Utah Department of Health

Medicaid Information Bulletin

April 2008

Utah Department of Health

Web address: http://health.utah.gov/medicaid

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BULLETINS BY TYPE OF SERVICE

World Wide Web: http://health.utah.gov/medicaid

Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

Requesting a Medicaid publication?

Send a Publication Request Form.

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

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08 - 23 National Provider Identifier (NPI)

Important Message to All Providers

Beginning April 14, 2008, Medicaid intends to reject claims that are submitted with NPI errors. If you are receiving a paper remittance advice, Medicaid is currently providing warning messages related to NPI non-compliant claims. Look for warning codes: **109: NPI missing, 111: NPI invalid format, and 110: NPI not matched**. If you see these messages on your remittance advice, there is a problem with the way your NPI is being submitted on your claims. If you continue to submit claims without correcting this problem, your claims will be rejected on April 14, 2008.

Medicaid will continue to accept both the NPI and Medicaid provider number on claims until April 14, 2008, as long as the NPI is in the primary identification fields. For examples of NPI billing procedures, visit the Medicaid website at http://health.utah.gov/medicaid . From the main page, you will find a section specifically for the National Provider Identifier with useful links and training resources. Examples of NPI billing procedures can be found under "Updates for Providers."

POS Prescriber
Effective April 14, 2008, claims submitted for payment without the prescribing NPI will be denied. The NPI of the prescribing provider must be included on prescription claims.

If you are currently submitting your claims through a clearinghouse or software vendor, contact them to verify that the correct NPI is being submitted in the appropriate location on the claim form. They may be manipulating the NPI prior to filing the claim to Medicaid. It is important for you to confirm that the NPI being submitted on the claim is the same NPI that you reported to Utah Medicaid as belonging to the Medicaid legacy provider number on the claim. Validation of this information is critical to avoid any potential reimbursement issues upon NPI implementation.

Providers should verify that their NPI has been registered by contacting Provider Enrollment at (801) 538-6155 or toll free at 1-800-662-9651. For those providers who have not registered their NPI with Medicaid, please fax it to (801) 536-0471 or mail the information along with your provider name, Medicaid provider number, taxonomy code, and 9-digit zip code to Medicaid Provider Enrollment, PO Box 143106, SLC, UT 84114-3106. For those providers who have not applied for a NPI, this can be done online at http://nppes.cms.hhs.gov . If a provider does not know if they are required to have a NPI, or would like to request a paper application, call the NPI enumerator at 1-800-465-3203.

Dissemination of data from the National Plan and Provider Enumeration System (NPPES) began September 2007. More detailed information is available at www.cms.hhs.gov/nationalprovidentstand/ .

Medicaid staff are currently working with the UHIN National Provider ID Subcommittee to assist in the implementation of NPI. Medicaid will keep you informed of our NPI Contingency Plan.

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08 - 24 Statewide Provider Training

Statewide provider training is being scheduled this year from August until October. Please watch for location information, dates, and registration information on the Medicaid website at http://health.utah.gov/medicaid/ . You will not want to miss the important information planned for our providers this year.

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08 - 25 Paper Claims - Old vs. New Format

Effective May 1, 2008, Medicaid will reject and return older versions of the CMS-1500 (professional), UB (institutional), and ADA (dental) paper claim forms. The CMS-1500 12/90 form, the UB-92, and the 1994, 1999, 2000, and 2002 ADA dental forms, along with any other similar forms used before the advent of the CMS-1500 08/05, UB-04, and ADA 2006 forms will not be processed.

Medicaid encourages electronic submission of claims. Providers should contact Utah Health Information Network (UHIN) at 801-466-7705 or online at http://health.utah.gov/hipaa and access 'Enrollment'. Refer to the Companion Guides on the Medicaid website at http://health.utah.gov/medicaid for instructions on electronic transactions.

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08 - 26 Paper Claims Backlog Update

Due to conversion to a new data entry contractor, Medicaid has experienced a delay in processing paper claims received after May 1, 2007. Professional claims received and held in storage since that date, including the old paper claim forms, are now being processed, generally with earliest dates processing first.

Medicaid is in final testing for dental claims. The processing of the dental backlog will begin shortly.

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08 - 27 Multiple-page Paper Claims

Effective April 1, 2008, Medicaid will no longer accept multi-page paper professional claims (CMS-1500) or dental claims. If services require more than one claim (6 lines for professional and 18 lines for dental), submit each claim as an individual claim:

- When billing for the Vaccines for Children (VFC) program, bill the appropriate amount of immunizations with the injection code on the same claim.
- When reporting Third Party Liability (TPL), be sure to split the payment appropriately between the claims.
- When submitting medical documentation for any reason, it must be attached to each claim.

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08 - 28 Billing and Reporting Third Party Liability (TPL)

Beginning May 1, 2008, Medicaid will require third party liability (TPL) information to be submitted on the claim, whether billing electronically or on paper. It is recommended that you work with your electronic software vendor to add TPL information on your claims. If your software vendor does not allow you to report TPL information, you will need to drop to paper and report the information on the claim.

Medicaid does not key TPL information from an attached Explanation of Benefits (EOB). Only the EOB's submitted for zero payment, or claim denials, will be reviewed. It is necessary to report the TPL amount and patient responsibility for claims to be paid by Medicaid.

For instructions on reporting TPL and other billing information, visit the website at http://health.utah.gov/medicaid/ .

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08 - 29 General Information, Section I, Additions and Clarification

The following chapters in the General Information, Section I, of the provider manual have been modified for April 2008.

6 - 6 Billing Medicaid

The provider may bill Medicaid only for services which were medically indicated and necessary for the patient and either personally rendered by him/her or rendered incident to his/her professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by Medicaid regulations. The billed charge may not exceed the usual and customary rate billed to the general public, such as individual patient accounts or third party payer accounts.

As indicated on the *CPT List of Medical and Surgical Procedures*, codes requiring manual review require submission of medical record documentation for staff review. When the exception code (error message on the remittance advice statement), stating documentation required, is reported, the provider should submit the medical record documentation to Medicaid Operations. In cases where the service has been denied after manual review, the remittance advice indicates manually reviewed and denied. This is the point in the process when the provider may consider submitting a request for a hearing.

Unlisted procedures require manual review and often manual pricing. Refer to Section 9 - 1 of this manual.

8 - 4 Diagnosis Must Agree with Procedure Code; Use of 'V' Codes

[Effective January 1, 2002, claims must have a diagnosis that fits the procedures completed, or they will be denied] *Deleted*. A diagnosis code in addition to the V code must also be on the claim form. Make sure that the diagnosis and procedure codes agree...Examples A and B.

Supplying the correct diagnosis and procedure for payment is the responsibility of the provider. The differential diagnosis must support the medical necessity of the procedure for reimbursement. Often, more than one diagnosis is required to explain and support a service. When the diagnosis does not support the procedure, a diagnosis to procedure discrepancy will be reported on the remittance advice. Providers should then resubmit a claim with additional or other appropriate diagnoses.

9 - 1 Unspecified Services and Procedures

Unspecified services or procedures covered by Medicaid do not require prior authorization. These codes typically are five numbers ending ". . . 99". Do not use unspecified service or procedure codes to provide services which are not a Medicaid benefit. Submit documentation for these codes with the claim for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure.

Unlisted procedures require manual review and often manual pricing. During review of medical record information, medical staff will determine payment based on reimbursement for similar procedures. Additional reimbursement may be considered only when care above similar standard procedures is medically necessary. Additional payment will not be considered when procedures are considered investigational or cosmetic.

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08 - 30 Gastric Bypass Surgery for Obesity - Criteria #22

Prior authorization for Medicaid payment of obesity surgery is required. Surgery for obesity (i.e. gastric bypass, gastroplasty) will be considered when the patient meets **each of the seven** items below:

1. To meet the weight criteria for morbid obesity the Body Mass Index (BMI) must be equal to or great than 40 before surgical intervention for a severely obese patient is considered. BMI is calculated by multiplying the person's weight in pounds by 704.5 and then dividing that product by the person's height in inches squared. (See National Institutes of Health website for BMI calculations at http://nhlbisupport.com/bmi/)

   $$BMI = 704.5 \times \frac{\text{weight in pounds}}{\text{height in inches} \times \text{height in inches}}$$

2. Must meet both A and B as follows:
   A. patient must be at least 18 years of age or older, (must be at or over legal age of consent) and,
   B. without the presence of any one of the following conditions below. These conditions could limit successful clinical outcome or interfere with compliance with the medical management regimen following surgery.
      1. Multi-system failure.
      2. Malignant disease which is not in remission.
      3. Substance abuse or drug addiction.
      4. Psychiatric disorders which will probably interfere with the long-term management of the patient after the operation despite being adequately treated.
      5. Non-compliance with current or past medical therapies.

3. Must meet either A or B as follows:
   A. One of the following major life threatening complications of obesity:
      1. Alveolar hypoventilation: insufficient ventilation leading to an increase in $PaCO_2$ > 45 mm Hg
      2. Uncontrolled diabetes: glycated hemoglobulin A1C ≥ 8
      3. Uncontrolled hypertension : BP ≥ 150/100 when compliant with medication regimen
   B. Two of the following conditions:
      1. Hypertension ≥ 140/90
      2. Dyslipidemia refers to an irregularity of the lipid profile, covering a variety of disorders relating to abnormal levels out of accepted laboratory range for total cholesterol, LDL-C, HDL-C, or triglycerides.
      3. Type II diabetes. The body does not produce enough insulin or the cells are resistant to using the insulin the body produces. This excess in blood glucose leads to the various complicating conditions in diabetic patients.
      4. Coronary heart disease
      5. Obstructive sleep apnea documented by sleep study

4. All of the following documentation requirements:
   A. Complete history and physical examination. Severe obesity often presents co-morbidity. Therefore, evaluations of the cardiovascular, pulmonary, endocrine, and gastrointestinal systems must be completed within the six months prior to surgery. Documentation should include laboratory studies, procedures, and/or imaging studies related to these issues.
   B. When the client has a history of substance abuse, the medical record must document six months of abstinence from substances of abuse, including but not limited to tobacco, marijuana, and alcohol. Documentation must include at least two negative drug screens within the three months of the request date for prior authorization.
   C. The medical record must document, with a supervised weight reduction program, a body weight loss of at least 10% within the six months prior to the request for bariatric surgery.
   D. A smoker must be compliant with smoking cessation for eight weeks prior to surgery which is confirmed and supported by approved laboratory tests (urine and/or serum).

5. There must not be evidence of non-compliance with medical or surgical treatments in the last year including:
   1. Non-compliance with medications or therapy
   2. Failure to keep scheduled appointments
   3. Leaving the hospital against medical advice
   4. Active substance abuse

6. Complete psychiatric evaluation by a board certified or board eligible psychiatrist who is a Medicaid provider. The evaluation must have been done within three months of the request and must include all of the following:
   A. Psychiatric evaluation must be documented in narrative form which includes all the elements in the Provider Manual, Section 2, under Limitations (N). Psychiatric evaluation requirements can be found at http://health.utah.gov/medicaid/ in the Physician Manual.

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B. Psychiatric disorders which would probably interfere with the long-term management of the patient after the operation must be adequately treated. MMPI can be included if available.
C. Psycho-social assessment that the client has sufficient mental, emotional, and social stability and support to ensure that the client will strictly adhere to long-term follow-up after surgery.

7. Facilities desiring to perform these services for Medicaid recipients must meet all of the following:
   A. Beginning January 1, 2010, bariatric surgical facilities must be Medicare approved. Before January 1, 2010, bariatric surgery will only receive prior approval for bariatric surgery in a Medicare approved facility or a facility currently in the process of becoming Medicare certified. Providers must have the staff and facilities required for Medicare certification.
   B. The facility must have surgeons experienced in the type of bariatric surgery procedure with a multi-disciplinary team as recommended by the American Society of Metabolic and Bariatric Surgery for surgical follow-up.
   C. The surgical team shall have a long-term patient follow-up program for the patient including access to the services of a nurse, dietician, psychologist for behavioral modification, exercise physiologist, and a support group. Note: most long-term bariatric programs see the patient at a minimum of every three months for the first year after surgery for laboratory work to evaluate glucose, creatinine, live function, protein, albumin, iron, vitamin B, folic acid, calcium, and parathyroid hormone. The patient may be seen more often to evaluation weight management efforts and offer support. Some programs follow the patient every two months for the first year, every three months for the second year, and every six months for years three, four, and five. After then, an annual visit is required for life.

8. The patient is informed of the surgical alternatives available. When laparoscopic adjustable gastric banding is the method chosen, the following criteria must be met in addition to items 1-7 above. The individual must meet all of the FDA and manufacturer requirements for the device.
   A. Age requirement of between 18 and 55 years of age
   B. History of obesity for at least five years
   C. The physician verifies that the patient does not have any one condition listed as a contraindication to the device:
      1. Inflammatory bowel disease
      2. Previous bariatric surgery
      3. Chronic pancreatitis
      4. Severe hiatal hernia
      5. Pregnancy or an intention to become pregnant in the next 12 months
      6. Autoimmune or connective disease
      7. Portal hypertension
      8. Congenital anomalies of the GI tract
      9. Cirrhosis

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08 - 31 Family Nurse Practitioner / Pediatric Nurse Practitioner

The Medicaid policy manual for family and pediatric nurse practitioners will be issued April 2008. Visit the Medicaid website at http://health.utah.gov/medicaid/tree/index.html to locate the new manual. If you do not have Internet access, please call Medicaid Information at (801) 538-6155 or 1-800-662-9651 and request a hard copy.

For your convenience, the following CPT codes, which are open to the family and pediatric nurse practitioner provider type, are listed below.

CPT List of Codes Covered for Family and Pediatric Nurse Practitioners

11975	INSERTION,IMPLANTABLE CONTRACEPTIVE CAPSULES
12001	SIMP REPAIR/SUPERFCL WNDS/SCLP,NK,EXTREMIT;2.5 CM<
12002	SIMP REPAIR/SUPER WNDS/SCLP,NK,EXTREMIT;2.6-7.5 CM
12004	SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;7.6-12.5 CM
12005	SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;12.6-20.0 CM
12006	SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;20.1-30.0 CM
12007	SIMP REPAIR/SUP WNDS/SCLP,NK,EXTREMIT;OVER 30.0 CM
12011	SIMP/REPAIR/SUP WNDS/FACE,EAR,LIP,MUC MEM;2.5 CM<
12013	SIMP REPAIR/SUP WNDS/FACE,EAR,LIP,MUC MEM;2.6-5 CM
12014	SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;5.1-7.5 CM
12015	SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;7.6-12.5 CM
12016	SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;12.6-20 CM
12017	SIMP REPAIR/SUP WNDS/FACE,EAR,MUC MEM;20.1-30.0 CM
12018	SIMP/REPAIR/SUP WNDS/FACE,EAR,MUC MEM;OVER 30 CM
16000	BURN-INIT TREAT,1ST DEGREE,LOCAL ONLY
17110	DESTRUCT OF BEN LESIONS OTHER THAN SKIN TAGS CUTAN
36415	COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE

36416 COLLECTION OF CAPILLARY BLOOD SPECIMEN
51701 INSERTION OF NON-INDWELLING BLADDER CATHETER (I.E. STRAIGHT CATHETERIZATION)
57170 DIAPHRAGM/CERVICAL CAP FITTING WITH INSTRUCTIONS
58300 INSERTION OF INTRAUTERINE DEVICE (IUD)
81002 URINALYSIS DIPSTICK/TAB REAGENT, NON-AUTO, W/O MICRO
81025 URINE PREGNANCY TST BY VISUAL COLOR COMPARISON METHODS
82044 URINE MICROALBUMIN
83036 HEMOGLOBIN, GLYCOSYLATED (A1C)
82270 BLOOD OCCULT, PEROXIDASE, FECES
82948 BLOOD GLUCOSE, REAGENT STRIP
84478 TRICYLCERIDES
84703 GONADOTROPIN, CHORIONIC, QUALITATIVE
85018 HEMOBLOBIN (HGB)
85014 BLOOD COUNT; HEMATOCRIT (HCT)
85651 SEDIMENTATION RATE, ERYTHROCYTE; NONAUTOMATED
86580 SKIN TEST; TUBERCULOSIS, INTRADERMAL
87210 SMEAR, PRIM SOURCE, W INTERP; WET MOUNT INFECT
87804 INFLUENZA
87807 RESPIRATORY SYNCYTIAL VIRUS
87880 GROUP A STREPTOCOCCUS
90471 IMMUNIZATION ADMIN;SINGLE OR COMB VACCINE/TOXOID ***Use SL modifier - VFC program***
90472 IMMUNIZATION ADMIN;2+SINGLE/COMB VACCINE/TOXOIDS ***Use SL modifier - VFC program***
90632 HEPATITIS A VACC,ADULT DOSAGE,INTRAMUSCULAR USE
90633 HEPATITIS A VACC,PED/ADOLE DOSE-2 DOSE,INTRMUSCLR
90634 HEPATITIS A VACC,PED/ADOLE DOSE-3 DOSE,INTRMUSCLR
90636 HEPATITIS A/HEPATITIS B VACC,ADULT,INTRAMUSCULAR
90645 HEMOPHILUS INFLUENZA B VACC,(4 DOSE),INTRAMUSCULAR
90649 HUMAN PAPILLOMA VIRUS VACCINE,3 DOSE SCHEDULE,INTR
90657 INFLUENZA VIRUS VACC,SPLT VIR,6-35 MO,INTRAMUSCLR
90658 INFLUENZA VIRUS VACC,SPLT VIR,3 YRS+,INTRAMUSCLR
90669 PNEUMOCOCCAL CONJUG VACC,POLYVALENT,INTRAM,<5 YRS
90700 DIPHTHERIA,TETANUS TOXOIDS,(DTAP),INTRAMUSCULAR
90701 DIPHTHERIA,TETANUS TOXOIDS,(DTP),INTRAMUSCULAR
90702 DIPHTHERIA/TETANUS TOXOIDS ADSORBED PED USE,INTRA
90703 TETANUS TOXOID ABSORBED,FOR INTRAMUSCULAR USE
90704 MUMPS VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90705 MEASLES VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90706 RUBELLA VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90707 MEASLES,MUMPS,RUBELLA VIRUS VACC,LIVE,SUBCUT/INJEC
90708 MEASLES & RUBELLA VIRUS VACCINE,LIVE,SUBCUTANEOUS
90710 MEASLES,MUMPS,RUBELLA, & (MMRV),LIVE,SUBCUTANEOUS
90712 POLIOVIRUS VACCINE,(ANY TYPE(S))(OPV),LIVE ORAL
90713 POLIOVIRUS VACCINE,INACTIVATED,(IPV),SUBCUTANEOUS
90714 TETANUS & DIPHTHERIA TOXOIDS PRESERVE FREE <7YRS
90715 TETANUS,DIPHTHERIA TOXOIDS PERTUSSIS VAC,>=7 YRS
90716 VARICELLA VIRUS VACCINE,LIVE,FOR SUBCUTANEOUS USE
90717 YELLOW FEVER VACCINE,LIVE,FOR SUBCUTANEOUS USE
90718 TETANUS/DIPHTHERIA ADSORBED 7+ YEARS,INTRAMUSCULAR
90719 DIPHTHERIA TOXOID, FOR INTRAMUSCULAR USE
90720 DIPHTHERIA,TETANUS,PERTUSSIS VACC,(DTP-HIB),INTRA
90721 DIPHTHERIA,TETANUS,PERTUSSIS VACC(DTAP-HIB),INTRA
90725 CHOLERA VACCINE FOR INJECTABLE USE
90727 PLAGUE VACCINE,FOR INTRAMUSCULAR USE
90732 PNEUMOCOCCAL POLYSACCHARIDE VACC,ADULT,SUBCUTAN
90733 MENINGOCOCCAL POLYSACCHARIDE VACC(ANY GROUP),SUBCU
90734 MENINGOCOCCAL CONJ VACCINE,(TETRAVALENT),INTRAMUSC
90735 JAPANESE ENCEPHALITIS VIRUS VACC,SUBCUTANEOUS
90744 HEPATITIS B VACCINE;PED PED/ADOLESNT DOSE,INTRAM
90746 HEPATITIS B VACCINE,ADULT DOSAGE,INTRAMUSCULAR
90748 HEPATITIS B & (HIB) VACCINE,INTRAMUSCULAR
90772 THERAPEUTIC OR DIAGNOSTIC INJECTION, SUBQ or IM
96150 HEALTH & BEHAV ASSESS, EA 15 MIN FACE-TO-FACE,INIT
96151 HEALTH & BEHAVIOR ASSESSMNT,EA 15 MIN;REASSESSMENT
96152 HEALTH & BEHAV INTERVENTION,EA 15 MIN,INDIVIDUAL
96153 HEALTH & BEHAV INTERVENTION,EA 15 MIN, GROUP
96154 HEALTH & BEHAV INTERVENTN,EA 15 MIN,FAMILY W/PATNT
96155 HEALTH & BEHAV INTERVENTN,EA 15 MIN,FAMILY W/O PAT
99050 SERVICES AFTER HOURS IN ADDITION TO BASIC SERVICES
99058 OFFICE SERVICES PROVIDED ON AN EMERGENCY BASIS
99080 SPECIAL REPORTS(EG INS,MED DATA)OVER USUAL COMMUN
99170 ANOGENITAL EXAM W COLPOSCOPIC MAGNIF CHILD TRAUMA ***This code is open only to Nurse Practitioners working with the Criminal Justice system who have completed special training to complete the procedure on children***
99201 OFFICE / OUTPAT VISIT NEW 3/3 H:PF E:PF D:SF

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99202 OFFICE / OUTPAT VISIT NEW 3/3 H:EP E:EP D:SF
99203 OFFICE / OUTPAT VISIT NEW 3/3 H:DT E:DT D:LC
99204 OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:MC
99205 OFFICE / OUTPAT VISIT NEW 3/3 H:CM E:CM D:HC
99211 OFC,OUTPAT VISIT E/M EST MAY NOT REQUIRE PHYSICIA
99212 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:PF E:PF D:SF
99213 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:EP E:EP D:LC
99214 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:DT E:DT D:MC
99215 OFFICE / OUTPAT VISIT ESTAB. 2/3 H:CM E:CM D:HC
99381 INIT E&M HEALTHY INDIVD, NEW PT,(AGE UNDER 1 YEAR)
99382 INIT E&M HEALTHY INDIVID,EARLY CHILDHOOD(AGE 1-4)
99383 INIT E&M HEALTHY INDIVID,LATE CHILDHOOD(AGE 5-11)
99384 INIT E&M HEALTHY INDIVIDUAL,ADOLESCENT(AGE 12-17)
99385 INITIAL E&M OF HEALTHY INDIVIDUAL 18-39 YEARS
99391 PERIODIC REEVAL&MGMT,HEALTHY INDIV AGE UNDER 1YR
99392 PERIODIC REEVAL & MGMT HEALTHY INDIVIDUAL(AGE 1-4)
99393 PERIODIC REEVAL & MGMT HEALTHLY INDIVID(AGE 5-11)
99394 PERIODIC REEVAL & MGMT HEALTHY INDIVID(AGE 12-17)
99395 PERIODIC REEVAL & MGMT HEALTHY INDIVID(18-39 YRS)
99432 NORM NB CARE(OTHER THAN HOSP/BIRTH RM)PE,CONFERENC
H1000 PRENATAL CARE, AT-RISK ASSESSMENT
H1001 PRENATAL CARE, AT-RISK ENHANCED; ANTEPARTUM MGMT
J0585 BOTULINUM TOXIN TYPE A, PER UNIT
J0696 INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J1055 INJ,MEDROXYPROGESTERONE ACETATE,CONTRACEPT 150 MG.
J1100 INJECTION,DEXAMETHASONE SODIUM PHOSPHATE, 1 MG
J7030 INFUSION, NORMAL SALINE SOLUTION, 1,000 CC
J7300 INTRAUTERINE COPPER CONTRACEPTIVE
J7302 LEVONORGESTREL-RELEASING IU CONTRACEPTIVE, 52 MG
S9446 PATIENT EDUCATION,NOC,NON-MD PROVDR,GROUP,PER SESSION
This code is open for pre-postnatal education for females 10-55 years of age–Limited to 8 within 12 months
S9981 MEDICAL RECORDS COPYING FEE, ADMINISTRATIVE
T1015 CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE (used in rural health centers)

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08 - 32 Anesthesiology Codes Covered for CRNA

The following CPT codes are covered for a Certified Registered Nurse Anesthetist (CRNA). The base code for the anesthesia is paid once. Therefore, if the CRNA fills in for the initial anesthesiologist, the time for the procedure is paid, but a second base for the code is not paid. A CRNA coverage section has been added to the anesthesiology provider manual.

00100 ANESTHESIA PROCEDURES SALIVARY GLANDS,INCL BIOPSY
00102 ANESTHESIA PROCEDURES PLASTIC REPAIR OF CLEFT LIP
00103 ANESTHESIA FOR RECONSTRUCTIVE PROCEDURES OF EYELID
00104 ANESTHESIA FOR ELECTROCONVULSIVE THERAPY
00120 ANESTH EXTERNAL, MIDDLE, INNER EAR INC BIOPSY;NOS
00124 ANESTH EXTRNL,MIDDLE,INNER EAR INC BIOPSY;OTOSCOPY
00126 ANES XTRNL,MIDDLE,INNER EAR INC BIOPSY;TYMPANOTOMY
00140 ANESTH PROCEDURES ON EYE;NOT OTHERWISE CLASSIFIED
00142 ANESTHESIA FOR PROCEDURES ON EYE; LENS SURGERY
00144 ANESTHESIA PROCEDURES ON EYE; CORNEAL TRANSPLANT
00145 ANESTHESIA FOR PROCEDURES ON EYE; VITREORETINAL
00147 ANESTHESIA FOR PROCEDURES ON EYE; IRIDECTOMY
00148 ANESTHESIA FOR PROCEDURES ON EYE; OPHTHALMOSCOPY
00160 ANES NOSE & ACCESSORY SINUSES;NOT OTHERWISE CLASS
00162 ANESTH NOSE AND ACCESSORY SINUSES;RADICAL SURGERY
00164 ANES NOSE AND ACCESSORY SINUSES;BIOPSY SOFT TISSUE
00170 ANES INTRAORAL PROC,INC BIOPSY;NOT OTHERWISE SPECI
00172 ANES INTRAORAL PROC,INC BIOPSY;REPAIR CLEFT PALATE
00174 ANES INTRAORL,INC BIOPSY;EXCIS RETROPHARYN TUMOR
00176 ANESTH INTRAORAL PROC,INC BIOPSY; RADICAL SURGERY
00190 ANESTHESIA FOR PROC ON FACIAL BONES OR SKULL;NOS
00192 ANESTH PROCEDURES ON FACIAL BONES;RADICAL SURGERY
00210 ANESTH INTRACRANIAL PROC;NOT OTHERWISE SPECIFIED
00212 ANESTH FOR INTRACRANIAL PROCEDURES; SUBDURAL TAPS
00214 ANESTHESIA FOR INTRACRANIAL PROCEDURES;BURR HOLES

00215 ANES INTRACRANIAL PROC;SKULL FRACTURE,EXTRADURAL
00216 ANESTH INTRACRANIAL PROCEDURES;VASCULAR PROCEDURES
00218 ANES INTRACRANIAL; PROCEDURES IN SITTING POSITION
00220 ANES INTRCRANIAL PROC;CEREBROSPINAL FLUID SHUNTING
00222 ANES INTRACRANIAL; ELECTROCOAGULATION OF NERVE
00300 ANESTH ALL INTEGUMENTARY SYS,MUSC/NERVES HEAD,NOS
00320 ANES ALL PROC NECK ORGANS;NOS,AGE 1 YEAR OR OLDER
00320 ANES ALL PROC NECK ORGANS;NOS,AGE 1 YR OR OLDER
00322 ANES ALL PROC NECK ORGANS;NEEDLE BIOPSY OF THYROID
00326 ANESTHESIA LARYNX & TRACHEA IN CHILDREN <1 YEAR
00350 ANES MAJOR VESSELS OF NECK;NOT OTHERWISE SPECIFIED
00352 ANESTH PROC MAJOR VESSELS OF NECK;SIMPLE LIGATION
00400 ANESTHES INTEGUMENTARY SYS EXTREMITIES,TRUNK;NOS
00402 ANES CHEST,RECONSTRUCT PROC BREAST,E.G.MAMMOPLASTY
00404 ANES CHEST,RECONSTUCT BREAST,RADICAL/MODIFIED PROC
00406 ANES BREAST,RADICAL/MODIFIED,MAMMARY NODE DISSECTN
00410 ANES BREAST,RADICL/MODIFD,ELEC CONVERSN ARRHYTHMIA
00450 ANES CLAVICLE AND SCAPULA;NOT OTHERWISE SPECIFIED
00452 ANESTH PROC CLAVICLE AND SCAPULA; RADICAL SURGERY
00454 ANES PROC CLAVICLE AND SCAPULA;BIOPSY OF CLAVICAL
00470 ANES PARTIAL RIB RESECTION;NOT OTHERWISE SPECIFIED
00472 ANES PARTIAL RIB RESECTION;THORACOPLASTY(ANY TYPE)
00474 ANES PARTL RIB RESECT;RADICL,E.G.PECTUS EXCAVATUM
00500 ANESTHESIA FOR ALL PROCEDURES ON ESOPHAGUS
00520 ANESTHESIA FOR CLOSED CHEST PROCEDURES; NOS
00522 ANES CLSD CHEST PROCEDURE;NEEDLE BIOPSY OF PLEURA
00524 ANES CLSD CHEST PROCEDURES; PNEUMOCENTESIS
00528 ANESTH CLOSED CHEST PROC;MEDIASTIN/DIAG THORACSCPY
00530 ANESTHESIA PERMANENT TRANSVENOUS PACEMAKER INSERT
00532 ANESTH FOR ACCESS TO CENTRAL VENOUS CIRCULATION
00534 ANES TRANSVENEOUS INSERT/REPLAC CARDIOVERTER/DEFIB
00537 ANES CARDIAC ELECTROPHYSIOLOGIC PROC INCL ABLATION
00539 ANESTHESIA FOR TRACHEOBRONCHIAL RECONSTRUCTION
00540 THORACOTOMY,LUNG,PLEURA,DIAPHRAGM,MEDIASTINUM;NOS
00541 ANESTH THORACOTOMY PROC,UTILIZ 1 LUNG VENTILATION
00542 THORACOTOMY(LUNGS,PLEURA,DIAPHRAGM);DECORTICATION
00546 THORACOTOMY;PULMONARY RESECTION WITH THORACOPLASTY
00548 THORACOTOMY;INTRATHORACIC PROC TRACHEA & BRONCHI
00550 ANESTHESIA FOR STERNAL DEBRIDEMENT
00560 HEART,PERICARDIUM,GREAT VESSELS,W/O PUMP OXYGENATR
00561 ANESTH PROC ON HEART SURG W/PUMP OXYGEN < AGE 1
00562 HEART,PERICARDIUM,GREAT VESSELS,W PUMP OXYGENATOR
00563 ANES PROC HEART;W PUMP OXY HYPOTHERMIC CIR ARREST
00566 ANES DIRECT CORONARY ART SYPASS W/O PUMP OXYGENTR
00580 ANESTHESIA FOR HEART OR HEART/LUNG TRANSPLANT
00600 ANES CERVICAL SPINE, CORD;NOT OTHERWISE SPECIFIED
00604 ANESTHESIA CERVICAL SPINE & CORD;SITTING POSITION
00620 ANES THORACIC SPINE, CORD;NOT OTHERWISE SPECIFIED
00622 THORACIC SPINE & CORD;THORACOLUMBAR SYMPATHECTOMY
00630 ANESTH PROC LUMBAR REGION;NOT OTHERWISE SPECIFIED
00632 ANESTH PROC LUMBAR REGION; LUMBAR SYMPATHECTOMY
00634 ANESTH PROC LUMBAR REGION; CHEMONUCLEOLYSIS
00635 ANES PROC LUMBAR REG;DIAG/THERAP LUMBAR PUNCTURE
00670 ANESTHESIA FOR EXTENSIVE SPINE & SPINAL CORD PROC
00700 UPPER ANTERIOR ABDOMINAL WALL;NOT OTHERWISE SPECIF
00702 UPPER ANTERIOR ABDOMINAL WALL;PERCUT LIVER BIOPSY
00730 ANES PROCEDURES ON UPPER POSTERIOR ABDOMINAL WALL
00740 ANES UPPER GASTROINTESTINAL ENDOSCOPIC PROCEDURES
00750 ANESTH FOR HERNIA REPAIRS IN UPPER ABDOMEN, NOS
00752 ANES HERNIA REPAIR UPPER ABDOMEN;LUMBAR & VENTRAL
00754 ANESTH HERNIA REPAIRS UPPER ABDOMEN; OMPHALOCELE
00756 HERNIA REPAIRS;TRANSABOMINAL DIAPHRAGMATIC HERNIA
00770 ANES FOR ALL PROC ON MAJOR ABDOMINAL BLOOD VESSELS
00790 INTRAPERITONEAL UPPER ABDOMEN;INC LAPAROSCOPY;NOS
00792 INTRAPERITONEAL,INC LAPAROSCOPY;PARTL HEPATECTOMY
00794 INTRAPERITONEAL;PANCREATECTOMY,PARTL/TOTL(WHIPPLE)
00796 ANES INTRAPERITONEAL;LIVER TRANSPLANT (RECIPIENT)
00800 ANESTH PROC ON LOWER ANTERIOR ABDOMINAL WALL; NOS
00810 ANESTHESIA FOR INTESTINAL ENDOSCOPIC PROCEDURES

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00820 ANESTH PROCEDURE ON LOWER POSTERIOR ABDOMINL WALL
00830 ANESTH FOR HERNIA REPAIRS IN LOWER ABDOMEN; NOS
00832 HERNIA REPAIRS LOWER ABDOMEN;VENTRAL & INCISIONAL
00834 ANESTH HERNIA REPAIRS IN LOWER ABDOMEN NOS,<1 YR
00836 ANESTH HERNIA REPAIRS IN LOWER ABDOMEN NOS,INFANT
00840 INTRAPERITONEAL LOWER ABDOMEN,INC LAPAROSCOPY;NOS
00842 ANESTH INTRAPERITONEAL LOWER ABDOMEN;AMNIOCENTESIS
00844 ANESTH INTRAPERITONEAL;ABDOMINOPERINEAL RESECTION
00846 INTRAPERITONEAL LOWR ABDOMEN;RADICAL HYSTERECTOMY
00848 INTRAPERITONEAL LOWER ABDOMEN;PELVIC EXENTERATION
00851 INTRAPERITONEAL LOWR ABDOMEN;TUBAL LIGATN/TRANSECT
00860 EXTRAPERITONEAL LOW ABDOMEN,INC URINARY TRACT;NOS
00862 RENAL,INC UPPER 1/3 OF URETER / DONOR NEPHRECTOMY
00863 EXTRAPERITONEAL; RADICAL PROSTATECTOMY
00864 EXTRAPERITONEAL; TOTAL CYSTECTOMY
00865 ANES EXTRAPERITONEAL LOWER ABDOMEN;PROSTATECTOMY
00866 ANES EXTRAPERITONEAL LOWER ABDOMEN; ADRENALECTOMY
00868 ANES EXTRAPERITONEAL; RENAL TRANSPLANT (RECIPIENT)
00870 ANES EXTRAPERITONEAL LOWER ABDOMEN;CYSTOLITHOTOMY
00872 LITHOTRIPSY,EXTRACORPOREAL SHOCK WAVE; WATER BATH
00873 LITHOTRIPSY,XTRACORPORL SHOCK WAVE;W/O WATER BATH
00880 ANESTH PROC ON MAJOR LOWER ABDOMINAL VESSELS; NOS
00882 LOWR ABDOMINAL VESSELS,INFERIOR VENA CAVA LIGATION
00902 ANESTHESIA FOR; ANORECTAL PROCEDURE
00904 PERINEAL(INC BIOPSY MALE GENITAL);RADICAL PERINEAL
00906 PERINEAL(INC BIOPSY MALE GENITAL SYSTM);VULVECTOMY
00908 PERINEAL(INC BIOPSY MALE GENITAL); PROSTATECTOMY
00910 ANES TRANSURETHRAL PROC(INC URETHROCYSTOSCOPY);NOS
00912 ANES; TRANSURETHRAL RESECTION OF BLADDER TUMOR(S)
00914 ANES;TRANSURETHRAL RESECTION OF PROSTATE
00916 ANES; POST-TRANSURETHRAL RESECTION BLEEDING
00918 ANES TRANSUR PROC;W FRAG,& OR REMOV URETERAL CALCU
00920 ANESTHESIA FOR PROCECURES ON MALE GENITALIA; NOS
00921 ANESTHESIA MALE GENITALIA;VASECTOMY,UNILAT/BILAT
00922 ANES PROC MALE EXTERNAL GENITALIA;SEMINAL VESICLES
00924 MALE XTNRL GENITALIA;UNDESCENDED TESTIS,UNI/BI LAT
00926 MALE XTRNL GENITALIA;RADICAL ORCHIECTOMY,INGUINAL
00928 MALE XTRNL GENITALIA;RADICAL ORCHIECTOMY,ABDOMINAL
00930 MALE XTRNL GENITALIA;ORCHIOPEXY,UNILATRL & BILATRL
00932 MALE XTRNL GENITALIA;COMPLETE AMPUTATION OF PENIS
00934 AMPUTATN PENIS W BILATRL INGUINAL LYMPHADENECTOMY
00936 AMPU PENIS W BILAT INGUINL & ILIAC LYMPHADENECTOMY
00940 VAGINAL(BIOPSY LABIA,VAGINA,CERVX,ENDOMETRUIM)NOS
00942 ANES VAG PROC;COLPOTOMY,VAGINECTOMY,COLPOR,URETHRA
00944 ANESTHESIA VAGINAL PROC; VAGINAL HYSTERECTOMY
00948 ANESTHESIA VAGINAL PROCEDURE; CERVICAL CERCLAGE
00950 ANESTHESIA FOR VAGINAL PROCEDURES; CULDOSCOPY
00952 ANESTHESIA FOR VAGINAL PROCEDURES; HYSTEROSCOPY
01112 ANES BONE MARROW ASPIRATION &/OR BIOPSY ANTER/POST
01120 ANESTHESIA FOR PROCEDURES ON BONY PELVIS
01130 ANESTHESIA FOR BODY CAST APPLICATION OR REVISION
01140 ANES INTERPELVIABDOMINAL(HIND QUARTER) AMPUTATION
01150 TUMOR OF PELVIS, EXCEPT HIND QUARTER AMPUTATION
01160 CLOSED PROC SYMPHYSIS PUBIS OR SACROILIAC JOINT
01170 OPEN PROC INV SYMPHYSIS PUBIS OR SACROILIAC JOINT
01180 ANESTH FOR OBTURATOR NEURECTOMY; EXTRAPELVIC
01190 ANESTH FOR OBTURATOR NEURECTOMY; INTRAPELVIC
01200 ANESTH FOR ALL CLOSED PROC INVOLVING HIP JOINT
01202 ANESTH FOR ARTHROSCOPIC PROCEDURES OF HIP JOINT
01210 OPEN PROC INV HIP JOINT; NOT OTHERWISE SPECIFIED
01212 ANES OPEN PROC INV HIP JOINT; HIP DISARTICULATION
01214 ANES OPEN PROC INV HIP JOINT;TOTAL HIP ARTHROPLSTY
01215 ANES OPEN PROC HIP JOINT;REVIS TOTAL HIP ARTHRO
01216 ANES HIP JOINT;REVISION OF TOTAL HIP ARTHROPLASTY
01220 ANES FOR ALL CLOSED PROC INV UPPER 2/3 OF FEMUR
01230 ANES FOR OPEN PROC INV UPPER 2/3 OF FEMUR; NOS
01232 ANES OPEN PROC INV UPPER 2/3 OF FEMUR;AMPUTATION
01234 OPEN PROC INV UPPER 2/3 OF FEMUR;RADICAL RESECTION
01250 NERVES,MUSCLES,TENDONS,FASCIA,& BURSAE UPPER LEG
01260 PROC INV VEINS OF UPPER LEG,INCLUDING EXPLORATION

01270 PROC ARTERIES OF UPPER LEG, INC BYPASS GRAFT, NOS
01272 ARTERIES UPPER LEG,INC BYPASS GRAFT,FEMORAL LIGATN
01274 UPPER LEG,BYPASS GRAFT;FEMORAL ARTERY EMBOLECTOMY
01320 NRVS,MUSCLES,TNDNS,FASCIA,BURSAE KNEE &/OR POPLITL
01340 FOR ALL CLOSED PROCEDURES ON LOWER 1/3 OF FEMUR
01360 FOR ALL OPEN PROCEDURES ON LOWER 1/3 OF FEMUR
01380 ANESTHESIA FOR ALL CLOSED PROCEDURES ON KNEE JOINT
01382 ANESTHESIA FOR DIAGNOST ARTHROSCOPIC PROC KNEE JNT
01390 CLOSED PRCDRS UPPER ENDS TIBIA,FIBULA,&/OR PATELLA
01392 OPEN PRCDRS UPPER ENDS TIBIA,FIBULA &/OR PATELLA
01400 ANESTHESIA OPEN OR SURG ARTHRO PROC KNEE JOINT;NOS
01402 ANES,OPEN PROC KNEE JOINT;TOTAL KNEE ARTHROPLASTY
01404 OPEN PROCEDURES KNEE JOINT;DISARTICULATN AT KNEE
01420 ALL CAST APPLICATION,REMOVAL OR REPAIR KNEE JOINT
01430 VEINS OF KNEE,POPLITEAL AREA;NOT OTHERWISE SPECFD
01432 VEINS KNEE & POPLITEAL AREA;ARTERIOVENOUS FISTULA
01440 PROCEDURES ARTERIES OF KNEE & POPLITEAL AREA;NOS
01442 POPLITEAL THROMBOENDARTERECTOMY, W/WO PATCH GRAFT
01444 POPLITEAL EXCSN & GRAFT/REPAIR OCCLUSION/ANEURYSM
01462 ANES FOR ALL CLOSED PROCEDURES,LOW LEG,ANKLE,FOOT
01464 ANESTHESIA FOR ARTHROSCOPIC PROC ANKLE &/OR FOOT
01470 ANES,PROC NERVES,MUSCLES,TENDONS,FASCIA; NOS
01472 ANES,LOW LEG;REPR RUPT ACHILLE TENDON,W W/O GRAFT
01474 ANES LOW LEG;GASTROCNEMIUS RECESSION(STRAYER PROC)
01480 ANES,OPEN PROCEDURES BONES LOW LEG,ANKLE,FOOT;NOS
01482 ANES,OPEN PROC BONE LOW LEG,ANK,FOOT;RADICL RESEC
01484 ANES,BONES LOW LEG;OSTEOTOMY/PLASTY TIBIA,FIBULA
01486 ANES,OPEN PROC BONE LOW LEG;TOTAL ANKLE REPLACMNT
01490 ANES,LOWER LEG CAST APPLICATION,REMOVAL OR REPAIR
01500 ANES,PROC ARTERIES LOW LEG,INCL BYPASS GRAFT; NOS
01502 ANES,PROC ARTERIES LOW LEG;EMBOLECTOMY,DIRECT/CATH
01520 ANESTHESIA FOR PROCEDURES ON VEINS,LOWER LEG; NOS
01522 ANES,VEINS LOW LEG;VENOUS THROMBECTOMY,DIRECT/CATH
01610 ANES,PROC NERVE,MUSC,TENDON,FASICA,BURSAE SHOULDER
01620 ANES,HUMER HEAD,NECK,STERNOCLAV,ACROMIO,SHOULD JT
01622 ANES DIAGNOSTIC ARTHROSCOPIC PROC SHOULDER JOINT
01630 ANES,HUMER HEAD,NECK,STERNO,ACROMIO,SHOULDR JT;NOS
01632 ANES,HEAD,NECK,STERNO,ACROMIO,SHOULD JT;RAD RESECT
01634 ANES,STERNO,ACROMIO JT; SHOULDER DISARTICULATION
01636 ANES;INTERTHORACOSCAPULAR (FOREQUARTER)AMPUTATION
01638 ANES,STERN,ACROM,SHOULD JT;TOTAL SHOULDR REPLACMT
01650 ANES,PROCEDURE ON ARTERIES OF SHOULDER,AXILLA;NOS
01652 ANES,ARTER SHOULD,AXILL;AXILLRY-BRACHIAL ANEURYSM
01654 ANES,PROCED ARTERIES SHOULDER,AXILLA;BYPASS GRAFT
01656 ANES,PROC ARTERIES;AXILLARY-FEMORAL BYPASS GRAFT
01670 ANES,FOR PROCEDURES ON VEINS OF SHOULDER,AXILLA
01680 ANES,SHOULDER CAST APPLICATION,REMOVAL/REPAIR NOS
01682 ANES,CAST APPLICATN,REMOVAL/REPAIR;SHOULDER SPICA
01710 NRVS,MSLS,TNDNS,FASCIA,BURSAE UPPER ARM/ELBOW;NOS
01712 UPPER ARM & ELBOW;TENOTOMY,ELBOW TO SHOULDER,OPEN
01714 UPPER ARM & ELBOW; TENOPLASTY,ELBOW TO SHOULDER
01716 UPPER ARM;TENODESIS,RUPTURE LONG TENDON OF BICEPS
01730 ANES FOR ALL CLOSED PROCEDURES ON HUMERUS & ELBOW
01732 ANES FOR DIAGNOSTIC ARTHROSCOPIC PROC ELBOW JOINT
01740 ANES FOR OPEN OR SURG ARTHROSCOPIC PROC ELBOW;NOS
01742 OPEN PROCEDURES HUMERUS & ELBOW;OSTEOTOMY HUMERUS
01744 HUMERUS & ELBOW; REPAIR NONUNION/MALUNION HUMERUS
01756 OPEN PROCEDURES HUMERUS & ELBOW;RADICAL PROCEDURES
01758 HUMERUS & ELBOW;EXCISION OF CYST/TUMOR OF HUMERUS
01760 PROCEDURES HUMERUS & ELBOW;TOTAL ELBOW REPLACEMNT
01770 PROCEDURES ON ARTERIES OF UPPER ARM & ELBOW; NOS
01772 PROCEDURES ARTERIES UPPER ARM & ELBOW;EMBOLECTOMY
01780 PROCEDURES ON VEINS OF UPPER ARM & ELBOW; NOS
01782 VEINS OF UPPER ARM & ELBOW; PHLEBORRHAPHY
01810 NRVS,MUSCLE,TNDN,FASCIA,BURSAE FOREARM,WRIST,HAND
01820 CLOSED PROC RADIUS,ULNA,WRIST OR HAND BONES; NOS
01829 ANESTHESIA FOR DX ARTHROSCOPIC PROCEDURES ON WRIST
01830 ANES OPEN PROC RADIUS,ULNA,WRIST/HAND JOINTS;NOS
01832 RADIUS,ULNA,WRIST,HAND BONES;TOTL WRIST REPLACMNT

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01840 ANES PROCED ON ARTERIES OF FOREARM,WRIST,HAND;NOS
01842 ANES ON ARTERIES FOREARM,WRIST,HAND; EMBOLECTOMY
01844 VASCULAR SHUNT OR SHUNT REVISN,ANY(E.G. DIALYSIS)
01850 ANES PROC ON VEINS OF FOREARM,WRIST AND HAND; NOS
01852 ANES VEINS OF FOREARM,WRIST AND HAND;PHLEBORRHAPHY
01860 FOREARM,WRIST,HAND CAST APPLICATION,REMOVL/REPAIR
01916 ANESTHESIA FOR DIAGNOSTIC ARTERIOGRAPHY/VENOGRAPHY
01920 ANES CARD.CATH.CORONARY ANGIOGRAPHY,VENTRICULOGR
01922 ANES FOR NON-INVASIVE IMAGING / RADIATION THERAPY
01925 THER INTERVEN RADIOLOGIC ARTERIAL;CAROTID/CORONARY
01926 THER INTERVEN RADIOLOGC PROC ARTERIAL;HRT/CRAN
01931 THER INTERVEN RADIOLOGC PROC VENOUS/LYMPHATIC;TIPS
01932 THER INTERVEN RAD PROC VENOUS/LYMPHATIC;THORACIC
01933 THER INTERVEN RAD VENOUS/LYMPHATIC;INTRACRANIAL
01951 ANES,2ND & 3RD DEGREE BURN EXCSN; <4% BODY AREA
01952 ANES,2ND & 3RD DEGREE BURN EXCSN; 4% TO 9% BODY AR
01960 ANESTHESIA FOR; VAGINAL DELIVERY ONLY
01961 ANESTHESIA FOR CESAREAN DELIVERY ONLY
01962 ANESTHESIA FOR URGENT HYSTERECTOMY FOLLOWING DELIV
01963 CESAREAN HYSTERECTOMY W/O LABOR ANALGSIA/ANES CARE
01965 ANES FOR INCOMPLETE OR MISSED ABORTION PROCEDURES
01967 NEURAXIAL LABOR ANALGSIA/ANES PLANNED VAGINAL DELV
01968 ANES CESAREAN DLVRY FOLLOW NEURAXIAL ANALGSIS/ANES
01968 ANES CESAREAN DLVRY FOLLOW NEURAXIAL ANALGSIA/ANES
01969 ANES CESAREAN HYSTEREC FOLLOW NEURAXIAL ANALG/ANES
01991 ANESTH NERVE BLOCKS & INJECTIONS;OTHER THAN PRONE
01992 ANESTH NERVE BLOCKS & INJECTIONS;PRONE POSITION
01996 DAILY HOSP MNGMNT EPIDURAL/SUBARACHNOID DRUG ADMIN
31500 INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE
36248 SELECT CATH PLACEMT,ART SYS;2ND,3RD ORD/LOW EXTRM
41899 UNLISTED PROC,DENTOALVEOLAR STRUCTURES
62273 INJECTION, EPIDURAL, OF BLOOD OR CLOT PATCH
62311 INJECTION,SNGL EPIDURAL/SUBARACHNOD;LUMBAR,SACRAL
92950 CARDIOPULMONARY RESUSCITATION
99148 MODERATE SEDATION SRVCS BY DIFF PHYS,<5 YRS,30 MIN
99149 MODERATE SEDATION SRVCS BY DIFF PHYS,5 YRS+,30 MIN
99150 MODERATE SEDATION SRVCS BY DIFF PHYS,EA ADD 15 MIN
99440 NB RESUSCITATION:PRESSURE VENILAT,CHEST COMPRESS

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08 - 33 Coding Updates

Correction to the January 2008 MIB

29905 Arthroscopy, subtalar joint, surgical, with synovectomy was inadvertently left off the list of 42 post operative days.

Issue Clarification

76819 Fetal biophysical profile with non-stress testing is the correct CPT code to use.
76818 Fetal biophysical profile without non-stress testing, submitted with CPT code 59025 (fetal non-stress test), is denied.

Global pregnancy is not to be unbundled. Some group practices have expressed an opinion that they should be able to unbundle the global pregnancy fee so that each physician in the group practice receives payment for a visit during the pregnancy. This is incorrect billing which may be subject to post payment review. As described in the manual, additional evaluation and management codes are not paid when the patient sees another physician in the group practice or the emergency room for the same or similar issues on the same date of service. The physician or group practice is to bill the evaluation and management code for the level of service provided on the date of service.

Physician Home Visit Clarification

99349 Physician home visits are covered for patients eligible for hospice in the hospice program. Patients eligible for hospice are not eligible to receive services through Medicaid. Medicaid will consider coverage of a physician home visit when the patient has a condition which makes travel (i.e. 50 miles) very difficult and they live in a rural area where access to medical care is limited. All services will continue to require prior authorization.