice (MSN) 21.25 –This service was denied because Medicare only covers this service in certain settings.
  - Claim Adjustment Reason Code (CARC) 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present.
  - Remittance Advice Remark Code (RARC) N428 –Not covered when performed in this place of service.
  - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
  - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Denying claims for alcohol misuse screening HCPCS code G0442 more than once in a 12-month period, and denying alcohol misuse counseling sessions HCPCS code G0443 more than four times in the same 12-month period:
  - Medicare Summary Notice (MSN) 20.5 –These services cannot be paid because your benefits are exhausted at this time.
  - Claim Adjustment Reason Code (CARC) 119 –Benefit maximum for this time period or occurrence has been reached.
  - Remittance Advice Remark Code (RARC) N362 – The number of Days or Units of service exceeds our acceptable maximum.
  - Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
  - Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

100-4, Chapter-18, 190

Screening for Depression in Adults (Effective October 14, 2011)

A. Coverage Requirements

Effective October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual screening up to 15 minutes for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in the primary care setting. Screening for depression is non-covered when performed more than one time in a 12-month period. The Medicare coinsurance and Part B deductible are waived for this preventive service.

Additional information on this National Coverage Determination (NCD) for Screening for Depression in Adults can be found in Publication 100-03, NCD Manual, Section 210.9.

100-4, Chapter-18, 190.1

A/B MAC (B) Billing Requirements

Effective October 14, 2011, contractors shall recognize new HCPCS G0444, annual depression screening, 15 minutes.

100-4, Chapter-18, 190.2

Frequency

A/B MACs (B) shall pay for annual depression screening, G0444, no more than once in a 12-month period.

NOTE: 11 full months must elapse following the month in which the last annual depression screening took place.

100-4, Chapter-18, 190.3

Place of Service (POS)

A/B MACs (B) shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):

11 –Office

22 –Outpatient Hospital

49 –Independent Clinic

71 –State or Local Public Health Clinic

100-4, Chapter-18, 200

Intensive Behavioral Therapy for Obesity (Effective November 29, 2011)

The United States Preventive Services Task Force (USPSTF) found good evidence that body mass index (BMI) is a reliable and valid indicator for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. It also good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI ≥30 kg/m2) produces modest, sustained weight loss.

100-4, Chapter-18, 200.1

Policy

For services furnished on or after November 29, 2011, Medicare will cover Intensive Behavioral Therapy for Obesity. Medicare beneficiaries with obesity (BMI ≥30 kg/m2) who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs.) weight loss requirement during the first 6 months as discussed below.

The counseling sessions are to be completed based on the 5As approach adopted by the United States Preventive Services Task Force (USPSTF.) The steps to the 5As approach are listed below:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/ methods.

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2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare will cover Face-to-Face Behavioral Counseling for Obesity, 15 minutes (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9-CM codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), up to 22 sessions in a 12-month period for Medicare beneficiaries. The Medicare coinsurance and Part B deductible are waived for this preventive service.

NOTE: Effective for claims with dates of service on or after January 1, 2015, codes G0473 and G0447 can be billed for a total of no more than 22 sessions in a 12-month period.

A/B MACs (A) and (B) shall note the appropriate ICD-10-CM code(s) that are listed below for future implementation. A/B MACs (A) and (B) shall track the ICD-10-CM codes and ensure that the updated edit is turned on when ICD-10 is implemented.

ICD-10-CM	Description
Z68.30	BMI 30.0-30.9, adult
Z68.31	BMI 31.0-31.9, adult
Z68.32	BMI 32.0-32.9, adult
Z68.33	BMI 33.0-33.9, adult
Z68.34	BMI 34.0-34.9, adult
Z68.35	BMI 35.0-35.9, adult
Z68.36	BMI 36.0-36.9, adult
Z68.37	BMI 37.0-37.9, adult
Z68.38	BMI 38.0-38.9, adult
Z68.39	BMI 39.0-39.9, adult
Z68.41	BMI 40.0-44.9, adult
Z68.42	BMI 45.0-49.9, adult
Z68.43	BMI 50.0-59.9, adult
Z68.44	BMI 60.0-69.9, adult
Z68.45	BMI 70 or greater, adult

See Pub. 100-03, Medicare National Coverage Determinations Manual, §210.12 for complete coverage guidelines.

100-4, Chapter-18, 200.3

Professional Billing Requirements

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-toface behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice

08 - Family Practice

11 - Internal Medicine

16 - Obstetrics/Gynecology

37 - Pediatric Medicine

38 - Geriatric Medicine

50 - Nurse Practitioner

89 - Certified Clinical Nurse Specialist

97 - Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-toface behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when submitted with one of the following place of service (POS) codes:

11 - Physician's Office

19 - Off Campus-Outpatient Hospital

22 - Outpatient Hospital

49 - Independent Clinic

71 - State or Local Public Health Clinic

Any claims that are not submitted with one of the POS codes noted above will be denied.

NOTE: HCPCS Code G0447 is effective November 29, 2011. HCPCS Code G0473 is effective January 1, 2015.

100-4, Chapter-18, 200.4

Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes, and Medicare Summary Notice (MSN) Messages

A/B MACs (A) and (B) shall use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes, or Medicare summary notice (MSN) messages when denying payment for obesity counseling sessions:

- Denying services submitted on a TOB other than 13X and 85X:

  CARC 171 - Payment is denied when performed by this type of provider on this type of facility. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC N428 - Not covered when performed in this place of service.

  MSN 16.2 - This service cannot be paid when provided in this location/facility.

  Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying services for obesity counseling sessions HCPCS code G0473 or G0447 with 1 of the ICD-9-CM codes (V85.30-V85.39 or V85.41-V85.45) or with one of the ICD-10-CM codes (Z68.30-Z68.39 or Z68.41-Z68.45) when billed for a total of more than 22 sessions in the same 12-month period:

  CARC 119 - Benefit maximum for this time period or occurrence has been reached.

  RARC N362 - The number of days or units of service exceeds our acceptable maximum.

  MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time.

  Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."

  Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines for obesity counseling sessions HCPCS code G0473 or G0447 without 1 of the appropriate ICD-9-CM codes (V85.30-V85.39 or V85.41-V85.45) or 1 of the ICD-10-CM codes (Z68.30-Z68.39 or Z68.41-Z68.45):

  CARC 167 - "This (these) diagnosis(es) is (are) not covered. ***NOTE:*** Refer to the ASC X12 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

  RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

  MSN 14.9 - "Medicare cannot pay for this service for the diagnosis shown on the claim."

  Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines without the appropriate POS code:

  CARC 5 - The procedure code/bill type is inconsistent with the place of service. ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

  RARC M77 - Missing/incomplete/invalid place of service.

  MSN 21.25 - This service was denied because Medicare only covers this service in certain settings.

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

- Denying claim lines that are not submitted from the appropriate provider specialties:

  CARC 8 - "The procedure code is inconsistent with the provider type/specialty (taxonomy). ***NOTE:*** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

  RARC N95 - "This provider type/provider specialty may not bill this service."

  MSN 21.18 - "This item or service is not covered when performed or ordered by this provider."

  Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

  NOTE: For modifier GZ, use CARC 50 and MSN 8.81.

100-4, Chapter-20, 30.1.2

Transcutaneous Electrical Nerve Stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental.

Effective June 8, 2012, CMS will allow coverage for TENS use in the treatment of chronic low back pain (CLBP) only under specific conditions which are described in the NCD Manual, Pub. 100-03, chapter 1 Section 160.27.

100-4, Chapter-20, 100.2.2

Evidence of Medical Necessity for Parenteral and Enteral Nutrition (PEN) Therapy

The PEN coverage is determined by information provided by the treating physician and the PEN supplier. A completed certification of medical necessity (CMN) must accompany and support initial claims for PEN to establish whether coverage criteria are met and to ensure that the PEN therapy provided is consistent with the attending or ordering physician's prescription. DME MACs ensure that the CMN contains pertinent information from the treating physician. Uniform specific medical data facilitate the review and promote consistency in coverage determinations and timelier claims processing.

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The medical and prescription information on a PEN CMN can be most appropriately completed by the treating physician or from information in the patient's records by an employee of the physician for the physician's review and signature. Although PEN suppliers sometimes may assist in providing the PEN services, they cannot complete the CMN since they do not have the same access to patient information needed to properly enter medical or prescription information. A/B MACs (B) and DME MACs use appropriate professional relations issuances, training sessions, and meetings to ensure that all persons and PEN suppliers are aware of this limitation of their role.

When properly completed, the PEN CMN includes the elements of a prescription as well as other data needed to determine whether Medicare coverage is possible. This practice will facilitate prompt delivery of PEN services and timely submittal of the related claim.

100-4, Chapter-20, 160.1

Billing for Total Parenteral Nutrition and Enteral Nutrition Furnished to Part B Inpatients

Inpatient Part A hospital or SNF care includes total parenteral nutrition (TPN) systems and enteral nutrition (EN).

For inpatients for whom Part A benefits are not payable (e.g., benefits are exhausted or the beneficiary is entitled to Part B only), total parenteral nutrition (TPN) systems and enteral nutrition (EN) delivery systems are covered by Medicare as prosthetic devices when the coverage criteria are met. When these criteria are met, the medical equipment and medical supplies (together with nutrients) being used comprise covered prosthetic devices for coverage purposes rather than durable medical equipment. However, reimbursement rules relating to DME continue to apply to such items.

When a facility supplies TPN or EN systems that meet the criteria for coverage as a prosthetic device to an inpatient whose care is not covered under Part A, the facility must bill one of the DME MACs. Additionally, HHAs, SNFs, and hospitals that provide PEN supplies, equipment and nutrients as a prosthetic device under Part B must use the ASC X12 837 professional claim format or if permissible the Form CMS-1500 paper form to bill the appropriate DME MAC. The DME MAC is determined according to the residence of the beneficiary. Refer to §10 for jurisdiction descriptions.

A/B MACs (A) and (HHH) return claims containing PEN charges for Part B services where the bill type is 12x, 13x, 22x, 23x, 32x, 33x, or 34x with instructions to the provider to bill the DME MAC.

100-4, Chapter-23, 60.3

Gap-filling DMEPOS Fees

Gap-filling is used in establishing fee schedule amounts for new DMEPOS items or services that do not have a fee schedule pricing history. If a HCPCS code is new and describes items and services that have a fee schedule pricing history (classified and paid for previously under a different code, including codes for miscellaneous items, e.g., E1399, and including fee schedule amounts established by CMS or the MACs), the fee schedule amounts for the new code are established using the process included in section 60.3.1 of this manual.

All DMEPOS items and services subject to payment on a fee schedule basis as mandated by sections 1833(o)(2)(A), 1834(a), (h), and (i) of the Social Security and/or by regulations at 42 CFR 414.102 and 414.210 must have national fee schedule amounts established by CMS or interim local fee schedule amounts established by the MACs for use in paying claims for the items and services. Effective February 28, 2022, interim local fee schedule amounts established by the MACs for paying claims on an interim basis are considered a fee schedule pricing history for continuity of pricing purposes under §60.3.1 below for the time before national fee schedule amounts are established, but can be considered by CMS in developing national fee schedule amounts. Once national fee schedule amounts are established for an item or service, the national fee schedule amounts become the new fee schedule pricing history for the item or service for continuity of pricing purposes under §60.3.1 below. Local fee schedule amounts established by the MACs for use in paying claims prior to February 28, 2022 are considered a fee schedule pricing history for continuity of pricing purposes under §60.3.1 below.

The DME MACs or A/B MACs must establish fee schedule amounts for DMEPOS items and services billed using HCPCS codes for miscellaneous items not otherwise classified under the HCPCS (e.g., E1399, L2999, and L8699). Once the fee schedule amounts are established for DMEPOS items and services billed using HCPCS codes for miscellaneous items, these fee schedule amounts would only change when update factors are applied, to correct an error in the calculation of the fee schedule amounts, for based on program instructions.

For DME items, the DME MACs must apply the DME payment method depending on the DME class the item falls under (e.g., the item would be paid on a capped rental basis if it is expensive, not customized, not oxygen and oxygen equipment, and does not require frequent and substantial servicing in order to avoid risk to the patient).

National fee schedule amounts established by CMS and interim local fee schedule amounts established by the DME MACs and A/B MACs Part B shall be gap-filled for items for which charge data were unavailable during the fee schedule data base year using the fee schedule amounts for comparable equipment. Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services. A comparison can be based on, but not limited to the following components: physical, mechanical, electrical, function and intended use, and additional attributes and features. When examining whether an item is comparable to another item, the analysis can be based on the items as a whole, its subcomponents, or a combination of items. A new product does not need to be comparable within each category, and there is no prioritization to the categories.

Examples of Attributes in Each Component Category

- Physical: Aesthetics, Design, Customized vs. Standard, Material, Portable, Size, Temperature Range/Tolerance, Weight
- Mechanical: Automated vs. Manual, Brittleness, Ductility, Durability, Elasticity, Fatigue, Flexibility, Hardness, Load Capacity, Flow-Control, Permeability, Strength
- Electrical: Capacitance, Conductivity, Dielectric Constant, Frequency, Generator, Impedance, Piezo-electric, Power, Power Source, Resistance
- Function and Intended Use: Function, Intended Use

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- Additional Attributes and Features: "Smart", Alarms, Constraints, Device Limitations, Disposable, Parts, Features, Invasive vs. Non-Invasive.

If unable to identify comparable item(s), other sources of pricing data can be used to calculate the gap-filled fee schedule amount for the new item. These sources include using supplier or commercial price lists with prices in effect during the fee schedule data base year. Data base "year" refers to the time period mandated by the statute and/or regulations from which Medicare allowed charge data is to be extracted in order to compute the fee schedule amounts for the various DMEPOS payment categories. For example, the fee schedule base year for inexpensive or routinely purchased durable medical equipment is the 12 month period ending June 30, 1987. Supplier price lists include catalogues and other retail price lists (such as internet retail prices) that provide information on commercial pricing for the item. Potential appropriate sources for such commercial pricing information can also include payments made by Medicare Advantage plans as well as verifiable information from supplier invoices and non-Medicare payer data (e.g., fee schedule amounts comprised of the median of the commercial pricing information adjusted as described below). DME MACs and A/B MACs shall gap-fill based on current instructions released each year for implementing and updating the payment amounts.

If the only available price information is from a period other than the base period, apply the deflation factors that are included in the current year implementation instructions against current pricing in order to approximate the base year price for gap-filling purposes.

The deflation factors for gap-filling purposes are shown below:

Year*	OX	CR	PO	SD	PE	SC	IL
1987	0.965	0.971	0.974	n/a	n/a	n/a	n/a
1988	0.928	0.934	0.936	n/a	n/a	n/a	n/a
1989	0.882	0.888	0.890	n/a	n/a	n/a	n/a
1990	0.843	0.848	0.851	n/a	n/a	n/a	n/a
1991	0.805	0.810	0.813	n/a	n/a	n/a	n/a
1992	0.781	0.786	0.788	n/a	n/a	n/a	n/a
1993	0.758	0.763	0.765	0.971	n/a	n/a	n/a
1994	0.740	0.745	0.747	0.947	n/a	n/a	n/a
1995	0.718	0.723	0.725	0.919	n/a	n/a	n/a
1996	0.699	0.703	0.705	0.895	0.973	n/a	n/a
1997	0.683	0.687	0.689	0.875	0.951	n/a	n/a
1998	0.672	0.676	0.678	0.860	0.936	n/a	n/a
1999	0.659	0.663	0.665	0.844	0.918	n/a	n/a
2000	0.635	0.639	0.641	0.813	0.885	n/a	n/a
2001	0.615	0.619	0.621	0.788	0.857	n/a	n/a
2002	0.609	0.613	0.614	0.779	0.848	n/a	n/a
2003	0.596	0.600	0.602	0.763	0.830	n/a	n/a
2004	0.577	0.581	0.582	0.739	0.804	n/a	n/a
2005	0.563	0.567	0.568	0.721	0.784	n/a	n/a
2006	0.540	0.543	0.545	0.691	0.752	n/a	n/a
2007	0.525	0.529	0.530	0.673	0.732	n/a	n/a
2008	0.500	0.504	0.505	0.641	0.697	n/a	n/a
2009	0.508	0.511	0.512	0.650	0.707	n/a	n/a
2010	0.502	0.506	0.507	0.643	0.700	n/a	n/a
2011	0.485	0.488	0.490	0.621	0.676	n/a	n/a
2012	0.477	0.480	0.482	0.611	0.665	n/a	n/a
2013	0.469	0.472	0.473	0.600	0.653	n/a	0.983
2014	0.459	0.462	0.464	0.588	0.640	0.980	0.963
2015	0.459	0.462	0.463	0.588	0.639	0.978	0.962
2016	0.454	0.457	0.458	0.582	0.633	0.969	0.952
2017	0.447	0.450	0.451	0.572	0.623	0.953	0.937
2018	0.435	0.437	0.439	0.556	0.605	0.927	0.911
2019	0.427	0.430	0.431	0.547	0.595	0.912	0.896
2020	0.425	0.427	0.429	0.544	0.592	0.906	0.891
2021	0.403	0.406	0.407	0.516	0.561	0.859	0.845
2022	0.370	0.372	0.373	0.473	0.515	0.788	0.774
2023	0.359	0.361	0.362	0.460	0.500	0.765	0.752

* Year price in effect

Payment Category Key:

OX	Oxygen & oxygen equipment (DME)
CR	Capped rental (DME)
IN	Inexpensive/routinely purchased (DME)
FS	Frequently serviced (DME)
SU	DME supplies
PO	Prosthetics & orthotics
SD	Surgical dressings
OS	Ostomy, tracheostomy, and urological supplies
PE	Parental and enteral nutrition
TS	Therapeutic Shoes
SC	Splints and Casts
IL	Intraocular Lenses inserted in a physician's office IN, FS, OS and SU category deflation factors=PO deflation factors

After deflation, the result must be increased by 1.7 percent and by the annual update factors shown below.

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DMEPOS Fee Schedule Update Factors for Gap-Filling Purposes (Updates applied to 1986/87 base year amounts unless otherwise noted) Update factors mandated by sections 1834(a)(14), 1834(h)(1)(E), 1834(h)(4)(A), 1834(i)(1)(B), and 1842(s)(1)(B) of the Social Security Act

Year	Class III DME	Other DME, Ostomy, Tracheostomy, and Urological Supplies	Parenteral and Enteral Nutrition[1]	Surgical Dressings[2]	Prosthetics, Orthotics, and Other Prosthetic Devices[3]
1989	1.7%	1.7%	n/a	n/a	1.7%
1990	0.0%	0.0%	n/a	n/a	0.0%
1991	3.7%	3.7%	n/a	n/a	0.0%
1992	3.7%	3.7%	n/a	n/a	4.7%
1993	3.1%	3.1%	n/a	3.1%	3.1%
1994	3.0%	3.0%	n/a	3.0%	0.0%
1995	2.5%	2.5%	n/a	2.5%	0.0%
1996	3.0%	3.0%	n/a	3.0%	3.0%
1997	2.8%	2.8%	n/a	2.8%	2.8%
1998	0.0%	0.0%	n/a	0.0%	1.0%
1999	0.0%	0.0%	n/a	0.0%	1.0%
2000	0.0%	0.0%	n/a	0.0%	1.0%
2001	3.7%	3.7%	n/a	3.7%	3.7%
2002	0.0%	0.0%	0.0%	0.0%	1.0%
2003	1.1%	1.1%	1.1%	1.1%	1.1%
2004	2.1%	0.0%	2.1%	0.0%	0.0%
2005	3.3%	0.0%	3.3%	0.0%	0.0%
2006	2.5%	0.0%	2.5%	0.0%	0.0%
2007	0.0%	0.0%	4.3%	0.0%	4.3%
2008	2.7%	0.0%	2.7%	0.0%	2.7%
2009	5.0%	5.0%	5.0%	5.0%	5.0%
2010	0.0%	0.0%	0.0%	0.0%	0.0%
2011	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
2012	2.4%	2.4%	2.4%	2.4%	2.4%
2013	0.8%	0.8%	0.8%	0.8%	0.8%
2014	1.0%	1.0%	1.0%	1.0%	1.0%
2015	1.5%	1.5%	1.5%	1.5%	1.5%
2016	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%
2017	0.7%	0.7%	0.7%	0.7%	0.7%
2018	1.1%	1.1%	1.1%	1.1%	1.1%
2019	2.3%	2.3%	2.3%	2.3%	2.3%
2020	0.9%	0.9%	0.9%	0.9%	0.9%
2021	0.2%	0.2%	0.2%	0.2%	0.2%
2022	5.1%	5.1%	5.1%	5.1%	5.1%
2023	8.7%	8.7%	8.7%	8.7%	8.7%
2024	2.6%	2.6%	2.6%	2.6%	2.6%

[1] Base Year is 1995

[2] Base Year is 1992

[3] Artificial legs, arms, and eyes (prosthetics); leg, arm, back, and neck braces (orthotics); and all other prosthetic devices other than ostomy, tracheostomy, and urological supplies, parenteral and enteral nutrition, and intraocular lenses inserted in a physician's office

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Note that when gap-filling for capped rental items, it is necessary to first gap-fill the purchase price and then compute the base period fee schedule at 10 percent of the base period purchase price.

For used equipment, establish fee schedule amounts at 75 percent of the fee schedule amount for new equipment.

Gap-filling is not used in establishing fee schedule amounts for new lymphedema compression treatment items that do not have a fee schedule pricing history. Additional information on payment for lymphedema compression treatment items is available at Pub. 100-04 Medicare Claims Processing Manual, Chapter 20, Section 181.1 Payment Policy for Lymphedema Compression Treatment Items.

If within 5 years of establishing fee schedule amounts using supplier or commercial prices, the supplier or commercial prices decrease by less than 15 percent, CMS can make a one-time adjustment to the fee schedule amounts using the new prices. The new supplier or commercial prices would be used to establish the new fee schedule amounts in the same way that the older prices were used, including application of the deflation formula of this section.

100-4, Chapter-32, 11.3.1

Policy

Effective for claims with dates of service on or after April 13, 2021, contractors shall accept and pay for autologous platelet-rich plasma (PRP) for the treatment of chronic non-healing diabetic wounds for a duration of 20 weeks, when prepared by devices whose Food and Drug Administration-cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers, in accordance with the coverage criteria outlined in Publication 100-03, chapter 1, section 270.3, of the National Coverage Determinations (NCD) Manual.

NOTE: Coverage of PRP services for the treatment of chronic non-healing diabetic wounds that are performed more than 20 weeks after the date of the first PRP service shall be determined by the local Medicare Administrative Contractor (MAC).

Coverage of autologous PRP for the treatment of all other chronic non-healing wounds (nondiabetic) will be determined by local MACs under section 1862(a)(1)(A) of the Social Security Act.

100-4, Chapter-32, 11.3.2

Healthcare Common Procedure Coding System (HCPCS) Codes and Diagnosis Coding

Healthcare Common Procedure Coding System (HCPCS) Code

Effective for claims with dates of service on or after April 13, 2021, Medicare providers shall report HCPCS code G0460 for PRP services for the treatment of chronic non-healing nondiabetic wounds.

Effective for claims with dates of service on or after April 13, 2021, Medicare providers shall report HCPCS code G0465 for PRP services for the treatment of chronic non-healing diabetic wounds under the conditions and criteria outlined in NCD Manual Section 270.3.

If ICD-10 Diagnosis coding is applicable

For claims with dates of service on or after April 13, 2021, PRP, for the treatment of chronic non-healing diabetic wounds must be billed reporting both an ICD-10 diagnosis code for diabetes mellitus and an ICD-10 diagnosis code for chronic ulcers.

- Two diagnosis codes are required- Diabetic Mellitus plus Chronic Ulcer

Diabetes Mellitus

E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer

Chronic Ulcer

L97.111	Non-pressure chronic ulcer of right thigh limited to breakdown of skin
L97.112	Non-pressure chronic ulcer of right thigh with fat layer exposed
L97.113	Non-pressure chronic ulcer of right thigh with necrosis of muscle
L97.115	Non-pressure chronic ulcer of right thigh with muscle involvement without evidence of necrosis
L97.116	Non-pressure chronic ulcer of right thigh with bone involvement without evidence of necrosis
L97.118	Non-pressure chronic ulcer of right thigh with other specified severity
L97.114	Non-pressure chronic ulcer of right thigh with necrosis of bone
L97.121	Non-pressure chronic ulcer of left thigh limited to breakdown of skin
L97.122	Non-pressure chronic ulcer of left thigh with fat layer exposed
L97.123	Non-pressure chronic ulcer of left thigh with necrosis of muscle
L97.124	Non-pressure chronic ulcer of left thigh with necrosis of bone
L97.125	Non-pressure chronic ulcer of left thigh with muscle involvement without evidence of necrosis

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L97.126	Non-pressure chronic ulcer of left thigh with bone involvement without evidence of necrosis
L97.128	Non-pressure chronic ulcer of left thigh with other specified severity
L97.211	Non-pressure chronic ulcer of right calf limited to breakdown of skin
L97.212	Non-pressure chronic ulcer of right calf with fat layer exposed
L97.213	Non-pressure chronic ulcer of right calf with necrosis of muscle
L97.214	Non-pressure chronic ulcer of right calf with necrosis of bone
L97.215	Non-pressure chronic ulcer of right calf with muscle involvement without evidence of necrosis
L97.216	Non-pressure chronic ulcer of right calf with bone involvement without evidence of necrosis
L97.218	Non-pressure chronic ulcer of right calf with other specified severity
L97.221	Non-pressure chronic ulcer of left calf limited to breakdown of skin
L97.222	Non-pressure chronic ulcer of left calf with fat layer exposed
L97.223	Non-pressure chronic ulcer of left calf with necrosis of muscle
L97.224	Non-pressure chronic ulcer of left calf with necrosis of bone
L97.225	Non-pressure chronic ulcer of left calf with muscle involvement without evidence of necrosis
L97.226	Non-pressure chronic ulcer of left calf with bone involvement without evidence of necrosis
L97.228	Non-pressure chronic ulcer of left calf with other specified severity
L97.315	Non-pressure chronic ulcer of right ankle with muscle involvement without evidence of necrosis
L97.316	Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis
L97.318	Non-pressure chronic ulcer of right ankle with other specified severity
L97.321	Non-pressure chronic ulcer of left ankle limited to breakdown of skin
L97.322	Non-pressure chronic ulcer of left ankle with fat layer exposed
L97.323	Non-pressure chronic ulcer of left ankle with necrosis of muscle
L97.324	Non-pressure chronic ulcer of left ankle with necrosis of bone
L97.325	Non-pressure chronic ulcer of left ankle with muscle involvement without evidence of necrosis
L97.326	Non-pressure chronic ulcer of left ankle with bone involvement without evidence of necrosis
L97.328	Non-pressure chronic ulcer of left ankle with other specified severity
L97.411	Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
L97.412	Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
L97.413	Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
L97.414	Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone
L97.415	Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis
L98.416	Non-pressure chronic ulcer of buttock with bone involvement without evidence of necrosis
L98.418	Non-pressure chronic ulcer of buttock with other specified severity
L98.421	Non-pressure chronic ulcer of back limited to breakdown of skin
L98.422	Non-pressure chronic ulcer of back with fat layer exposed
L98.423	Non-pressure chronic ulcer of back with necrosis of muscle
L98.424	Non-pressure chronic ulcer of back with necrosis of bone
L98.425	Non-pressure chronic ulcer of back with muscle involvement without evidence of necrosis
L98.426	Non-pressure chronic ulcer of back with bone involvement without evidence of necrosis
L98.428	Non-pressure chronic ulcer of back with other specified severity
L98.491	Non-pressure chronic ulcer of skin of other sites limited to breakdown of skin
L98.492	Non-pressure chronic ulcer of skin of other sites with fat layer exposed
L98.493	Non-pressure chronic ulcer of skin of other sites with necrosis of muscle
L98.494	Non-pressure chronic ulcer of skin of other sites with necrosis of bone

Frequency Requirements:

Effective for claims with dates of service on and after April 13, 2021, contractors shall cover PRP services for chronic non-healing diabetic wounds, G0465, for a maximum of 20 weeks beginning with the first week of treatment.

Effective for claims with dates of services on or after April 13, 2021, the local MACs shall have discretion to pay PRP services for chronic non-healing diabetic wounds, G0465, that are performed more than 20 weeks after the date of the first PRP service when the -KX modifier is reported on the claim.

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Effective for claims with dates of service on and after April 13, 2021, contractors shall have discretion to cover, and determine frequency for, PRP services for chronic non-healing nondiabetic wounds, G0460.

100-4, Chapter-32, 11.3.3

Types of Bill (TOB)

(Rev. 11214, Issued: 01-20-22, Effective:04-13-21, Implementation: 01-03-22 Shared Systems Contractors, 02-14-22 MACs)

100-4, Chapter-32, 11.3.5

Place of Service (POS) for Professional Claims

Effective for claims with dates of service on or after August 2, 2012, place of service (POS) codes 11, 22, and 49 shall be used for PRP services.

Effective for claims with dates of service on or after April 13, 2021, POS codes 11, 19, 22, and 49 shall be used for PRP services.

100-4, Chapter-32, 11.3.6

Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs) and Group Codes

Contractors shall deny claims for PRP services when provided on other than TOBs 12X, 13X, 22X, 23X, 71X, 75X, 77X, and 85X using:

MSN 21.25 - "This service was denied because Medicare only covers this service in certain settings."

Spanish Version - "El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

CARC 58 - "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **NOTE:** Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

RARC N428 - "Service/procedure not covered when performed in this place of service."

Group Code - CO (Contractual Obligation)

Contractors shall reject claims for PRP services for the treatment of chronic non-healing diabetic wounds, G0465, that are performed more than 20 weeks after the date of the first PRP service when the –KX modifier is NOT included on the claim using the following messages:

CARC 119 – Benefit Maximum for this time period or occurrence has been reached.

RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered.

A copy of this policy is available www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Medicare Summary Notice (MSN) 20.5 – These services cannot be paid because your benefits are exhausted at this time.

Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se hanagotado."

Group Code – CO (Contractual Obligation)

Contractors shall deny/reject claims for PRP services for the treatment of chronic non-healing diabetic wounds, G0465, that don't contain the appropriate diagnosis codes as noted above and use the following messages:

Claim Adjustment Reason Code (CARC) 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at: www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Medicare Summary Notice (MSN) 15.19 - "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."

Spanish Version -Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicarecoverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") yenviela con la información de su médico.

MSN 15.20 - "The following polices were used when we made this decision: NCD 270.3."

Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 270.3."

NOTE: Due to system requirement, the Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.

Group Code – Contractual Obligation (CO).

100-4, Chapter-32, 40.1

Coverage Requirements

Effective January 1, 2002, sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome and urinary retention. Sacral nerve stimulation involves both a temporary test stimulation to determine if an implantable stimulator would be effective and a permanent implantation in appropriate candidates. Both the test and the permanent implantation are covered.

The following limitations for coverage apply to all indications:

- Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.
- Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) that are associated with secondary manifestations of the above three indications are excluded.

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- Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.
- Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

100-4, Chapter-32, 50

Deep Brain Stimulation for Essential Tremor and Parkinson's Disease

Deep brain stimulation (DBS) refers to high-frequency electrical stimulation of anatomic regions deep within the brain utilizing neurosurgically implanted electrodes. These DBS electrodes are stereotactically placed within targeted nuclei on one (unilateral) or both (bilateral) sides of the brain. There are currently three targets for DBS —the thalamic ventralis intermedius nucleus (VIM), subthalamic nucleus (STN) and globus pallidus interna (GPi).

Essential tremor (ET) is a progressive, disabling tremor most often affecting the hands. ET may also affect the head, voice and legs. The precise pathogenesis of ET is unknown. While it may start at any age, ET usually peaks within the second and sixth decades. Beta-adrenergic blockers and anticonvulsant medications are usually the first line treatments for reducing the severity of tremor. Many patients, however, do not adequately respond or cannot tolerate these medications. In these medically refractory ET patients, thalamic VIM DBS may be helpful for symptomatic relief of tremor.

Parkinson's disease (PD) is an age-related progressive neurodegenerative disorder involving the loss of dopaminergic cells in the substantia nigra of the midbrain. The disease is characterized by tremor, rigidity, bradykinesia and progressive postural instability. Dopaminergic medication is typically used as a first line treatment for reducing the primary symptoms of PD. However, after prolonged use, medication can become less effective and can produce significant adverse events such as dyskinesias and other motor function complications. For patients who become unresponsive to medical treatments and/or have intolerable side effects from medications, DBS for symptom relief may be considered.

100-4, Chapter-32, 60.4.1

Allowable Covered Diagnosis Codes

For services furnished on or after the implementation of ICD-10 the applicable ICD-10-CM diagnosis codes for this benefit are:

ICD-10-CM Code	Code Description
D68.51	Activated protein C resistance
D68.52	Prothrombin gene mutation
D68.59	Other primary thrombophilia
D68.61	Antiphospholipid syndrome
D68.62	Lupus anticoagulant syndrome
I23.6	Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction
I26.01	Septic pulmonary embolism with acute cor pulmonale
I26.09	Other pulmonary embolism with acute cor pulmonale
I26.90	Septic pulmonary embolism without acute cor pulmonale
I26.93	Single subsegmental pulmonary embolism without acute cor pulmonale
I26.94	Multiple subsegmental pulmonary emboli without acute cor pulmonale
I26.99	Other pulmonary embolism without acute cor pulmonale
I27.24	Chronic thromboembolic pulmonary hypertension
I27.82	Chronic pulmonary embolism
I48.0	Paroxysmal atrial fibrillation
I48.11	Longstanding persistent atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.21	Permanent atrial fibrillation
I67.6	Nonpyogenic thrombosis of intracranial venous system
I80.211	Phlebitis and thrombophlebitis of right iliac vein
I80.212	Phlebitis and thrombophlebitis of left iliac vein
I80.213	Phlebitis and thrombophlebitis of iliac vein, bilateral
I80.221	Phlebitis and thrombophlebitis of right popliteal vein
I80.222	Phlebitis and thrombophlebitis of left popliteal vein
I80.223	Phlebitis and thrombophlebitis of popliteal vein, bilateral
I80.231	Phlebitis and thrombophlebitis of right tibial vein
I80.232	Phlebitis and thrombophlebitis of left tibial vein
I80.233	Phlebitis and thrombophlebitis of tibial vein, bilateral
I80.241	Phlebitis and thrombophlebitis of right peroneal vein
I80.242	Phlebitis and thrombophlebitis of left peroneal vein
I80.243	Phlebitis and thrombophlebitis of peroneal vein, bilateral
I80.251	Phlebitis and thrombophlebitis of right calf muscular vein
I80.252	Phlebitis and thrombophlebitis of left calf muscular vein
I80.253	Phlebitis and thrombophlebitis of calf muscular vein, bilateral
I80.291	Phlebitis and thrombophlebitis of other deep vessels of right lower extremity
I80.292	Phlebitis and thrombophlebitis of other deep vessels of left lower extremity
I80.293	Phlebitis and thrombophlebitis of other deep vessels of lower extremity, bilateral
I82.0	Budd-Chiari syndrome
I82.210	Acute embolism and thrombosis of superior vena cava
I82.211	Chronic embolism and thrombosis of superior vena cava
I82.220	Acute embolism and thrombosis of inferior vena cava
I82.221	Chronic embolism and thrombosis of inferior vena cava
I82.290	Acute embolism and thrombosis of other thoracic veins
I82.291	Chronic embolism and thrombosis of other thoracic veins
I82.3	Embolism and thrombosis of renal vein
I82.411	Acute embolism and thrombosis of right femoral vein
I82.412	Acute embolism and thrombosis of left femoral vein
I82.413	Acute embolism and thrombosis of femoral vein, bilateral
I82.421	Acute embolism and thrombosis of right iliac vein
I82.422	Acute embolism and thrombosis of left iliac vein

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ICD-10-CM Code	Code Description
I82.423	Acute embolism and thrombosis of iliac vein, bilateral
I82.431	Acute embolism and thrombosis of right popliteal vein
I82.432	Acute embolism and thrombosis of left popliteal vein
I82.433	Acute embolism and thrombosis of popliteal vein, bilateral
I82.441	Acute embolism and thrombosis of right tibial vein
I82.442	Acute embolism and thrombosis of left tibial vein
I82.443	Acute embolism and thrombosis of tibial vein, bilateral
I82.451	Acute embolism and thrombosis of right peroneal vein
I82.452	Acute embolism and thrombosis of left peroneal vein
I82.453	Acute embolism and thrombosis of peroneal vein, bilateral
I82.461	Acute embolism and thrombosis of right calf muscular vein
I82.462	Acute embolism and thrombosis of left calf muscular vein
I82.463	Acute embolism and thrombosis of calf muscular vein, bilateral
I82.491	Acute embolism and thrombosis of other specified deep vein of right lower extremity
I82.492	Acute embolism and thrombosis of other specified deep vein of left lower extremity
I82.493	Acute embolism and thrombosis of other specified deep vein of lower extremity, bilateral
I82.511	Chronic embolism and thrombosis of right femoral vein
I82.512	Chronic embolism and thrombosis of left femoral vein
I82.513	Chronic embolism and thrombosis of femoral vein, bilateral
I82.521	Chronic embolism and thrombosis of right iliac vein
I82.522	Chronic embolism and thrombosis of left iliac vein
I82.523	Chronic embolism and thrombosis of iliac vein, bilateral
I82.531	Chronic embolism and thrombosis of right popliteal vein
I82.532	Chronic embolism and thrombosis of left popliteal vein
I82.533	Chronic embolism and thrombosis of popliteal vein, bilateral
I82.541	Chronic embolism and thrombosis of right tibial vein
I82.542	Chronic embolism and thrombosis of left tibial vein
I82.543	Chronic embolism and thrombosis of tibial vein, bilateral
I82.551	Chronic embolism and thrombosis of right peroneal vein
I82.552	Chronic embolism and thrombosis of left peroneal vein
I82.553	Chronic embolism and thrombosis of peroneal vein, bilateral
I82.561	Chronic embolism and thrombosis of right calf muscular vein
I82.562	Chronic embolism and thrombosis of left calf muscular vein
I82.563	Chronic embolism and thrombosis of calf muscular vein, bilateral
I82.591	Chronic embolism and thrombosis of other specified deep vein of right lower extremity
I82.592	Chronic embolism and thrombosis of other specified deep vein of left lower extremity
I82.593	Chronic embolism and thrombosis of other specified deep vein of lower extremity, bilateral
I82.621	Acute embolism and thrombosis of deep veins of right upper extremity
I82.622	Acute embolism and thrombosis of deep veins of left upper extremity
I82.623	Acute embolism and thrombosis of deep veins of upper extremity, bilateral
I82.721	Chronic embolism and thrombosis of deep veins of right upper extremity
I82.722	Chronic embolism and thrombosis of deep veins of left upper extremity
I82.723	Chronic embolism and thrombosis of deep veins of upper extremity, bilateral
I82.890	Acute embolism and thrombosis of other specified veins
I82.891	Chronic embolism and thrombosis of other specified veins
I82.A11	Acute embolism and thrombosis of right axillary vein
I82.A12	Acute embolism and thrombosis of left axillary vein
I82.A13	Acute embolism and thrombosis of axillary vein, bilateral
I82.A21	Chronic embolism and thrombosis of right axillary vein
I82.A22	Chronic embolism and thrombosis of left axillary vein
I82.A23	Chronic embolism and thrombosis of axillary vein, bilateral
I82.B11	Acute embolism and thrombosis of right subclavian vein
I82.B12	Acute embolism and thrombosis of left subclavian vein
I82.B13	Acute embolism and thrombosis of subclavian vein, bilateral
I82.B21	Chronic embolism and thrombosis of right subclavian vein
I82.B22	Chronic embolism and thrombosis of left subclavian vein
I82.B23	Chronic embolism and thrombosis of subclavian vein, bilateral
I82.C11	Acute embolism and thrombosis of right internal jugular vein
I82.C12	Acute embolism and thrombosis of left internal jugular vein
I82.C13	Acute embolism and thrombosis of internal jugular vein, bilateral
I82.C21	Chronic embolism and thrombosis of right internal jugular vein
I82.C22	Chronic embolism and thrombosis of left internal jugular vein
I82.C23	Chronic embolism and thrombosis of internal jugular vein, bilateral
O87.3	Cerebral venous thrombosis in the puerperium
Z79.01	Long term (current) use of anticoagulants
Z86.718	Personal history of other venous thrombosis and embolism
Z95.2	Presence of prosthetic heart valve

Coverage policy can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, section 190.11 PT/INR.

http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp

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100-4, Chapter-32, 80

Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes

Coverage Requirements -Peripheral neuropathy is the most common factor leading to amputation in people with diabetes. In diabetes, peripheral neuropathy is an anatomically diffuse process primarily affecting sensory and autonomic fibers; however, distal motor findings may be present in advanced cases. Long nerves are affected first, with symptoms typically beginning insidiously in the toes and then advancing proximally. This leads to loss of protective sensation (LOPS), whereby a person is unable to feel minor trauma from mechanical, thermal, or chemical sources. When foot lesions are present, the reduction in autonomic nerve functions may also inhibit wound healing.

Peripheral neuropathy with LOPS, secondary to diabetes, is a localized illness of the feet and falls within the regulation's exception to the general exclusionary rule (see 42 C.F.R. §411.15(l)(l)(i)). Foot exams for people with diabetic peripheral neuropathy with LOPS are reasonable and necessary to allow for early intervention in serious complications that typically afflict diabetics with the disease.

Effective for services furnished on or after July 1, 2002, Medicare covers, as a physician service, an evaluation (examination and treatment) of the feet no more often than every 6 months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim. LOPS shall be diagnosed through sensory testing with the 5.07 monofilament using established guidelines, such as those developed by the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. Five sites should be tested on the plantar surface of each foot, according to the National Institute of Diabetes and Digestive and Kidney Diseases guidelines. The areas must be tested randomly since the loss of protective sensation may be patchy in distribution, and the patient may get clues if the test is done rhythmically. Heavily callused areas should be avoided. As suggested by the American Podiatric Medicine Association, an absence of sensation at two or more sites out of 5 tested on either foot when tested with the 5.07 Semmes-Weinstein monofilament must be present and documented to diagnose peripheral neuropathy with loss of protective sensation.

100-4, Chapter-32, 80.2

Applicable HCPCS Codes

G0245 - Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include:

1. The diagnosis of LOPS;
2. A patient history;
3. A physical examination that consists of at least the following elements:
   a. visual inspection of the forefoot, hindfoot, and toe web spaces,
   b. evaluation of a protective sensation,
   c. evaluation of foot structure and biomechanics,
   d. evaluation of vascular status and skin integrity,
   e. evaluation and recommendation of footwear, and
4. Patient education.

G0246 -Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following:

1. a patient history;
2. a physical examination that includes:
   a. visual inspection of the forefoot, hindfoot, and toe web spaces,
   b. evaluation of protective sensation,
   c. evaluation of foot structure and biomechanics,
   d. evaluation of vascular status and skin integrity,
   e. evaluation and recommendation of footwear, and
3. patient education.

G0247 -Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a LOPS to include if present, at least the following:

1. local care of superficial (i.e., superficial to muscle and fascia) wounds;
2. debridement of corns and calluses; and
3. trimming and debridement of nails.

NOTE: Code G0247 must be billed on the same date of service with either G0245 or G0246 in order to be considered for payment.

The short descriptors for the above HCPCS codes are as follows:

G0245 – INITIAL FOOT EXAM PTLOPS

G0246 – FOLLOW-UP EVAL OF FOOT PT LOP

G0247 – ROUTINE FOOTCARE PT W LOPS

100-4, Chapter-32, 80.8

CWF Utilization Edits

Edit 1- Should CWF receive a claim from an FI for G0245 or G0246 and a second claim from a contractor for either G0245 or G0246 (or vice versa) and they are different dates of service and less than 6 months apart, the second claim will reject. CWF will edit to allow G0245 or G0246 to be paid no more than every 6 months for a particular beneficiary, regardless of who furnished the service. If G0245 has been paid, regardless of whether it was posted as a facility or professional claim, it must be 6 months before G0245 can be paid again or G0246 can be paid. If G0246 has been paid, regardless of whether it was posted as a facility or professional claim, it must be 6 months before G0246 can be paid again or G0245 can be paid. CWF will not impose limits on how many times each code can be paid for a beneficiary as long as there has been 6 months between each service.

The CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the contractors and FIs must deny the claims and return the following messages:

> MSN 18.4 — This service is being denied because it has not been __ months since your last examination of this kind (***NOTE:*** Insert 6 as the appropriate number of months.)

RA claim adjustment reason code 96 – Non-covered charges, along with remark code M86 – Service denied because payment already made for same/similar procedure within set time frame.

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Edit 2

The CWF will edit to allow G0247 to pay only if either G0245 or G0246 has been submitted and accepted as payable on the same date of service. CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on this reject code, contractors and FIs will deny the claims and return the following messages:

MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 107 – The related or qualifying claim/service was not identified on this claim.

Edit 3

Once a beneficiary's condition has progressed to the point where routine foot care becomes a covered service, payment will no longer be made for LOPS evaluation and management services. Those services would be considered to be included in the regular exams and treatments afforded to the beneficiary on a routine basis. The physician or provider must then just bill the routine foot care codes, per Pub 100-02, Chapter 15, §290.

The CWF will edit to reject LOPS codes G0245, G0246, and/or G0247 when on the beneficiary's record it shows that one of the following routine foot care codes were billed and paid within the prior 6 months: 11055, 11056, 11057, 11719, 11720, and/or 11721.

The CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the contractors and FIs must deny the claims and return the following messages:

MSN 21.21 - This service was denied because Medicare only covers this service under certain circumstances.

The RA claim adjustment reason code 96 –Non-covered charges, along with remark code M86 –Service denied because payment already made for same/similar procedure within set time frame.

100-4, Chapter-32, 100

Billing Requirements for Expanded Coverage of Cochlear Implantation

Effective for dates of services on and after September 26, 2022, the Centers for Medicare & Medicaid Services (CMS) has expanded the coverage for cochlear implantation to cover bilateral pre- or post- linguistic, sensorineural, moderate-to-profound hearing loss in individuals with hearing test scores equal to or less than 60% correct in the best aided listening condition on recorded tests of open-set sentence recognition and who demonstrate limited benefit from amplification. (See Publication 100-03, Chapter 1, Section 50.3, for complete coverage criteria).

In addition, CMS is covering cochlear implants for beneficiaries not meeting the coverage criteria listed under Publication 100-03, Chapter 1, Section 50.3 when performed in context with:

- A Food and Drug Administration (FDA)-approved category B investigational device exemption (IDE) clinical trial as defined at 42 CFR 405.201; or
- As a routine cost in a clinical trial under the CMS clinical trial policy (see Pub. 100-03, section 310.1).

100-4, Chapter-32, 110.5

DMERC Billing Instructions

Effective for dates of service on or after April 27, 2005, DMERCs shall allow payment for ultrasonic osteogenic stimulators with the following HCPCS codes:

E0760 for low intensity ultrasound (include modifier "KF"), or;

E1399 for other ultrasound stimulation (include modifier "KF")

100-4, Chapter-32, 120.1

Payment for Services and Supplies

For an IOL inserted following removal of a cataract in a hospital, on either an outpatient or inpatient basis, that is paid under the hospital Outpatient Prospective Payment System (OPPS) or the Inpatient Prospective Payment System (IPPS), respectively; or in a Medicare-approved ambulatory surgical center (ASC) that is paid under the ASC fee schedule:

- Medicare does not make separate payment to the hospital or ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure.
- Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.
- For a P-C IOL or A-C IOL inserted subsequent to removal of a cataract in a hospital, on either an outpatient or inpatient basis, that is paid under the OPPS or the IPPS, respectively; or in a Medicare-approved ASC that is paid under the ASC fee schedule:
- The facility shall bill for the removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional, P-C IOL, or A-C IOL is inserted. When a beneficiary receives a P-C or A-C IOL following removal of a cataract, hospitals and ASCs shall report the same CPT® code that is used to report removal of a cataract with insertion of a conventional IOL. Physicians, hospitals and ASCs may also report an additional HCPCS code, V2788, to indicate any additional charges that accrue when a P-C IOL or A-C IOL is inserted in lieu of a conventional IOL until January 1, 2008. Effective for A-C IOL insertion services on or after January 1, 2008, physicians, hospitals and ASCs should use V2787 to report any additional charges that accrue. On or after January 1, 2008, physicians, hospitals, and ASCs should continue to report HCPCS code V2788 to indicate any additional charges that accrue for insertion of a P-C IOL. See Section 120.2 for coding guidelines.
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives a P-C or A-C IOL following removal of a cataract that exceeds the facility charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

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A -For a P-C IOL or A-C IOL inserted in a physician's office

-A physician shall bill for a conventional IOL, regardless of a whether a conventional, P-C IOL, or A-C IOL is inserted (see section 120.2, General Billing Requirements).

-There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.

-There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, service and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of a P-C or A-C IOL that exceed physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

B - For a P-C IOL or A-C IOL inserted in a hospital

-A physician may not bill Medicare for a P-C or A-C IOL inserted during a cataract procedure performed in a hospital setting because the payment for the lens is included in the payment made to the facility for the surgical procedure.

-There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies required for the insertion of a conventional IOL.

C - For a P-C IOL or A-C IOL inserted in an Ambulatory Surgical Center

-Refer to Chapter 14, Section 40.3 for complete guidance on payment for P-C IOL or A-C IOL in Ambulatory Surgical Centers.

100-4, Chapter-32, 120.2

Coding and General Billing Requirements

Physicians and hospitals must report one of the following Current Procedural Terminology (CPT®) codes on the claim:

- 66982 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic development stage.
- 66983- Intracapsular cataract with insertion of intraocular lens prosthesis (one stage procedure)
- 66984 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)
- 66985 - Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract extraction
- 66986 - Exchange of intraocular lens

In addition, physicians inserting a P-C IOL or A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL. Medicare will make payment for the lens based on reasonable cost for a conventional IOL. Place of Service (POS) = 11.

Effective for dates of service on and after January 1, 2006, physician, hospitals and ASCs may also bill the non-covered charges related to the P-C function of the IOL using HCPCS code V2788. Effective for dates of service on and after January 22, 2007 through January 1, 2008, non-covered charges related to A-C function of the IOL can be billed using HCPCS code V2788. The type of service indicator for the non-covered billed charges is Q. (The type of service is applied by the Medicare carrier and not the provider). Effective for A-C IOL insertion services on or after January 1, 2008, physicians, hospitals and ASCs should use V2787 rather than V2788 to report any additional charges that accrue.

When denying the non-payable charges submitted with V2787 or V2788, contractors shall use an appropriate Medical Summary Notice (MSN) such as 16.10 (Medicare does not pay for this item or service) and an appropriate claim adjustment reason code such as 96 (non-covered charges) for claims submitted with the non-payable charges.

Hospitals and physicians may use the proper CPT® code(s) to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

A - Applicable Bill Types

The hospital applicable bill types are 12X, 13X, 83X and 85X.

B - Other Special Requirements for Hospitals

Hospitals shall continue to pay CAHs method 2 claims under current payment methodologies for conditional IOLs.

100-4, Chapter-32, 130

External Counterpulsation (ECP) Therapy

Commonly referred to as enhanced external counterpulsation, is a non-invasive outpatient treatment for coronary artery disease refractory medical and/or surgical therapy. Effective for dates of service July 1, 1999, and after, Medicare will cover ECP when its use is in patients with stable angina (Class III or Class IV, Canadian Cardiovascular Society Classification or equivalent classification) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention, such as PTCA or cardiac bypass, because:

- Their condition is inoperable, or at high risk of operative complications or post-operative failure;
- Their coronary anatomy is not readily amenable to such procedures; or
- They have co-morbid states that create excessive risk.

(Refer to Publication 100-03, section 20.20 for further coverage criteria.)

100-4, Chapter-32, 130.1

Billing and Payment Requirements

Effective for dates of service on or after January 1, 2000, use HCPCS code G0166 (External counterpulsation, per session) to report ECP services. The codes for external cardiac assist (92971), ECG rhythm strip and report (93040 or 93041), pulse oximetry (94760 or 94761) and plethysmography (93922 or 93923) or other monitoring tests for examining the effects of this treatment are not clinically necessary with this service and should not be paid on the same day, unless they occur in a clinical setting not connected with the delivery of the ECP.

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Daily evaluation and management service, e.g., 99201- 99205, 99211-99215, 99217-99220, 99241- 99245, and G0463 cannot be billed with the ECP treatments. Any evaluation and management service must be justified with adequate documentation of the medical necessity of the visit. Deductible and coinsurance apply.

Note: Please note that effective December 31, 2020 evaluation and management service code 99201 is enddated. Effective December 31, 2022 codes 99217,99218,99219,99220 and 99241 are end dated. For Part A, remove CPT® codes 99202-99215, 99242-99245 and replace with G0463 (the OPPS equivalent of E/M codes) effective retroactive to 10/1/2015.

100-4, Chapter-32, 140.2.2.1

Correct Place of Service (POS) Code for CR and ICR Services on Professional Claims

Effective for claims with dates of service on and after January 1, 2010, place of service (POS) code 11 shall be used for CR and ICR services provided in a physician's office and POS 22 shall be used for services provided in a hospital outpatient setting. All other POS codes shall be denied. Contractors shall adjust their prepayment procedure edits as appropriate.

The following messages shall be used when contractors deny CR and ICR claims for POS:

Claim Adjustment Reason Code (CARC) 171 –Payment is denied when performed/billed by this type of provider in this type of facility.

NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

Remittance Advice Remark Code (RARC) N428 - Service/ procedure not covered when performed in this place of service.

Medicare Summary Notice (MSN) 21.25 -This service was denied because Medicare only covers this service in certain settings.

Group Code PR (Patient Responsibility) -Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) –Where a claim is received with the GZ modifier indicating that no signed ABN is on file.

100-4, Chapter-32, 140.3

140.3 – ICR Program Services Effective for Dates of Service On or After January 1, 2024

As specified at 42 CFR 410.49, Medicare Part B covers ICR for beneficiaries who have experienced one or more of the following:

- An acute MI within the preceding 12 months;
- A coronary artery bypass surgery; Current stable angina pectoris;
- Heart valve repair or replacement;
- PTCA or coronary stenting;
- A heart or heart-lung transplant;
- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and NYHA class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, on or after February 9, 2018; or,
- Other cardiac conditions as specified through an NCD. The NCD process may also be used to specify noncoverage of a cardiac condition for ICR if coverage is not supported by clinical evidence.

ICR must include all of the following components:

- Physician prescribed exercise each day CR items and services are furnished.
- Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the individual's needs.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

A list of approved ICR programs, identified through the NCD process, will be listed in the Federal Register and is available on the CMS website at https://www.cms.gov/Medicare/Medicare-GeneralInformation/MedicareApprovedFacilitie/ICR. In order to be approved, a program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following for its patients:

- Positively affected the progression of coronary heart disease.
- Reduced the need for coronary bypass surgery.
- Reduced the need for percutaneous coronary interventions.

An ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before CR services to after CR services:

- Low density lipoprotein.
- Triglycerides.
- Body mass index.
- Systolic blood pressure.
- Diastolic blood pressure.
- The need for cholesterol, blood pressure, and diabetes medications.

Medicare Part B pays for ICR in a physician's office or a hospital outpatient setting. All settings must have a physician or nonphysician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician or nonphysician practitioner meets the requirements for direct supervision for physician office services, at 42 CFR 410.26, and for hospital outpatient services at 42 CFR 410.27.

Note: Nonphysician practitioners are eligible to supervise ICR effective January 1, 2024.

As specified at 42 CFR 410.49(f)(2), ICR sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

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100-4, Chapter-32, 140.3.1

Coding Requirements for ICR Services Furnished On or After January 1, 2010

The following are the applicable HCPCS codes for ICR:

G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session)

G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 6 1-hour sessions per day. In order to report one session of ICR in a day, the duration of treatment must be at least 31 minutes. Additional sessions of ICR beyond the first session may only be reported in the same day if the duration of treatment is 31 minutes or greater beyond the hour increment. In other words, in order to report 6 sessions of ICR on a given date of service, the first five sessions would account for 60 minutes each and the sixth session would account for at least 31 minutes. If several shorter periods of ICR are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

Example: If the patient receives 20 minutes of ICR in the day, no ICR session may be reported because less than 31 minutes of services were furnished.

Example: If a patient receives 20 minutes of ICR in the morning and 35 minutes of ICR in the afternoon of a single day, the hospital or practitioner would report 1 session of ICR under1 unit of the appropriate HCPCS code for the total duration of 55 minutes of ICR on that day.

Example: If the patient receives 70 minutes of ICR in the morning and 25 minutes of ICR in the afternoon of a single day, the hospital or practitioner would report two sessions of ICR under the appropriate HCPCS code(s) because the total duration of ICR on that day of 95 minutes exceeds 90 minutes.

Example: If the patient receives 70 minutes of ICR in the morning and 85 minutes of ICR in the afternoon of a single day, the hospital or practitioner would report three sessions of ICR under the appropriate HCPCS code(s) because the total duration of ICR on that day is 155 minutes, which exceeds 150 minutes and is less than 211 minutes.

100-4, Chapter-32, 140.4

PR Program Services Effective for Dates of Service On or After January 1, 2024

As specified in 42 CFR 410.47, Medicare Part B covers PR for beneficiaries:

- With moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease;
- Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks (effective January 1, 2022);
- Additional medical indications for coverage for PR may be established through an NCD.

PR must include all of the following components:

- Physician-prescribed exercise during each pulmonary rehabilitation session.
- Education or training that is closely and clearly related to the individual's care and treatment which is tailored to the individual's needs and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life. Education must include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
- Psychosocial assessment.
- Outcomes assessment.
- An individualized treatment plan detailing how components are utilized for each patient.

The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Medicare Part B pays for PR in a physician's office or a hospital outpatient setting. All settings must have the following: (i) A physician immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services, at 42 CFR 410.26. and for hospital outpatient services at 42 CFR 410.27, and, (ii) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

Note: Nonphysician practitioners are eligible to supervise PR effective January 1, 2024.

As specified at 42 CFR 410.47(e), the number of PR sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the MACs.

100-4, Chapter-32, 140.4.1

Coding Requirements for PR Services Furnished On or After January 1, 2010

The following are the applicable HCPCS codes for PR:

Effective January 1, 2010 through December 31, 2021

G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session)

Effective January 1, 2022

94625 (Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session))

94626 (Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 2 1-hour sessions per day. In order to report one session of PR in a day, the duration of treatment must be at least 31 minutes. Two sessions of PR may only be reported in the same day if the duration of treatment is at least 91 minutes. In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes, if two sessions

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are reported. If several shorter periods of PR are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

Example: If the patient receives 20 minutes of PR in the day, no PR session may be reported because less than 31 minutes of services were furnished.

Example: If a patient receives 20 minutes of PR in the morning and 35 minutes of PR in the afternoon of a single day, the hospital or practitioner would report 1 session of PR under 1 unit of HCPCS code/CPT® code for the total duration of 55 minutes of PR on that day.

Example: If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 25 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of pulmonary rehabilitation services under the HCPCS G-code/CPT® codes because the total duration of pulmonary rehabilitation services on that day of 95 minutes exceeds 90 minutes.

Example: If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 85 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of pulmonary rehabilitation services under the HCPCS G-code/CPT® codes for the total duration of pulmonary rehabilitation services of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of pulmonary rehabilitation services.

100-4, Chapter-32, 250.1

Coverage Requirements

Effective August 3, 2009, pharmacogenomic testing to predict warfarin responsiveness is covered only when provided to Medicare beneficiaries who are candidates for anticoagulation therapy with warfarin; i.e., have not been previously tested for CYP2C9 or VKORC1 alleles; and have received fewer than five days of warfarin in the anticoagulation regimen for which the testing is ordered; and only then in the context of a prospective, randomized, controlled clinical study when that study meets certain criteria as outlined in Pub 100-03, section 90.1, of the NCD Manual.

NOTE: A new temporary HCPCS Level II code effective August 3, 2009, G9143, warfarin responsiveness testing by genetic technique using any method, any number of specimen(s), was developed to enable implementation of CED for this purpose.

100-4, Chapter-32, 250.2

Billing Requirements

Institutional clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- Value Code D4 and 8-digit clinical trial number (when present on the claim) - Refer to Transmittal 310, Change Request 5790, dated January 18, 2008;
- ICD-10 diagnosis code Z00.6 (secondary) - Refer to Transmittal 310, Change Request 5790, dated January 18, 2008; and Z79.01 (primary);
- Condition Code 30 - Refer to Transmittal 310, Change Request 5790, dated January 18, 2008;
- HCPCS modifier Q0: outpatient claims only - Refer to Transmittal 1418, Change Request 5805, dated January 18, 2008; and,
- HCPCS code G9143 (mandatory with the April 2010 Integrated Outpatient Code Editor (IOCE) and the January 2011 Clinical Laboratory Fee Schedule (CLFS) updates. Prior to these times, any trials should bill FIs for this test as they currently do absent these instructions, and the FIs should process and pay those claims accordingly.)

Practitioner clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- ICD-10-diagnosis code Z00.6 (secondary), and ICD-10 diagnosis code Z79.01
- (primary) MCS edit 031L70.7;
- 8-digit clinical trial number(when present on the claim);
- HCPCS modifier Q0; and, MCS edit 031L
- HCPCS code G9143 (to be carrier priced for claims with dates of service on and after August 3, 2009, that are processed prior to the January 2011 CLFS update.)

NOTE: This NCD does not determine coverage to identify CYP2C9 or VKORC1 alleles for other purposes beside warfarin responsiveness, nor does it determine national coverage to identify other alleles to predict warfarin responsiveness. These decisions are made at the local MAC level.

100-4, Chapter-32, 260.1

Policy

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial lipodystrophy syndrome (LDS) for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. Facial LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy. Due to their appearance and stigma of the condition, patients with facial LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

Effective for claims with dates of service on and after March 23, 2010, dermal injections for facial LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigmata of HIV treatment.

See Pub. 100-03, National Coverage Decision manual, section 250.5, for detailed policy information concerning treatment of LDS.

100-4, Chapter-32, 260.2.1

Hospital Billing Instructions

A -Hospital Outpatient Claims

For hospital outpatient claims, hospitals must bill covered dermal injections for treatment of facial LDS by having all of the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a Line Item Date of service (LIDOS) on or after March 23, 2010,
- A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010,
- If ICD-9-CM is applicable,ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy)or,

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- If ICD-10-CM is applicable, ICD-10-CM diagnosis codes B20 Human Immunodeficiency Virus (HIV) disease and E88.1 Lipodystrophy, not elsewhere classified

The applicable NCD is 250.5 Facial Lipodystrophy.

B - Outpatient Prospective Payment System (OPPS) Hospitals or Ambulatory Surgical Centers (ASCs):

For line item dates of service on or after March 23, 2010, and until HCPCS codes Q2026 and Q2027 are billable, facial LDS claims shall contain a temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

C -Hospital Inpatient Claims

Hospitals must bill covered dermal injections for treatment of facial LDS by having all of the required elements on the claim:

- Discharge date on or after March 23, 2010,

If ICD-9-CM is applicable,

- ICD-9-CM procedure code 86.99 (other operations on skin and subcutaneous tissue, i.e., injection of filler material), or
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy)

If ICD-10-PCS is applicable,

- ICD-10-PCS procedure code 3E00XGC Introduction of Other Therapeutic Substance into Skin and Mucous Membranes, External Approach, or
- ICD-10-CM diagnosis codes B20 Human Immunodeficiency Virus [HIV] disease and E88.1 Lipodystrophy not elsewhere classified.

A diagnosis code for a comorbidity of depression may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

100-4, Chapter-32, 260.2.2

Practitioner Billing Instructions

Practitioners must bill covered claims for dermal injections for treatment of facial LDS by having all of the required elements on the claim:

Performed in a non-facility setting:

- A line with HCPCS codes Q2026 or Q2027 with a LIDOS on or after March 23, 2010,

NOTE: Q2027 is replaced with Q2028 effective 1/1/14 per the 2014 HCPCS update.

- A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010, 51 If ICD-10-CM applies, diagnosis codes B20 Human Immunodeficiency Virus (HIV) disease and E88.1 (Lipodystrophy not elsewhere classified). Both diagnoses are required on the claim.

NOTE: A diagnosis code for a comorbidity of depression may also be required for coverage based on the individual Medicare contractor's policy.

52 A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010,

53 If ICD-10 CM- applies, ICD-10-CM diagnosis codes B20 Human immunodeficiency Virus (HIV) disease and E88.1 (Lipodystrophy not elsewhere classified). Both diagnoses are required on the claim.

NOTE: A diagnosis code for a comorbidity of depression may also be required for coverage based on the individual Medicare contractor's policy.

100-4, Chapter-32, 280.1

Policy

Effective for services furnished on or after June 30, 2011, a National Coverage Determination (NCD) provides coverage of sipuleucel-T (PROVENGE®) for patients with asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer. Conditions of Medicare Part A and Medicare Part B coverage for sipuleucel-T are located in the Medicare NCD Manual, Publication 100-03, section 110.22.

100-4, Chapter-32, 280.2

Healthcare Common Procedure Coding System (HCPCS) Codes and Diagnosis Coding

HCPCS Codes

Effective for claims with dates of service on June 30, 2011, Medicare providers shall report one of the following HCPCS codes for PROVENGE®:

- C9273 - Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion, or
- J3490 –Unclassified Drugs, or
- J3590 –Unclassified Biologics.

NOTE: Contractors shall continue to process claims for HCPCS code C9273, J3490, and J3590, with dates of service June 30, 2011, as they do currently.

Effective for claims with dates of service on and after July 1, 2011, Medicare providers shall report the following HCPCS code:

Q2043 – Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion; short descriptor, Sipuleucel-T auto CD54+.

ICD-9 Diagnosis Coding

For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:

ICD-9 Code	Description
196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified -The spread of cancer to and establishment in the lymph nodes.
197.0	Secondary malignant neoplasm of lung –Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.

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ICD-9 Code	Description
197.7	Malignant neoplasm of liver secondary -Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.
198.0	Secondary malignant neoplasm of kidney -The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow –Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of bone and bone marrow –Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.82	Secondary malignant neoplasm of genital organs

Coding for Off-Label PROVENGE® Services

The use of PROVENGE® off-label for the treatment of prostate cancer is left to the discretion of the Medicare Administrative Contractors. Claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate), or ICD-9 code 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043. Effective with the implementation date for ICD-10 codes, off-label PROVENGE® services must be billed with either ICD-10 code D075(carcinoma in situ of prostate), or C61 (malignant neoplasm of prostate) in addition to HCPCS Q2043.

ICD-10 Diagnosis Coding

Contractors shall note the appropriate ICD-10 code(s) that are listed below for future implementation. Contractors shall track the ICD-10 codes and ensure that the updated edit is turned on as part of the ICD-10 implementation effective October 1, 2013.

ICD-10	Description
C61	Malignant neoplasm of prostate (for on-label or off-label indications)
D075	Carcinoma in situ of prostate (for off-label indications only)
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.7	Secondary malignant neoplasm of liver
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.82	Secondary malignant neoplasm of genital organs

100-4, Chapter-32, 280.4

Payment Method

Payment for PROVENGE® is as follows:

- TOBs 12X, 13X, 22X and 23X -based on the Average Sales Price (ASP) + 6%,
- TOB 85X –based on reasonable cost,
- TOBs 71X and 77X –based on all-inclusive rate.

For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6%.

Contractors shall not pay separately for routine costs associated with PROVENGE®, HCPCS Q2043, except for the cost of administration. (Q2043 is all-inclusive and represents all routine costs except for its cost of administration).

100-4, Chapter-32, 280.5

Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs), and Group Codes

Contractors shall use the following messages when denying claims for the on-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 185 and at least one diagnosis code from the ICD-9 table in Section 280.2 above:

MSN 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

Spanish Version -Medicare no puede pagar por este servicio debido al diagnóstico indicado en la reclamación.

RARC 167 - This (these) diagnosis (es) are not covered.

NOTE: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.

Group Code – CO (Contractual Obligation)

Contractors shall use the following messages when denying claims for the off-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 233.4:

MSN 14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

Spanish Version - Medicare no puede pagar por este servicio debido al diagnóstico indicado en la reclamación.

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RARC 167 - This (these) diagnosis (es) are not covered.

NOTE: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.

Group Code –CO (Contractual Obligation)

For claims with dates of service on or after July 1, 2012, processed on or after July 2, 2012, when denying claims for PROVENGE®, HCPCS Q2043 that exceed three (3) services in a patient's lifetime, contractors shall use the following messages:

MSN 20.5 - These services cannot be paid because your benefits are exhausted at this time.

Spanish Version - Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

RARC N362 - The number of Days or Units of Service exceeds our acceptable maximum.

CARC 149 -Lifetime benefit maximum has been reached for this service/benefit category.

Group Code – CO (Contractual Obligation)

100-4, Chapter-32, 300

Billing Requirements for Ocular Photodynamic Therapy (OPT) with Verteporfin

Ocular Photodynamic Therapy (OPT) is used in the treatment of ophthalmologic diseases; specifically, for age-related macular degeneration (AMD), a common eye disease among the elderly. OPT involves the infusion of an intravenous photosensitizing drug called Verteporfin, followed by exposure to a laser. For complete Medical coverage guidelines, see National Coverage Determinations (NCD) Manual (Pub 100-03) § 80.2 through 80.3.1.

100-4, Chapter-32, 300.1

Coding Requirements for OPT with Verteporfin

The following are applicable Current Procedural Terminology (CPT®) codes for OPT with Verteporfin:

67221- Destruction of localized lesion of choroid (e.g. choroidal neovascularization); photodynamic therapy (includes intravenous infusion)

67225- Destruction of localized lesion of choroid (e.g. choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)

The following are applicable Healthcare Common Procedure Coding System (HCPCS) code for OPT with Verteporfin:

J3396- Injection, Verteporfin, 0.1 mg

100-4, Chapter-32, 300.2

Claims Processing Requirements for OPT with Verteporfin Services on Professional Claims and Outpatient Facility Claims

OPT with Verteporfin is a covered service when billed with the below ICD-10-CM codes

Nationally Covered ICD-10-CM codes

H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar

ICD-10- Codes for OPT with Verteporfin for other ocular indications are eligible for local coverage determinations through individual contractor discretion.

B39.4	Histocapsulati, unspecified
	(Translates to combination of both B39.4 & H32)
B39.5	Histoplasmosis duboisii
	(Requires H32 coverage)
B39.9	Histoplasmosis, unspecified
	(Requires H32 coverage)
H32	Chorioretinal disorders in diseases classified elsewhere
	(Requires B39.4 coverage)
H44.2A1	Degenerative myopia with choroidal neovascularization, right eye
H44.2A2	Degenerative myopia with choroidal neovascularization, left eye
H44.2A3	Degenerative myopia with choroidal neovascularization, bilateral eye
H44.2B1	Degenerative myopia with macular hole, right eye
H44.2B2	Degenerative myopia with macular hole, left eye
H44.2B3	Degenerative myopia with macular hole, bilateral eye
H44.2C1	Degenerative myopia with retinal detachment, right eye
H44.2C2	Degenerative myopia with retinal detachment, left eye
H44.2C3	Degenerative myopia with retinal detachment, bilateral eye
H44.2D1	Degenerative myopia with foveoschisis, right eye
H44.2D2	Degenerative myopia with foveoschisis, left eye
H44.2D3	Degenerative myopia with foveoschisis, bilateral eye
H44.2E1	Degenerative myopia with other maculopathy, right eye

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H44.2E2	Degenerative myopia with other maculopathy, left eye
H44.2E3	Degenerative myopia with other maculopathy, bilateral eye
H44.21	Degenerative Myopia, right eye
H44.22	Degenerative Myopia, left eye
H44.23	Degenerative Myopia, bilateral
H35.711	Central serous chorioretinopathy, right eye
H35.712	Central serous chorioretinopathy, left eye
H35.713	Central serous chorioretinopathy, bilateral

Coverage is denied when billed with the below Nationally Non-Covered ICD-10-CM codes

Nationally Non-Covered ICD-10-CM codes:

H35.30	Unspecified macular degeneration
H35.3110	Nonexudative age-related macular degeneration, right eye, stage unspecified
H35.3111	Nonexudative age-related macular degeneration, right eye, early dry stage
H35.3112	Nonexudative age-related macular degeneration, right eye, intermediate dry stage
H35.3113	Nonexudative age-related macular degeneration, right eye, advanced atrophic without subfoveal involvement
H35.3114	Nonexudative age-related macular degeneration, right eye, advanced atrophic with subfoveal involvement
H35.3120	Nonexudative age-related macular degeneration, left eye, stage unspecified
H35.3121	Nonexudative age-related macular degeneration, left eye, early dry stage
H35.3122	Nonexudative age-related macular degeneration, left eye, intermediate dry stage
H35.3123	Nonexudative age-related macular degeneration, left eye, advanced atrophic without subfoveal involvement
H35.3124	Nonexudative age-related macular degeneration, left eye, advanced atrophic with subfoveal involvement
H35.3130	Nonexudative age-related macular degeneration, bilateral, stage unspecified
H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage
H35.3132	Nonexudative age-related macular degeneration, bilateral, intermediate dry stage
H35.3133	Nonexudative age-related macular degeneration, bilateral, advanced atrophic without subfoveal involvement
H35.3134	Nonexudative age-related macular degeneration, bilateral, advanced atrophic with subfoveal involvement

Payment for OPT service (CPT® code 67221/67225) must be billed on the same claim as the drug (J3396) for the same date of service.

Claims for OPT with Verteporfin for dates of service prior to April 3, 2013 are covered at the initial visit as determined by a fluorescein angiogram (FA) CPT® code 92235. Subsequent follow-up visits also require a FA prior to treatment.

For claims with dates of service on or after April 3, 2013, contractors shall accept and process claims for subsequent follow-up visits with either a FA, CPT® code 92235, or optical coherence tomography (OCT), CPT® codes 92133 or 92134, prior to treatment.

Regardless of the date of service of the claim, the FA or OCT is not required to be submitted on the claim for OPT and can be maintained in the patient's file for audit purposes.

100-4, Chapter-32, 310

Transesophageal Doppler Used for Cardiac Monitoring

Effective May 17, 2007, Transesophageal Doppler used for cardiac monitoring is covered for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization was deemed reasonable and necessary. See National Coverage Determinations Manual (Pub. 100-03)§220.5, for complete coverage guidelines.

A new Healthcare Common Procedure Coding System (HCPCS) code, G9157, Transesophageal Doppler used for cardiac monitoring, will be made effective for use for dates of service on or after January 1, 2013.

100-4, Chapter-32, 310.2

Coding Requirements for Transesophageal Doppler Cardiac Monitoring Furnished On or After January 1, 2013

After January 1, 2013, the applicable HCPCS code for Transesophageal Doppler cardiac monitoring is:

HCPCS G9157: Transesophageal Doppler used for cardiac monitoring

Contractors shall allow HCPCS G9157 to be billed when services are provided in POS 21 for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization.

Contractors shall deny HCPCS 76999 when billed for Esophageal Doppler for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization using the following messages:

CARC 189: "'Not otherwise classified' or 'unlisted' procedure code (CPT®/HCPCS) was billed when there is a specific procedure code for this procedure/service."

RARC M20: "Missing/incomplete/invalid HCPCS."

MSN 16.13: "The code(s) your provider used is/are not valid for the date of service billed." (English version) or "El/los código(s) que usó su proveedor no es/son válido(s) en la fecha de servicio facturada." (Spanish version).

Group Code: Contractual Obligation (CO)

100-4, Chapter-32, 310.3

Correct Place of Service (POS) Code for Transesophageal Doppler Cardiac Monitoring Services on Professional Claims

Contractors shall pay for Transesophageal Doppler cardiac monitoring, G9157, only when services are provided at POS 21.

Contractors shall deny HCPCS G9157 when billed globally in any POS other than 21 for ventilated patients in the ICU or for operative patients with a need for intra-operative fluid optimization using the following messages:

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CARC 58:"Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. *NOTE:* Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

MSN 16.2: This service cannot be paid when provided in this location/facility.

Group Code: CO

100-4, Chapter-36, 50.14

Purchased Accessories & Supplies for Use With Grandfathered Equipment

Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:

- Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562
- Hospital Beds and Related Accessories – E0271, E0272, E0280, and E0310
- Walkers and Related Accessories – E0154, E0156, E0157 and E0158

Grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

100-4, Chapter-36, 50.15

Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day that they submit the claim for the walker to ensure timely and accurate claims processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier to claims submitted for these items.

The J4 modifier should not be used by contract suppliers.

100-8, Chapter-4, 4.7.3.1.1

Proof of Delivery and Delivery Methods

This section applies to UPICs. This section is applicable to DME MACs, RACs, SMRC, and CERT medical review contractors, as noted in Ch. 5, Section 5.8.

For the purpose of the delivery methods noted below, **designee** is defined as:

"Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

Three methods of delivery are:

- Supplier delivering directly to the beneficiary or designee;
- Supplier utilizing a delivery/shipping service to deliver items; and
- Delivery of items to a nursing facility on behalf of the beneficiary.

The date of delivery may be entered by the beneficiary, designee or the supplier. As a general Medicare rule, the date of service shall be the date of delivery. Exceptions are made for suppliers who use a delivery/shipping service. If the supplier uses a delivery/shipping service, the supplier may use the shipping date as the date of service on the claim. The shipping date may be defined as the date the delivery/shipping service label is created or the date the item is retrieved for delivery; however, such dates should not demonstrate significant variation. (See Pub. 100-08, chapter 5, section 5.2.4 for further information on written orders prior to delivery.)

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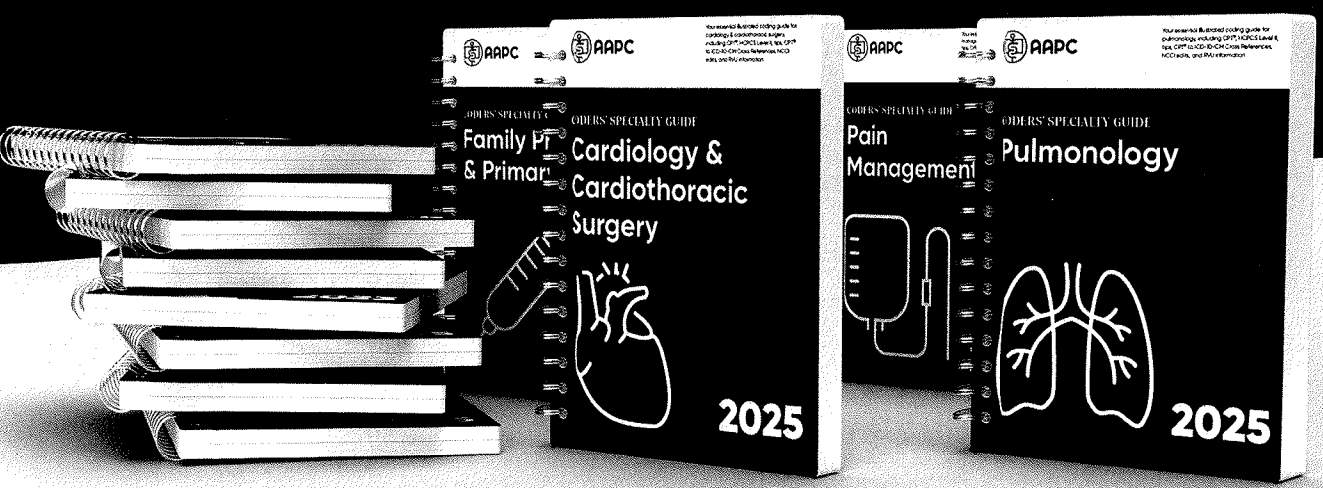
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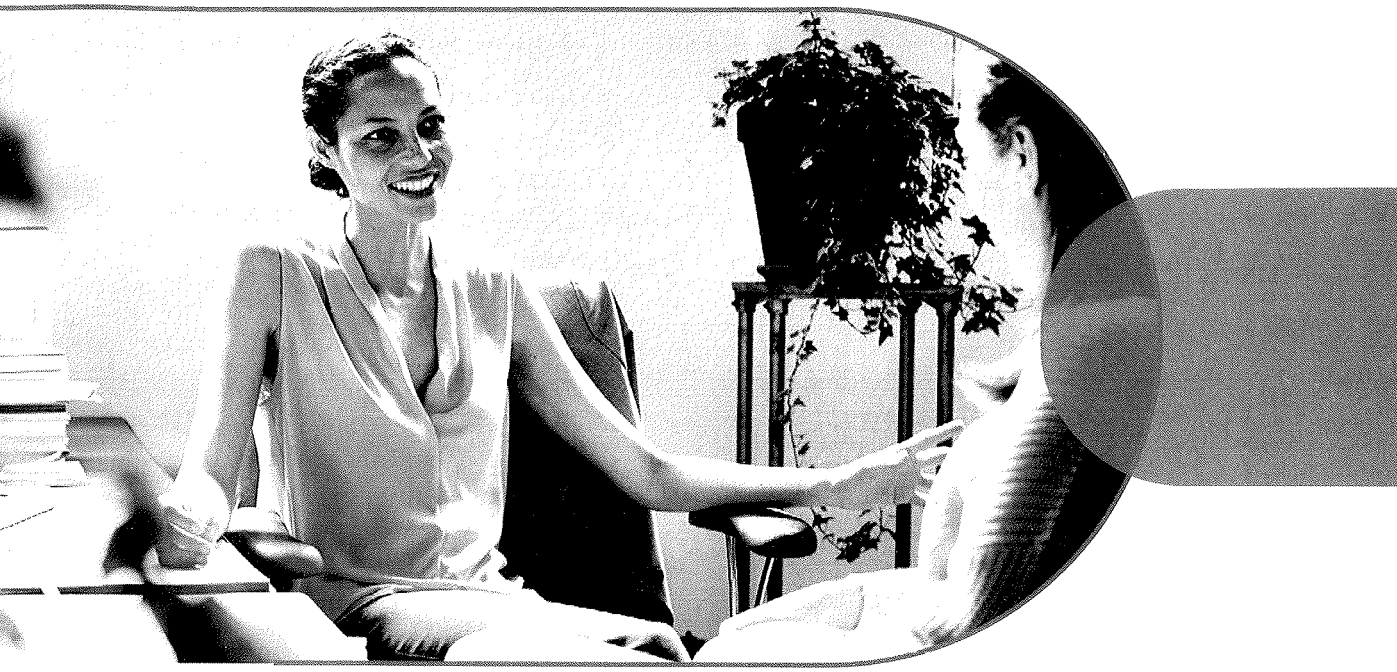
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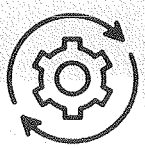
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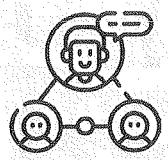
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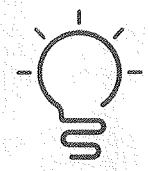
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