wisconsin Medicaid update
and BadgerCare

February 2004 ● No. 2004-03

Wisconsin Medicaid and BadgerCare Information for Providers

To:

- Ambulatory Surgery Centers
- Anesthesiologist Assistants/ Certified Registered Nurse Anesthetists
- Federally Qualified Health Centers
- Independent Labs
- Inpatient Hospital Providers
- Institutes for Mental Disease Providers
- Nurse Practitioners
- Opticians
- Optometrists
- Outpatient Hospital Providers
- Physician Assistants
- Physician Clinics
- Physicians
- Podiatrists
- Portable X-ray Providers
- Rural Health Clinics
- HMOs and Other Managed Care Programs

Procedure code updates

Each year, the American Medical Association and the federal government adopt new *Current Procedural Terminology* (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for providers. Wisconsin Medicaid has adopted many of these new procedure codes. Attachments 1-6 of this *Wisconsin Medicaid and BadgerCare Update* list the CPT and HCPCS codes that may be reimbursable by Wisconsin Medicaid. All new codes are effective for dates of service (DOS) on and after January 1, 2004.

New procedure codes effective with dates of service on and after January 1, 2004

Effective for dates of service (DOS) on and after January 1, 2004, Wisconsin Medicaid is adding procedure codes previously not reimbursed by Wisconsin Medicaid. The procedure codes are included in the Attachments of this *Wisconsin Medicaid and BadgerCare Update* for the providers in the following list.

Refer to Attachments 1-6 for lists of procedure codes, procedure code descriptions, modifiers, copayment amounts, maximum fees, and procedure code requirements. The procedure codes do not require prior authorization (PA) or a second surgical opinion.

The procedure codes listed in the attachments affect the following providers:

- Ambulatory surgery centers (See Attachment 1).
- Anesthesiologist assistants/certified registered nurse anesthetists (See Attachment 6).
- Federally qualified health centers (See Attachment 6).
- Independent labs (See Attachment 6).
- Inpatient hospital providers (See Attachment 2).
- Institutes for mental disease providers (See Attachment 3).
- Nurse practitioners (See Attachment 6).
- Opticians (See Attachment 4).
- Optometrists (See Attachment 4).
- Outpatient hospital providers (See Attachment 2).
- Physician assistants (See Attachment 6).
- Physician clinics (See Attachment 6).
- Physicians (See Attachment 6).
- Podiatrists (See Attachment 5).
- Portable X-ray providers (See Attachment 6).
- Rural health clinics (See Attachment 6).

This *Update* does not list new procedure codes *not* reimbursed by Wisconsin Medicaid. For procedure codes with description changes or deleted procedure codes, refer to the *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) books.

Fee schedules are updated on a quarterly basis and posted on the Wisconsin Medicaid Web site. The Medicaid Web site address is *dhfs.wisconsin.gov/medicaid/*. Refer to this *Update* until the fee schedule is modified.

If CPT and HCPCS codes are enddated effective with DOS prior to April 1, 2004, Wisconsin Medicaid will enddate the codes effective with DOS on and after April 1, 2004.

For specific coverage limitations on the procedure codes listed in this *Update*, refer to service-specific *Updates* and handbooks.

Prior authorization

Wisconsin Medicaid does not require PA for any of the procedure codes listed in this *Update*.

Providers with questions regarding the codes in this *Update* may call Provider Services at (800) 947-9627 or (608) 221-9883.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
New procedure codes for ambulatory surgery centers

Effective for dates of service on and after January 1, 2004

Procedure code	Description	Allowable modifier	Provider type*	Copay	Max fee	Restrictions
20982	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance		70	$3.00	manually priced	
21685	Hyoid myotomy and suspension		70	$3.00	manually priced	
22532	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic		70	$3.00	manually priced	
22533	lumbar		70	$3.00	manually priced	
22534	thoracic or lumbar, each additional vertebral segment (list separately in addition to code for primary procedure)		70	$3.00	manually priced	
31632	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)		70	$0.00	manually priced	
31633	With transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)		70	$0.00	manually priced	
34805	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis		70	$3.00	manually priced	
35510	Bypass graft, with vein; carotid-brachial		70	$3.00	manually priced	
35512	subclavian-brachial		70	$3.00	manually priced	
35522	axillary-brachial		70	$3.00	manually priced	
35525	brachial-brachial		70	$3.00	manually priced	
35697	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (list separately in addition to code for primary procedure)		70	$3.00	manually priced	
36555	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age		70	$0.00	manually priced	Under 5 years of age
36556	age 5 years or older		70	$3.00	manually priced	Ages 5-99
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age		70	$0.00	manually priced	Under 5 years of age
36558	age 5 years or older		70	$3.00	manually priced	Ages 5-99

*Provider type

Code	Description
70	Ambulatory Surgery Centers

Procedure code	Description	Allowable modifier	Provider type	Copay	Max fee	Restrictions
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age		70	$0.00	manually priced	Under 5 years of age
36561	age 5 years or older		70	$3.00	manually priced	Ages 5-99
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump		70	$3.00	manually priced	
36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (eg, tesio type catheter)		70	$3.00	manually priced	
36566	with subcutaneous port(s)		70	$3.00	manually priced	
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age		70	$0.00	manually priced	Under 5 years of age
36569	age 5 years or older		70	$3.00	manually priced	Ages 5-99
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; under 5 years of age		70	$0.00	manually priced	Under 5 years of age
36571	age 5 years or older		70	$3.00	manually priced	Ages 5-99
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site		70	$3.00	manually priced	
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site		70	$3.00	manually priced	
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site		70	$3.00	manually priced	
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access		70	$3.00	manually priced	
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access		70	$3.00	manually priced	
36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access		70	$3.00	manually priced	
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access		70	$3.00	manually priced	
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access		70	$3.00	manually priced	
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access		70	$3.00	manually priced	
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump		70	$3.00	manually priced	
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion		70	$3.00	manually priced	
36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access		70	$3.00	manually priced	

Procedure code	Description	Allowable modifier	Provider type	Copay	Max fee	Restrictions
36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen		70	$0.00	manually priced	
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance		70	$3.00	manually priced	
36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)		70	$3.00	manually priced	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions		70	$3.00	manually priced	
37766	more than 20 incisions		70	$3.00	manually priced	
43237	Upper gastrointestinal endoscopy including esophagus, stomach, and either the doudenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus		70	$3.00	manually priced	
43238	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)		70	$3.00	manually priced	
47140	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)		70	$3.00	manually priced	
47141	total left lobectomy (segments II, III, and IV)		70	$3.00	manually priced	
47142	total right lobectomy (segments V, VI, VII and VIII)		70	$3.00	manually priced	
53500	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)		70	$3.00	manually priced	Females only
57425	Laparascopy, surgical, colpopexy (suspension of vaginal apex)		70	$3.00	manually priced	Females only
59070	Transabdominal amnioinfusion, including ultrasound guidance		70	$3.00	manually priced	Females only
59072	Fetal umbilical cord occlusion, including ultrasound guidance		70	$3.00	manually priced	Females only
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance		70	$3.00	manually priced	Females only
59076	Fetal shunt placement, including ultrasound guidance		70	$3.00	manually priced	Females only
59897	Unlisted fetal invasive procedure, including ultrasound guidance		70	$3.00	manually priced	Females only
61537	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery		70	$3.00	manually priced	
61540	for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery		70	$3.00	manually priced	
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy		70	$3.00	manually priced	
61567	for multiple subpial transections, with electrocorticography during surgery		70	$3.00	manually priced	

Procedure code	Description	Allowable modifier	Provider type	Copay	Max fee	Restrictions
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array		70	$3.00	manually priced	
61864	each additional array (list separately in addition to primary procedure)		70	$3.00	manually priced	
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array		70	$3.00	manually priced	
61868	each additional array (List separately in addition to primary procedure)		70	$0.00	manually priced	
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment		70	$3.00	manually priced	
63102	lumbar, single segment		70	$3.00	manually priced	
63103	thoracic or lumbar, each additional segment (list separately in addition to code for primary procedure)		70	$3.00	manually priced	
64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration		70	$3.00	manually priced	
64517	Injection, anesthetic agent; superior hypogastric plexus		70	$3.00	manually priced	
64681	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus		70	$3.00	manually priced	
65780	Ocular surface reconstruction; amniotic membrane transplantation		70	$3.00	manually priced	
65781	limbal stem cell allograft (eg, cadaveric or living donor)		70	$3.00	manually priced	
65782	limbal conjunctival autograft (includes obtaining graft)		70	$3.00	manually priced	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)		70	$3.00	manually priced	
68371	Harvesting conjunctival allograft, living donor		70	$3.00	manually priced	
95991	Refilling and maintenance of inplantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician		70	$3.00	manually priced	

ATTACHMENT 2
New procedure codes for inpatient and outpatient hospital providers

Effective for dates of service on and after January 1, 2004

Procedure code	Description	Allowable modifier*	Provider type(s)**	Copay	Restrictions
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count		61, 62	$0.00	
G0307	Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count)		61, 62	$0.00	
P9051	Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit		61, 62	$0.00	
P9052	Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit		61, 62	$0.00	
P9053	Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit		61, 62	$0.00	
P9054	Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit		61, 62	$0.00	
P9055	Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit		61, 62	$0.00	
P9056	Whole blood, leukocytes reduced, irradiated, each unit		61, 62	$0.00	
P9057	Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit		61, 62	$0.00	
P9058	Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit		61, 62	$0.00	
P9059	Fresh frozen plasma between 8-24 hours of collection, each unit		61, 62	$0.00	
P9060	Fresh frozen plasma, donor retested, each unit		61, 62	$0.00	
84156	Protein, total, except by refractometry; urine	26, TC	61, 62	$0.00	
84157	other source (eg, synovial fluid, cerebrospinal fluid)	26, TC	61, 62	$0.00	
85055	Reticulated platelet assay	26, TC	61, 62	$0.00	
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	26, TC	61, 62	$0.00	
87269	Infectious agent antigen detection by immunofluorescent technique; giardia	26, TC	61, 62	$0.00	

*Allowable modifier
26 = Professional component
TC = Technical component

**Provider Type

Code	Description
61	Inpatient Hospital Providers
62	Outpatient Hospital Providers

Note: For inpatient hospital services, these procedure codes will be reimbursed as part of the inpatient hospital Diagnosis Related Group (DRG) rate. For outpatient hospital services, these procedure codes will be reimbursed as part of the outpatient rate.

Procedure code	Description	Allowable modifier*	Provider type(s)	Copay	Restrictions
87329	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; giardia	26, TC	61, 62	$0.00	
87660	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique	26, TC	61, 62	$0.00	
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	26, TC	61, 62	$0.00	
88361	Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative	26, TC	61, 62	$0.00	
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	26, TC	61, 62	$0.00	
89225	Starch granules, feces	26, TC	61, 62	$0.00	
89230	Sweat collection by iontophoresis	26, TC	61, 62	$0.00	
89235	Water load test	26, TC	61, 62	$0.00	
89240	Unlisted miscellaneous pathology test	26, TC	61, 62	$0.00	

ATTACHMENT 3
New procedure codes for institutes for mental disease providers

Effective for dates of service on and after January 1, 2004

Procedure code	Description	Allowable modifier	Provider type*	Copay	Max fee	Restrictions
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count		64	$0.00	manually priced	
G0307	Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count)		64	$0.00	manually priced	

*Provider type

Code	Description
64	Institutes for Mental Disease Providers

ATTACHMENT 4
New procedure codes for opticians and optometrists

Effective for dates of service on and after January 1, 2004

Procedure code	Description	Allowable modifier	Provider type*	Copay	Max fee	Restrictions
76514	Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)		28	$3.00	$11.85	
V2321	Lenticular lens, per lens, trifocal		28, 29	$0.00	manually priced	
V2762	Polarization, any lens material, per lens		28, 29	$0.00	manually priced	
V2786	Specialty occupational multifocal lens, per lens		28, 29	$0.00	manually priced	PA** required
V2797	Vision supply, accessory and/or service component of another HCPCS vision code		28, 29	$0.00	manually priced	PA required

*Provider type

Code	Description
28	Optometrists
29	Opticians

**PA = Prior authorization.

ATTACHMENT 5
New procedure codes for podiatrists

Effective for dates of service on and after January 1, 2004

Procedure code	Description	Allowable modifier	Provider type*	Copay	Max fee	Restrictions
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count		32	$1.00	manually priced	
G0307	Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count)		32	$1.00	manually priced	
P9051	Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit		32	$1.00	manually priced	
P9052	Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit		32	$1.00	manually priced	
P9053	Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit		32	$1.00	manually priced	
P9054	Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit		32	$1.00	manually priced	
P9055	Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit		32	$1.00	manually priced	
P9056	Whole blood, leukocytes reduced, irradiated, each unit		32	$1.00	manually priced	
P9057	Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit		32	$1.00	manually priced	
P9058	Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit		32	$1.00	manually priced	
P9059	Fresh frozen plasma between 8-24 hours of collection, each unit		32	$1.00	manually priced	
P9060	Fresh frozen plasma, donor retested, each unit		32	$1.00	manually priced	

*Provider type

Code	Description
32	Podiatrists

ATTACHMENT 6

New procedure codes for physicians, physician clinics, physician assistants, nurse practitioners, certified registered nurse anesthetists, anesthesiologist assistants, independent labs, portable X-ray providers, federally qualified health centers, and rural health clinics

Effective for dates of service on and after January 1, 2004

Provider types			
19-22	Physicians/Physician Clinics	45	Nurse Practitioners
23	Independent Labs	75	Portable X-ray Providers
24	Federally Qualified Health Centers	88	Physician Assistants
43	Anesthesiologist Assistants/ Certified Registered Nurse Anesthetists	94	Rural Health Clinics

Allowable modifiers	
26 = Professional component	50 = Bilateral procedure
80 = Assistant surgeon	TC = Technical component
AA = Anesthesia services performed personally by anesthesiologist	
QK = Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	
QX = CRNA service: with medical direction by a physician	
QY = Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	
QZ = CRNA service: without medical direction by a physician	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee*	Restrictions
A9525	Supply of low or iso-osmolar contrast material, 10 mg of iodine		19-22	$0.00	manually priced	
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13, per dose		19-22	$0.00	manually priced	
A9528	Supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide capsule, per millicurie		19-22	$0.00	manually priced	
A9529	Supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide solution, per millicurie		19-22	$0.00	manually priced	
A9530	Supply of radiopharmaceutical therapeutic agent, I-131 sodium iodide solution, per millicurie		19-22	$0.00	manually priced	
A9531	Supply of radiopharmaceutical diagnostic agent, I-131 sodium iodide, per microcurie (up to 100 microcuries)		19-22	$0.00	manually priced	
A9532	Supply of radiopharmaceutical therapeutic agent, iodinated I-125, serum albumin, 5 microcuries		19-22	$0.00	manually priced	
A9533	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per millicurie		19-22	$0.00	manually priced	
A9534	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per millicurie		19-22	$0.00	manually priced	

*Maximum fees listed in this table are for physicians, nurse practitioners, and independent labs. Physician assistants receive 90% of the physician rate for most procedures. Certified registered nurse anesthetists are reimbursed on a formula basis. Refer to the maximum allowable fee schedules for actual rates for each affected provider group.

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
G0297	Insertion of single chamber pacing cardioverter defibrillator pulse generator		19-22, 24, 94	$3.00	manually priced	
G0297	Insertion of single chamber pacing cardioverter defibrillator pulse generator	80	19-22, 24, 45, 88, 94	$0.00	manually priced	
G0298	Insertion of dual chamber pacing cardioverter defibrillator pulse generator		19-22, 24, 94	$3.00	manually priced	
G0298	Insertion of dual chamber pacing cardioverter defibrillator pulse generator	80	19-22, 24, 45, 88, 94	$0.00	manually priced	
G0299	Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator		19-22, 24, 94	$3.00	manually priced	
G0299	Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator	80	19-22, 24, 45, 88, 94	$0.00	manually priced	
G0300	Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator		19-22, 24, 94	$3.00	manually priced	
G0300	Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator	80	19-22, 24, 45, 88, 94	$0.00	manually priced	
G0306	Complete CBC, automated (HgB, HCT, RBC, WBC, without platelet count) and automated WBC differential count		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
G0307	Complete CBC, automated (HgB, HCT, RBC, WBC; without platelet count)		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
G3001	Administration and supply of tositumomab, 450 mg		19-22, 24, 45, 88, 94	$0.00	$2,343.28	
J0152	Injection, adenosine, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270)		19-22, 24, 45, 88, 94	$0.00	manually priced	
J0215	Injection, alefacept, 0.5 mg		19-22, 24, 45, 88, 94	$0.00	$883.28	
J0583	Injection, bivalirudin, 1 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J0595	Injection, butorphanol tartrate, 1 mg		19-22, 24, 45, 88, 94	$0.00	$12.18	
J1335	Injection, ertapenem sodium, 500 mg		19-22, 24, 45, 88, 94	$0.00	$47.93	
J1595	Injection, glatiramer acetate, 20 mg		19-22, 24, 45, 88, 94	$0.00	$1,073.28	
J2001	Injection, lidocaine HCl for intravenous infusion, 10 mg		19-22, 24, 45, 88, 94	$0.00	$5.78	
J2185	Injection, meropenem, 100 mg		19-22, 24, 45, 88, 94	$0.00	$10.58	
J2280	Injection, moxifloxacin, 100 mg		19-22, 24, 45, 88, 94	$0.00	$16.23	
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J2505	Injection, pegfilgrastim, 6 mg		19-22, 24, 45, 88, 94	$0.00	$2,603.28	
J2783	Injection, rasburicase, 0.5 mg		19-22, 24, 45, 88, 94	$0.00	$115.28	
J3411	Injection, thiamine HCl, 100 mg		19-22, 24, 45, 88, 94	$0.00	$6.88	
J3415	Injection, pyridoxine HCl, 100 mg		19-22, 24, 45, 88, 94	$0.00	$8.98	
J3465	Injection, voriconazole, 10 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J3486	Injection, ziprasidone mesylate, 10 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J7303	Contraceptive supply, hormone containing vaginal ring, each		19-22, 24, 45, 88, 94	$0.00	manually priced	Ages 10-70
J7621	Albuterol, all formulations, including separated isomers, up to 5 mg (albuterol) or 2.5 mg (levoalbuterol), and ipratropium bromide, up to 1 mg, compounded inhalation solution, administered through DME		19-22, 24, 45, 88, 94	$0.00	manually priced	
J9098	Cytarabine liposome, 10 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J9178	Injection, epirubicin HCl, 2 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J9263	Injection, oxaliplatin, 0.5 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
J9395	Injection, fulvestrant, 25 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
P9051	Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9052	Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9053	Platelets, pheresis, leukocytes reduced, CMV-negative, irradiated, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9054	Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9055	Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9056	Whole blood, leukocytes reduced, irradiated, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	

Procedure code	Description	Allowable modifier(s)	Provider type(s)	Copay	Max fee	Restrictions
P9057	Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9058	Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9059	Fresh frozen plasma between 8-24 hours of collection, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
P9060	Fresh frozen plasma, donor retested, each unit		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
Q0137	Injection, darbepoetin alfa, 1 mcg (non-ESRD use)		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q0182	Dermal and epidermal, tissue of non-human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q3031	Collagen skin test		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q4054	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q4055	Injection, epoetin alfa, 1000 units (for ESRD on dialysis)		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q4075	Injection, acyclovir, 5 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q4076	Injection, dopamine HCl, 40 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
Q4077	Injection, treprostinil, 1 mg		19-22, 24, 45, 88, 94	$0.00	manually priced	
00529	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation	AA, QY, QK, QX, QZ	19-22, 43	$0.00	11 relative value units (RVUs) plus time units	
01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	AA, QY, QK, QX, QZ	19-22, 43	$0.00	12 RVUs plus time units	
01958	Anesthesia for external cephalic version procedure	AA, QY, QK, QX, QZ	19-22, 43	$0.00	5 RVUs plus time units	Females only, ages 10-70
20982	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance		19-22, 24, 94	$3.00	$2,308.29	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
20982	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance	80	19-22, 24, 45, 88, 94	$0.00	$461.66	
21685	Hyoid myotomy and suspension		19-22, 24, 94	$3.00	$883.72	
21685	Hyoid myotomy and suspension	80	19-22, 24, 45, 88, 94	$0.00	$176.74	
22532	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic		19-22, 24, 94	$3.00	$1,555.93	
22532	Arthrodesis, lateral extracavitary technique, including minimal diskectomy to prepare interspace (other than for decompression); thoracic	80	19-22, 24, 45, 88, 94	$0.00	$311.19	
22533	lumbar		19-22, 24, 94	$3.00	$1,453.71	
22533	lumbar	80	19-22, 24, 45, 88, 94	$0.00	$290.74	
22534	thoracic or lumbar, each additional vertebral segment (list separately in addition to code for primary procedure)		19-22, 24, 94	$3.00	$367.21	
22534	thoracic or lumbar, each additional vertebral segment (list separately in addition to code for primary procedure)	80	19-22, 24, 45, 88, 94	$0.00	$73.44	
31632	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)		19-22, 24, 45, 88, 94	$0.00	$70.31	
31633	with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)		19-22, 24, 45, 88, 94	$0.00	$86.34	
34805	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis		19-22, 24, 94	$3.00	$1,208.53	
34805	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis	80	19-22, 24, 45, 88, 94	$0.00	$241.65	
35510	Bypass graft, with vein; carotid-brachial		19-22, 24, 94	$3.00	$1,278.22	
35510	Bypass graft, with vein; carotid-brachial	80	19-22, 24, 45, 88, 94	$0.00	$255.64	
35512	subclavian-brachial		19-22, 24, 94	$3.00	$1,253.66	
35512	subclavian-brachial	80	19-22, 24, 45, 88, 94	$0.00	$256.73	
35522	axillary-brachial		19-22, 24, 94	$3.00	$1,217.01	
35522	axillary-brachial	80	19-22, 24, 45, 88, 94	$0.00	$243.40	
35525	brachial-brachial		19-22, 24, 94	$3.00	$1,161.29	
35525	brachial-brachial	80	19-22, 24, 45, 88, 94	$0.00	$232.26	
35697	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (list separately in addition to code for primary procedure)		19-22, 24, 94	$3.00	$160.98	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
35697	Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (list separately in addition to code for primary procedure)	80	19-22, 24, 45, 88, 94	$0.00	$32.20	
36555	Insertion of non-tunneled centrally inserted center venous catheter; under 5 years of age		19-22, 24, 43, 45, 88, 94	$0.00	$314.97	Under 5 years of age
36556	age 5 years or older		19-22, 24, 43, 45, 88, 94	$3.00	$299.49	Ages 5-99
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age		19-22, 24, 45, 88, 94	$0.00	$679.45	Under 5 years of age
36558	age 5 years or older		19-22, 24, 45, 88, 94	$3.00	$664.43	Ages 5-99
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age		19-22, 24, 45, 88, 94	$0.00	$1,264.53	Under 5 years of age
36561	age 5 years or older		19-22, 24, 45, 88, 94	$3.00	$1,252.43	Ages 5-99
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump		19-22, 24, 45, 88, 94	$3.00	$1,574.29	
36565	Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)		19-22, 24, 45, 88, 94	$3.00	$1,011.01	
36566	with subcutaneous port(s)		19-22, 24, 45, 88, 94	$3.00	$1,057.43	
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age		19-22, 24, 45, 88, 94	$0.00	$362.55	Under 5 years of age
36569	age 5 years or older		19-22, 24, 45, 88, 94	$3.00	$329.45	Ages 5-99
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; under 5 years of age		19-22, 24, 45, 88, 94	$0.00	$1,614.14	Under 5 years of age
36571	age 5 years or older		19-22, 24, 45, 88, 94	$3.00	$1,452.79	Ages 5-99
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site		19-22, 24, 45, 88, 94	$3.00	$160.27	
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site		19-22, 24, 45, 88, 94	$3.00	$405.59	
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site		19-22, 24, 45, 88, 94	$3.00	$514.96	
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access		19-22, 24, 45, 88, 94	$3.00	$288.56	
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access		19-22, 24, 45, 88, 94	$3.00	$607.41	
36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access		19-22, 24, 45, 88, 94	$3.00	$1,136.54	
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access		19-22, 24, 45, 88, 94	$3.00	$670.14	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access		19-22, 24, 45, 88, 94	$3.00	$300.76	
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access		19-22, 24, 45, 88, 94	$3.00	$1,427.88	
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump		19-22, 24, 45, 88, 94	$3.00	$169.14	
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion		19-22, 24, 45, 88, 94	$3.00	$358.80	
36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access		19-22, 24, 45, 88, 94	$3.00	$826.75	
36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen		19-22, 24, 45, 88, 94	$3.00	$181.89	
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance		19-22, 24, 45, 88, 94	$3.00	$157.74	
36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)		19-22, 24, 45, 88, 94	$3.00	$1,190.38	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions		19-22, 24, 45, 88, 94	$3.00	$447.38	
37766	more than 20 incisions		19-22, 24, 45, 88, 94	$3.00	$544.82	
43237	Upper gastrointestinal endoscopy including esophagus, stomach, and either the doudenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus		19-22, 24, 45, 88, 94	$3.00	$213.17	
43237	Upper gastrointestinal endoscopy including esophagus, stomach, and either the doudenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus	80	19-22, 24, 45, 88, 94	$0.00	$42.63	
43238	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)		19-22, 24, 45, 88, 94	$3.00	$264.49	
43238	with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)	80	19-22, 24, 45, 88, 94	$0.00	$52.90	
47140	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)		19-22, 24, 45, 88, 94	$3.00	$2,308.29	
47140	Donor hepatectomy, with preparation and maintenance of allograft, from living donor; left lateral segment only (segments II and III)	80	19-22, 24, 45, 88, 94	$0.00	$461.65	
47141	total left lobectomy (segments II, III, and IV)		19-22, 24, 45, 88, 94	$3.00	$2,308.29	
47141	total left lobectomy (segments II, III, and IV)	80	19-22, 24, 45, 88, 94	$0.00	$461.65	
47142	total right lobectomy (segments V, VI, VII and VIII)		19-22, 24, 45, 88, 94	$3.00	$2,308.29	
47142	total right lobectomy (segments V, VI, VII and VIII)	80	19-22, 24, 45, 88, 94	$0.00	$461.65	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
53500	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)		19-22, 24, 45, 88, 94	$3.00	$698.60	Females only
57425	Laparascopy, surgical, colpopexy (suspension of vaginal apex)		19-22, 24, 45, 88, 94	$3.00	$875.57	Females only
59070	Transabdominal amnioinfusion, including ultrasound guidance		19-22, 24, 45, 88, 94	$3.00	$382.29	Females only
59072	Fetal umbilical cord occlusion, including ultrasound guidance		19-22, 24, 45, 88, 94	$3.00	$466.19	Females only
59074	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance		19-22, 24, 45, 88, 94	$3.00	$364.60	Females only
59076	Fetal shunt placement, including ultrasound guidance		19-22, 24, 45, 88, 94	$3.00	$466.19	Females only
59897	Unlisted fetal invasive procedure, including ultrasound guidance		19-22, 24, 45, 88, 94	$3.00	manually priced	Females only
61537	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery		19-22, 24, 45, 88, 94	$3.00	$1,642.77	
61537	Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery	80	19-22, 24, 45, 88, 94	$0.00	$328.55	
61540	for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery		19-22, 24, 45, 88, 94	$3.00	$1,982.68	
61540	for lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery	80	19-22, 24, 45, 88, 94	$0.00	$396.54	
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy		19-22, 24, 45, 88, 94	$3.00	$1,969.44	
61566	Craniotomy with elevation of bone flap; for selective amygdalohippocampectomy	80	19-22, 24, 45, 88, 94	$0.00	$393.89	
61567	for multiple subpial transections, with electrocorticography during surgery		19-22, 24, 45, 88, 94	$3.00	$2,252.27	
61567	for multiple subpial transections, with electrocorticography during surgery	80	19-22, 24, 45, 88, 94	$0.00	$450.45	
61863	Twist drill, burr hole, craniotomy, craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array		19-22, 24, 45, 88, 94	$3.00	$1,182.45	
61864	each additional array (list separately in addition to primary procedure)		19-22, 24, 45, 88, 94	$3.00	$283.57	
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array		19-22, 24, 45, 88, 94	$3.00	$1,802.01	
61868	each additional array (List separately in addition to primary procedure)		19-22, 24, 45, 88, 94	$0.00	$474.20	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment		19-22, 24, 45, 88, 94	$3.00	$2,047.53	
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment	80	19-22, 24, 45, 88, 94	$0.00	$409.51	
63102	lumbar, single segment		19-22, 24, 45, 88, 94	$3.00	$2,047.53	
63102	lumbar, single segment	80	19-22, 24, 45, 88, 94	$0.00	$409.51	
63103	thoracic or lumbar, each additional segment (list separately in addition to code for primary procedure)		19-22, 24, 45, 88, 94	$3.00	$239.51	
63103	thoracic or lumbar, each additional segment (list separately in addition to code for primary procedure)	80	19-22, 24, 45, 88, 94	$0.00	$47.90	
64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration		19-22, 24, 45, 88, 94	$3.00	$148.89	
64517	Injection, anesthetic agent; superior hypogastric plexus		19-22, 24, 45, 88, 94	$3.00	$179.99	
64681	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus		19-22, 24, 45, 88, 94	$3.00	$440.11	
65780	Ocular surface reconstruction; amniotic membrane transplantation		19-22, 24, 45, 88, 94	$3.00	$738.05	
65781	limbal stem cell allograft (eg, cadaveric or living donor)		19-22, 24, 45, 88, 94	$3.00	$1,131.61	
65782	limbal conjunctival autograft (includes obtaining graft)		19-22, 24, 45, 88, 94	$3.00	$975.06	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)		19-22, 24, 45, 88, 94	$3.00	$927.66	
68371	Harvesting conjunctival allograft, living donor		19-22, 24, 45, 88, 94	$3.00	$349.61	
70557	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	26	19-22, 24, 45, 75, 88, 94	$0.00	$144.85	
70558	with contrast material(s)	26	19-22, 24, 45, 75, 88, 94	$0.00	$160.17	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
70559	without contrast material(s), followed by contrast material(s) and further sequences	26	19-22, 24, 45, 75, 88, 94	$0.00	$160.82	
75998	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final cathether position) (list separately in addition to code for primary procedure)		19-22, 24, 45, 75, 88, 94	$3.00	$68.98	
75998	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final cathether position) (list separately in addition to code for primary procedure)	26	19-22, 24, 45, 75, 88, 94	$0.00	$20.31	
75998	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final cathether position) (list separately in addition to code for primary procedure)	TC	19-22, 24, 45, 75, 88, 94	$0.00	$48.67	
76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)		19-22, 24, 45, 75, 88, 94	$3.00	$17.80	
76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)	26	19-22, 24, 45, 75, 88, 94	$0.00	$3.26	
76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (list separately in addition to code for primary procedure)	TC	19-22, 24, 45, 75, 88, 94	$0.00	$14.54	
76083	screening mammography (list separately in addition to code for primary procedure)		19-22, 24, 45, 75, 88, 94	$3.00	$17.80	
76083	screening mammography (list separately in addition to code for primary procedure)	26	19-22, 24, 45, 75, 88, 94	$0.00	$3.26	
76083	screening mammography (list separately in addition to code for primary procedure)	TC	19-22, 24, 45, 75, 88, 94	$0.00	$14.54	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
76514	Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)		19-22, 24, 28, 45, 75, 88, 94	$3.00	$11.85	
76514	Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	26	19-22, 24, 45, 75, 88, 94	$0.00	$2.40	
76514	Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	TC	19-22, 24, 45, 75, 88, 94	$0.00	$9.45	
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)		19-22, 24, 45, 75, 88, 94	$3.00	$32.35	
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)	26	19-22, 24, 45, 75, 88, 94	$0.00	$16.28	
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)	TC	19-22, 24, 45, 75, 88, 94	$0.00	$16.06	
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation		19-22, 24, 45, 75, 88, 94	$3.00	$163.51	
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation	26	19-22, 24, 45, 75, 88, 94	$0.00	$101.42	
76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation	TC	19-22, 24, 45, 75, 88, 94	$0.00	$62.09	
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging		19-22, 24, 45, 75, 88, 94	$2.00	$212.57	
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging	26	19-22, 24, 45, 75, 88, 94	$0.00	$54.08	
78804	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging	TC	19-22, 24, 45, 75, 88, 94	$0.00	$158.49	
79403	Radiopharmaceutical therapy, radiolableled monoclonal antibody by intravenous infusion		19-22, 24, 45, 75, 88, 94	$0.00	$271.78	
79403	Radiopharmaceutical therapy, radiolableled monoclonal antibody by intravenous infusion	26	19-22, 24, 45, 75, 88, 94	$0.00	$118.46	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
79403	Radiopharmaceutical therapy, radiolableled monoclonal antibody by intravenous infusion	TC	19-22, 24, 45, 75, 88, 94	$0.00	$153.33	
84156	Protein, total, except by refractometry; urine		19-22, 23, 24, 45, 88, 94	$1.00	$5.12	
84157	other source (eg, synovial fluid, cerebrospinal fluid)		19-22, 23, 24, 45, 88, 94	$1.00	$5.12	
85055	Reticulated platelet assay		19-22, 23, 24, 45, 88, 94	$1.00	$37.41	
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	26	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	TC	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
87269	Infectious agent antigen detection by immunofluorescent technique; giardia		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
87269	Infectious agent antigen detection by immunofluorescent technique; giardia	26	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
87269	Infectious agent antigen detection by immunofluorescent technique; giardia	TC	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
87329	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; giardia		19-22, 23, 24, 45, 88, 94	$1.00	$16.76	
87660	Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe techinique		19-22, 23, 24, 45, 88, 94	$1.00	$28.02	
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal		19-22, 23, 24, 45, 88, 94	$1.00	$115.32	
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	26	19-22, 23, 24, 45, 88, 94	$0.00	$63.69	
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal	TC	19-22, 23, 24, 45, 88, 94	$0.00	$51.64	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
88361	Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative		19-22, 23, 24, 45, 88, 94	$1.00	$131.07	
88361	Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative	26	19-22, 23, 24, 45, 88, 94	$0.00	$53.19	
88361	Morphometric analysis; tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative	TC	19-22, 23, 24, 45, 88, 94	$0.00	$77.88	
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	26	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
89220	Sputum, obtaining specimen, aerosol induced technique (separate procedure)	TC	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
89225	Starch granules, feces		19-22, 23, 24, 45, 88, 94	$1.00	$4.67	
89230	Sweat collection by iontophoresis		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
89230	Sweat collection by iontophoresis	26	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
89230	Sweat collection by iontophoresis	TC	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
89235	Water load test		19-22, 23, 24, 45, 88, 94	$1.00	$7.69	
89240	Unlisted miscellaneous pathology test		19-22, 23, 24, 45, 88, 94	$1.00	manually priced	
89240	Unlisted miscellaneous pathology test	26	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
89240	Unlisted miscellaneous pathology test	TC	19-22, 23, 24, 45, 88, 94	$0.00	manually priced	
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP — Hib — IPV), for intramuscular use		19-22, 24, 45, 88, 94	$0.00	manually priced	

Procedure code	Description	Allowable modifier	Provider type(s)	Copay	Max fee	Restrictions
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals seven years or older, for intramuscular use		19-22, 24, 45, 88, 94	$0.00	manually priced	Ages 7-99
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use		19-22, 24, 45, 88, 94	$0.00	manually priced	
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report		19-22, 24, 45, 88, 94	$2.00	$871.74	
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report	TC	19-22, 24, 45, 88, 94	$2.00	$690.09	
95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician		19-22, 24, 45, 88, 94	$3.00	$80.29	