ForwardHealth
Wisconsin serving you

Update
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Affected Programs: Wisconsin Chronic Disease Program
To: All Providers

Allowable Wisconsin Chronic Disease Program Diagnosis, Procedure, and Revenue Codes and Revised Claim Form Instructions

This *ForwardHealth Update* includes allowable diagnosis codes, procedure codes, and revenue codes for Wisconsin Chronic Disease Program (WCDP) providers.

In addition, ForwardHealth has revised the UB-04 (CMS 1450) Claim Form instructions for WCDP services. Providers are required to indicate "WCDP" as their payer name and the name of the commercial health insurance, if applicable, in Form Locator 50.

Lists of Allowable Diagnosis Codes, Procedure Codes, and Revenue Codes Are Now Available

ForwardHealth has created lists of allowable diagnosis codes for Wisconsin Chronic Disease Program (WCDP) chronic renal disease, adult cystic fibrosis, and hemophilia home care programs. Providers may refer to Attachments 1 through 3 of this *ForwardHealth Update* for lists of valid, allowable diagnosis codes.

At least one allowable diagnosis code must be indicated on claims. On outpatient hospital claims, the allowable diagnosis code must be indicated as the primary diagnosis. On professional claims, the allowable diagnosis code may be indicated in any position; it does not need to be indicated as the primary diagnosis.

ForwardHealth has also created lists of allowable procedure codes and revenue codes that may be reimbursed by WCDP chronic renal disease, adult cystic fibrosis, and hemophilia home care programs. Refer to Attachments 4 through 9 for current lists of valid, allowable procedure codes and revenue codes for WCDP services.

Note: Codes for inpatient hospitals are included in these lists.

Valid Codes Required

Wisconsin Chronic Disease Program requires that all codes indicated on claims, including diagnosis codes, revenue codes, Healthcare Common Procedure Coding System (HCPCS) procedure codes, and *Current Procedural Terminology* (CPT) procedure codes be valid codes. Claims received without valid diagnosis, revenue, and HCPCS or CPT procedure codes will be denied.

All diagnosis codes indicated on claims (and prior authorization [PA] requests when applicable) must be the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied. Providers are responsible for keeping current with diagnosis code changes. Etiology

and manifestation codes may not be used as a primary diagnosis.

The diagnosis codes, procedure codes, and revenue codes that are considered to be valid may change. Providers should refer to the current ICD-9-CM code book for valid diagnosis codes, to the current HCPCS and CPT code books for valid procedure codes, and to the current UB-04 manual for valid revenue codes.

Covered Services

Wisconsin Chronic Disease Program covers services directly related to chronic renal disease, adult cystic fibrosis, and hemophilia home care. It is expected that prescribing and referring physicians only prescribe or render services that are medically necessary and the most cost-effective.

Wisconsin Chronic Disease Program may deny or recoup payment if a service fails to meet the medical necessity requirements.

Revised UB-04 Claim Form Instructions

The UB-04 (CMS 1450) Claim Form instructions for WCDP services have been revised. In Form Locator 50, providers are required to indicate "WCDP" as the payer name and the name of the commercial health insurance, if applicable. In addition, information is not required in Form Locators 39 through 41 on WCDP claims.

Sample claim forms in the Online Handbook have been revised since their initial publication. Providers should refer to the Online Handbook for the revised sample claims.

Claim Submissions for Core Plan Members

For members enrolled in the BadgerCare Plus Core Plan for Adults with No Dependent Children who are also enrolled in WCDP, providers should submit claims for all covered services to the Core Plan *first* and then to WCDP. For pharmacy services, if the Core Plan *and* WCDP deny a pharmacy claim, providers should submit the claim to BadgerRx Gold.

Diagnosis-Restricted Provider-Administered Drugs Reminder

A limited number of WCDP-covered provider-administered drugs are diagnosis restricted. Providers are required to indicate an allowable diagnosis code on claims submitted to ForwardHealth for provider-administered drugs. If an allowable diagnosis code is *not* indicated on a claim, the claim will be denied.

Providers may refer to the Physician page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for a list of Wisconsin Medicaid diagnosis-restricted provider-administered drugs. To search for drugs covered by WCDP, providers may access the Drug Search Tool on the Pharmacy page of the Portal.

Diagnosis-Restricted Enteral Nutrition Products

Prior authorization is required for enteral nutrition products with a diagnosis other than an approved diagnoses. To request PA, providers should complete and submit the following to ForwardHealth:

- Prior Authorization Request Form (PA/RF), F-11018 (10/08).
- Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), F-11054 (10/08).
- Clinical documentation that supports the medical necessity of the drug's use outside approved diagnoses.

Providers may refer to the Diagnosis Restricted Drugs data table on the provider-specific Physician page of the Portal for a list of approved diagnosis codes.

Providers may refer to the Prior Authorization Guidelines for Food Supplements topic in the Enteral Nutrition Products chapter of the PA section of the BadgerCare Plus and Medicaid Enteral Nutrition

Products service area of the Online Handbook for diagnosis approval criteria for enteral nutrition products.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Wisconsin Chronic Disease Program Chronic Renal Disease-Allowable Diagnosis Codes

The following *International Classification of Diseases*, *Ninth Revision*, *Clinical Modification* diagnosis codes may be indicated on claims for Wisconsin Chronic Disease Program chronic renal disease services. At least one of the following diagnosis codes may be indicated on claims to be considered for reimbursement. The required use of valid diagnosis codes includes the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- or five-digit codes are available will be denied.

Allowable Wisconsin Chronic Disease Program Chronic Renal Disease Diagnosis Codes	
Diagnosis Code	**Description**
403.01	Hypertensive chronic kidney disease, malignant
403.11	Hypertensive chronic kidney disease, benign
403.91	Hypertensive chronic kidney disease, unspecified
404.02 – 404.03	Hypertensive heart and chronic kidney disease, malignant
404.12 – 404.13	Hypertensive heart and chronic kidney disease, benign
404.92 – 404.93	Hypertensive heart and chronic kidney disease, unspecified
585	Chronic kidney disease (CKD)
585.1	Chronic kidney disease, Stage I
585.2	Chronic kidney disease, Stage II (mild)
585.3	Chronic kidney disease, Stage III (moderate)
585.4	Chronic kidney disease, Stage IV (severe)
585.5	Chronic kidney disease, Stage V
585.6	End stage renal disease
585.9	Chronic kidney disease, unspecified
586	Renal failure, unspecified
593.4	Other ureteric obstruction
996.59	Mechanical complication of other prosthetic device, implant, and graft due to other implant and internal device, not elsewhere classified
996.62	Infection and inflammatory reaction due to internal prosthetic device, implant, and graft due to other vascular device, implant, and graft
996.68	Infection and inflammatory reaction due to internal prosthetic device, implant, and graft due to peritoneal dialysis catheter
996.69	Infection and inflammatory reaction due to internal prosthetic device, implant, and graft due to other internal prosthetic device, implant, and graft
996.73	Other complications of internal (biological) (synthetic) prosthetic device, implant, and graft due to renal dialysis device, implant, and graft

Allowable Wisconsin Chronic Disease Program Chronic Renal Disease Diagnosis Codes (Cont.)	
Diagnosis Code	**Description**
996.81	Complications of transplanted organ, kidney
V42.0	Organ or tissue replaced by transplant, kidney
V45.1	Renal dialysis status
V56	Encounter for dialysis and dialysis catheter care
V56.0	Extracorporeal dialysis
V56.1	Fitting and adjustment of extracorporeal dialysis catheter
V56.8	Other dialysis
V59.4	Donors, kidney
V70.0	Routine general medical examination at a health care facility
V72.83	Other specified examinations, other specified pre-operative examination

ATTACHMENT 2
Wisconsin Chronic Disease Program Adult Cystic Fibrosis-Allowable Diagnosis Codes

The following *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes may be indicated on claims for Wisconsin Chronic Disease Program adult cystic fibrosis services. At least one of the following diagnosis codes may be indicated on claims to be considered for reimbursement. The required use of valid diagnosis codes includes the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- or five-digit codes are available will be denied.

Allowable Wisconsin Chronic Disease Program Adult Cystic Fibrosis Diagnosis Codes	
Diagnosis Code	**Description**
277.0	Cystic fibrosis
277.00	Without mention of meconium ileus
277.01	With meconium ileus
277.02	With pulmonary manifestations
277.03	With gastrointestinal manifestations
277.09	With other manifestations
482.1	Pneumonia due to Psuedomonas

ATTACHMENT 3
Wisconsin Chronic Disease Program Hemophilia Home Care Allowable Diagnosis Codes

The following *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes may be indicated on claims for Wisconsin Chronic Disease Program hemophilia home care services. At least one of the following diagnosis codes may be indicated on claims to be considered for reimbursement. The required use of valid diagnosis codes includes the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- or five-digit codes are available will be denied.

Allowable Wisconsin Chronic Disease Program Hemophilia Home Care Diagnosis Codes	
Diagnosis Code	**Description**
286.0	Congenital factor VIII disorder
286.1	Congenital factor IX disorder
286.2	Congenital factor XI deficiency
286.3	Congenital deficiency of other clotting factors
286.4	von Willebrand's disease

ATTACHMENT 4
Wisconsin Chronic Disease Program Chronic Renal Disease Procedure Codes

The following procedure codes are reimbursable for Wisconsin Chronic Disease Program chronic renal disease services.

Procedure Code	Description
00532	Anesthesia for access to central venous circulation
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified
00862	renal procedures, including upper 1/3 of ureter, or donor
00868	renal transplant (recipient)
01770	Anesthesia for procedures on arteries of upper arm or elbow; not otherwise specified
01844	Anesthesia for vascular shunt, or shunt revision, any type (eg, dialysis)
10021	Fine needle aspiration; without imaging guidance
10022	with imaging guidance
10180	Incision and drainage, complex, postoperative wound infection
35011	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35190	Repair, acquired or traumatic arteriovenous fistula; extremities
35201	Repair blood vessel, direct; neck
35206	upper extremity
35221	intra-abdominal
35251	Repair blood vessel with vein graft; intra-abdominal
35281	Repair blood vessel with graft other than vein; intra-abdominal
36000	Introduction of needle or intracatheter, vein
36010	Introduction of catheter, superior or inferior vena cava
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)
36145	Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)
36410	Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36430	Transfusion, blood or blood components
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
36600	Arterial puncture, withdrawal of blood for diagnosis
36800	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
36810	arteriovenous, external (Scribner type)
36815	arteriovenous, external revision, or closure

Procedure Code	Description
36819	Arteriovenous anastomosis, open, by upper arm basilica vein transposition
36821	direct, any site (eg, Cimino type) (separate procedure)
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft
36830	nonautogenous graft (eg, biological collagen, thermoplastic graft)
36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36833	with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
36834	Plastic repair of arteriovenous aneurysm (separate procedure)
36860	External cannula declotting (separate procedure); without balloon catheter
36861	with balloon catheter
37203	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)
37205	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous, initial vessel
37607	Ligation or banding of angioaccess arteriovenous fistula
38220	Bone marrow; aspiration only
38221	biopsy, needle or trocar
47000	Biopsy of liver, needle; percutaneous
49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent
50010	Renal exploration, not necessitating other specific procedures
50020	Drainage of perirenal or renal abscess; open
50040	Nephrostomy, nephrotomy with drainage
50100	Transection or repositioning of aberrant renal vessels (separate procedure)
50200	Renal biopsy; percutaneous, by trocar or needle
50205	by surgical exposure of kidney
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection
50225	complicated because of previous surgery on same kidney
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
50320	open, from living donor
50340	Recipient nephrectomy (separate procedure)
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy
50365	with recipient nephrectomy
50370	Removal of transplanted renal allograft
50380	Renal autotransplantation, reimplantation of kidney
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50393	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous

Procedure Code	Description
50394	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
50398	Change of nephrostomy or pyelostomy tube
50520	Closure of nephrocutaneous or pyelocutaneous fistula
50740	Ureteropyelostomy, anastomosis of ureter and renal pelvis
50760	Ureteroureterostomy
50780	Ureteroneocystostomy; anastomosis of single ureter to bladder
51600	Injection procedure for cystography or voiding urethrocystography
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610	Injection procedure for retrograde urethrocystography
51700	Bladder irrigation, simple, lavage and/or instillation
51725	Simple cystometrogram (CMG) (eg, spinal manometer)
51726	Complex cystometrogram (eg, calibrated electronic equipment)
51736	Simple uroflowmetry (URF) (eg, stop-watch flow rate, mechanical uroflowmeter)
51741	Complex uroflowmetry (eg, calibrated electronic equipment)
52000	Cystourethroscopy (separate procedure)
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde
71010	Radiologic examination, chest; single view, frontal
71015	stereo, frontal
71020	Radiologic examination, chest, 2 views, frontal and lateral;
71022	with oblique projections
71035	Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)
72191	Computed tomographic angiography, pelvis; with contrast material(s), including noncontrast images, if performed, and image post-processing
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)
74000	Radiologic examination, abdomen; single anteroposterior view
74022	complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image post-processing
74190	Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation
74400	Urography (pyelography), intravenous, with our without KUB, with or without tomography

Procedure Code	Description
74410	Urography, infusion, drip technique and/or bolus technique;
74415	with nephrotomography
74420	Urography, retrograde, with or without KUB
74425	Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation
74430	Cystography, minimum of three views, radiological supervision and interpretation
74455	Urethrocystography, voiding, radiological supervision and interpretation
74475	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation
74480	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation
74485	Division of nephrostomy, ureters, or urethra, radiological supervision and interpretation
75722	Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation
75724	Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation
75790	Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation
75893	Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	limited
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857	limited for follow-up (eg, for follicles)
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device imaging supervision and interpretation
78445	Non-cardiac vascular flow imaging (ie, angiography, venography)
78460	Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification
78465	tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification
78478	Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)
78480	Myocardial perfusion study with ejection fraction (List separately in addition to code for primary procedure)
78700	Kidney imaging morphology;
78701	with vascular flow

Procedure Code	Description
78707	with vascular flow and function, single study without pharmacological intervention
78710	tomographic (SPECT)
78725	Kidney function study, non-imaging radioisotopic study
78730	Urinary bladder residual study (List separately in addition to code for primary procedure)
78740	Ureteral reflux study (radiopharmaceutical voiding cystogram)
80050	General health panel
80150	Amikacin
80158	Cyclosporine
80170	Gentamicin
80200	Tobramycin
80202	Vancomycin
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	non-automated, without microscopy
81003	automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	bacteriuria screen, except by culture or dipstick
82040	Albumin; serum, plasma or whole blood
82108	Aluminum
82232	Beta-2 microglobulin
82308	Calcitonin
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82565	Creatinine; blood
82575	clearance
82652	Dihydroxyvitamin D, 1, 25-
82668	Erythropoietin
82728	Ferritin
82735	Fluoride
82746	Folic acid; serum
82951	Glucose; tolerance test (GTT), three specimens (includes glucose)
83540	Iron
83550	Iron binding capacity
83735	Magnesium
83970	Parathormone (parathyroid hormone)
84075	Phosphatase, alkaline;
84078	heat stable (total not included)
84080	isoenzymes
84100	Phosphorus inorganic (phosphate);

Procedure Code	Description
84132	Potassium; serum, plasma or whole blood
84146	Prolactin
84155	Protein, total, except for refractometry; serum, plasma or whole blood
84160	Protein, total, by refractometry, any source
84207	Pyridoxal phosphate (Vitamin B-6)
84244	Renin
84295	Sodium; serum, plasma or whole blood
84402	Testosterone; free
84403	total
84443	Thyroid stimulating hormone (TSH)
84520	Urea nitrogen; quantitative
84630	Zinc
85002	Bleeding time
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	blood smear, microscopic examination without manual differential WBC count
85009	manual differential WBC count, buffy coat
85013	spun microhematocrit
85014	hematocrit (Hct)
85018	hemoglobin (Hgb)
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85032	manual cell count (erythrocyte, leukocyte, or platelet) each
85041	red blood cell (RBC), automated
85044	reticulocyte, manual
85045	reticulocyte, automated
85046	reticulocytes, automated, including one or more cellular parameters (eg, reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [mrv], RNA content), direct measurement
85048	leukocyte (WBC), automated
85049	platelet, automated
85060	Blood smear, peripheral, interpretation by physician with written report
85097	Bone marrow, smear interpretation
85345	Coagulation time; Lee and White
85347	activated
85348	other methods
85520	Heparin neutralization
85610	Prothrombin time
85730	Thromboplastin time, partial (PTT); plasma or whole blood

Procedure Code	Description
86077	Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report
86078	investigation of transfusion reaction including suspicion of transmissible disease, interpretation and written report
86079	authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report
86580	Skin test; tuberculosis, intradermal
86687	Antibody; HTLV-I
86688	HTLV-II
86689	HTLV or HIV antibody, confirmatory test (eg, Western Blot)
86692	hepatitis, delta agent
86701	HIV-1
86702	HIV-2
86703	HIV-1 and HIV-2, single assay
86805	Lymphocytotoxicity assay, visual crossmatch; with titration
86806	without titration
86807	Serum screening for cytotoxic percent reactive antibody (PRA); standard method
86808	quick method
86812	HLA typing; A, B, or C (eg, A10, B7, B27), single antigen
86813	A, B, or C, multiple antigens
86816	DR/DQ, single antigens
86817	DR/DQ, multiple antigens
86821	lymphocyte culture, mixed (MLC)
86822	lymphocyte culture, primed (PLC)
86850	Antibody screen, RBC, each serum technique
86860	Antibody elution (RBC), each elution
86870	Antibody identification, RBC antibodies, each panel for each serum technique
86880	Antihuman globulin test (Coombs test); direct, each antiserum
86885	indirect, qualitative, each reagent red cell
86886	indirect, each antibody titer
86890	Autologous blood or component, collection processing and storage; predeposited
86891	intra- or postoperative salvage
86900	Blood typing; ABO
86901	Rh (D)
86903	antigen screening for compatible blood unit using reagent serum, per unit screened
86904	antigen screening for compatible unit using patient serum, pre unit screened
86905	RBC antigens, other than ABO or Rh (D), each
86906	Rh phenotyping, complete
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN
86911	each additional antigen system

Procedure Code	Description
86920	Compatibility test each unit; immediate spin technique
86921	incubation technique
86922	antiglobulin technique
86927	Fresh frozen plasma, thawing, each unit
86930	Frozen blood, each unit; freezing (includes preparation)
86931	thawing
86932	freezing (includes preparation) and thawing
86940	Hemolysins and agglutinins; auto, screen each
86941	incubated
86945	Irradiation of blood product, each unit
86950	Leukocyte transfusion
86965	Pooling of platelets or other blood products
86970	Pretreatment of RBCs for use in RBC antibody detection, identification, and/or compatibility testing; incubation with chemical agents or drugs, each
86971	incubation with enzymes, each
86972	by density gradient separation
86975	Pretreatment of serum for use in RBC antibody identification; incubation with drugs, each
86976	by dilution
86977	incubation with inhibitors, each
86978	by differential red cell absorption using patient RBCs or RBCs of known phenotype, each absorption
86985	Splitting of blood or blood products, each unit
86999	Unlisted transfusion medicine procedure
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
87070	any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87075	any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	anaerobic isolate, additional methods required for definitive identification, each isolate
87077	aerobic isolate, additional methods required for definitive identification, each isolate
87086	Culture, bacterial; quantitative colony count, urine
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail
87102	other source (except blood)
87103	blood
87106	Culture, fungi, definitive identification, each organism; yeast
87116	Culture, tubercle or other acid-fast bacilli (eg, TB, AFB, mycobacteria) any source, with isolation and presumptive identification of isolates
87118	Culture, mycobacterial, definitive identification, each isolate
87181	Susceptibility studies, antimicrobial agent; agar diffusion method, per agent (eg, antibiotic gradient strip)
87184	disk method, per plate (12 or fewer disks)

Procedure Code	Description
87186	microdilution or agar dilution (minimum inhibitory concentration [MIC] or breakpoint), each multi-antimicrobial, per plate
87187	microdilution or agar dilution, minimum lethal concentration (MLC), each plate (List separately in addition to code for primary procedure)
87188	macrobroth dilution method, each agent
87190	mycobacteria, proportion method, each agent
87197	Serum bactericidal titer (Schlicter test)
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87206	fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87207	special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87210	wet mount for infectious agents (eg, saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)
87230	Toxin or antitoxin assay, tissue culture (eg, Clostridium difficile toxin)
87250	Virus isolation; inoculation of embryonated eggs, or small animal, includes observation and dissection
87252	tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87253	tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluorescence stain) each isolate
88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation
88106	simple filter method with interpretation
88107	smears and simple filter preparation with interpretation
88108	Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)
88125	Cytopathology, forensic (eg, sperm)
88130	Sex chromatin identification; Barr bodies
88140	peripheral blood smear, polymorphonuclear drumsticks
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition code[s] for other technical and interpretation services)
88160	Cytopathology, smears, any other source; screening and interpretation
88161	preparation, screening and interpretation
88162	extended study involving over 5 slides and/or multiple stains
88170	*there's a note in the 2009 CPT that 88170 and 88171 have been deleted.
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)
88173	interpretation and report
88182	Flow cytometry; cell cycle or DNA analysis
88199	Unlisted cytopathology procedure

Procedure Code	Description
88300	Level I — Surgical pathology, gross examination only
88302	Level II — Surgical pathology, gross and microscopic examination
88304	Level III — Surgical pathology, gross and microscopic examination
88305	Level IV — Surgical pathology, gross and microscopic examination
88307	Level V — Surgical pathology, gross and microscopic examination
88309	Level VI — Surgical pathology, gross and microscopic examination
88311	Decalcification procedure (List separately in addition to code for surgical pathology examination)
88312	Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each
88314	histochemical staining with frozen section(s)
88321	Consultation and report on referred slides prepared elsewhere
88323	Consultation and report on referred material requiring preparation of slides
88325	Consultation, comprehensive, with review of records and specimens, with report on referred material
88329	Pathology consultation during surgery;
88331	first tissue block, with frozen section(s), single specimen
88332	each additional tissue block with frozen section(s)
88348	Electron microscopy; diagnostic
88355	Morphometric analysis; skeletal muscle
88356	nerve
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90935	Hemodialysis procedure with single physician evaluation
90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
90945	Dialysis procedure other than hemodialysis (eg, peritoneal, hemofiltration or other continuous replacement therapies), with single physician evaluation
90947	Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription
90989	Dialysis training, patient, including helper where applicable, any mode, completed course
90993	Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
93880	Duplex scan of extracranial arteries; complete bilateral study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	unilateral or limited study

Procedure Code	Description
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study
93971	unilateral or limited study
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	unilateral or limited study
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
94642	Aerosol inhalation of pentamidine or pneumocystis carinii pneumonia treatment or prophylaxis
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Procedure Code	Description
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a problem focused history; • a problem focused examination; • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused history; • an expanded problem focused examination; • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a detailed history; • a detailed examination; • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a comprehensive history; • a comprehensive examination; • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a detailed or comprehensive history; • a detailed or comprehensive examination; and • medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99222	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99223	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; • medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • an expanded problem focused interval history; • an expanded problem focused examination; • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • a detailed interval history; • a detailed examination; • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.
99238	Hospital discharge day management; 30 minutes or less
99241	Office consultation for a new or established patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99243	Office consultation for a new or established patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
99251	Inpatient consultation for a new or established patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99252	Inpatient consultation for a new or established patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.
99253	Inpatient consultation for a new or established patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.
99255	Inpatient consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

Procedure Code	Description
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99288	Physician direction of emergency medical systems (EMS) emergency care, advanced life support
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	each additional 30 minutes (List separately in addition to code for primary service)
99354	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service, first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)
99355	each additional 30 minutes (List separately in addition to code for prolonged physician service)
99356	Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
99357	each additional 30 minutes (List separately in addition to code for prolonged physician service)
99358	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (List separately in addition to code[s] for other physician service[s] and/or inpatient or outpatient Evaluation and Management service)
99359	each additional 30 minutes (List separately in addition to code for prolonged physician service)
99499	Unlisted evaluation and management service
A0382	BLS routine disposable supplies
A0384	BLS specialized service disposable supplies, defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)
A0394	ALS specialized service disposable services; IV drug therapy
A0396	ALS specialized service disposable supplies; esophageal intubation
A0398	ALS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)

Procedure Code	Description
A4206	Syringe with needle; sterile 1cc or less, each
A4207	sterile 2cc, each
A4208	sterile 3cc, each
A4209	sterile 5cc or greater, each
A4300	Implantable access catheter (eg, venous, arterial, epidural subarachnoid, or peritoneal, etc) External access
A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour
A4306	Disposable drug delivery system, flow rate of less than 50 ml per hour
A4450	Tape, non-waterproof, per 18 square inches
A4452	Tape, waterproof, per 18 square inches
A4550	Surgical trays
A4626	Tracheostomy cleaning brush, each
A4650	Implantable radiation dosimeter, each
A4651	Calibrated microcapillary tube, each
A4652	Microcapillary tube sealant
A4657	Syringe, with or without needle, each
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
A4663	Blood pressure cuff only
A4670	Automatic blood pressure monitor
A4680	Activated carbon filter for hemodialysis, each
A4690	Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each
A4706	Bicarbonate concentrate, solution, for hemodialysis, per gallon
A4707	Bicarbonate concentrate, powder, for hemodialysis, per packet
A4708	Acetate concentrate solution, for hemodialysis, per gallon
A4709	Acid concentrate solution, for hemodialysis, per gallon
A4714	Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon
A4719	Y set tubing for peritoneal dialysis
A4720	Dialysate solution, any concentration of dextrose, fluid volume greater than 249cc, but less than or equal to 999cc , for peritoneal dialysis
A4721	Dialysate solution, any concentration of dextrose, fluid volume greater than 999cc, but less than or equal to 1999cc, for peritoneal dialysis
A4722	Dialysate solution, any concentration of dextrose, fluid volume greater than 1999cc, but less than or equal to 2999cc, for peritoneal dialysis
A4723	Dialysate solution, any concentration of dextrose, fluid volume greater than 2999cc, but less than or equal to 3999cc, for peritoneal dialysis
A4724	Dialysate solution, any concentration of dextrose, fluid volume greater than 3999cc, but less than or equal to 4999cc, for peritoneal dialysis
A4725	Dialysate solution, any concentration of dextrose, fluid volume greater than 4999cc, but less than or equal to 5999cc, for peritoneal dialysis
A4726	Dialysate solution, any concentration of dextrose, fluid volume greater than 5999cc, for peritoneal dialysis
A4730	Fistula cannulation set for hemodialysis, each

Procedure Code	Description
A4736	Topical anesthetic, for dialysis, per gram
A4737	Injectable anesthetic, for dialysis, per 10 ml
A4740	Shunt accessory, for hemodialysis, any type, each
A4750	Blood tubing, arterial or venous, for hemodialysis, each
A4755	Blood tubing, arterial and venous combined, for hemodialysis, each
A4760	Dialysate solution test kit, for peritoneal dialysis, any type, each
A4765	Dialysate concentrate, powder, additive for peritoneal dialysis, per packet
A4766	Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml
A4770	Blood collection tube, vacuum, for dialysis, per 50
A4771	Serum clotting time tube, for dialysis, per 50
A4772	Blood glucose test strips, for dialysis, per 50
A4773	Occult blood test strips, for dialysis, per 50
A4774	Ammonia test strips, for dialysis, per 50
A4802	Protamine sulfate, for hemodialysis, per 50 mg
A4860	Disposable catheter tips for peritoneal dialysis, per 10
A4890	Contracts, repair and maintenance, for hemodialysis equipment
A4911	Drain bag/bottle, for dialysis, each
A4913	Miscellaneous dialysis supplies, not otherwise specified
A4918	Venous pressure clamp, for hemodialysis, each
A4927	Gloves, non-sterile, per 100
A4928	Surgical mask, per 20
A4929	Tourniquet for dialysis, each
A6209	Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6257	Transparent film, sterile 16 sq. in. or less, each dressing
A9500	Technetium Tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

Procedure Code	Description
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit
D0120	Periodic oral evaluation — established patient
D0140	Limited oral evaluation — problem focused
D0150	Comprehensive oral evaluation — new or established patient
D0160	Detailed and extensive oral evaluation — problem focused, by report
E0776	IV pole
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0791	Parenteral infusion pump, stationary, single or multi-channel
E1399	Durable medical equipment, miscellaneous
E1500	Centrifuge, for dialysis
E1510	Kidney dialysate delivery system; kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temp control with alarm, I.V. poles, pressure gauge, concentrate container
E1520	Heparin infusion pump for hemodialysis
E1530	Air bubble detector for hemodialysis, each, replacement
E1540	Pressure alarm for hemodialysis, each, replacement
E1550	Bath conductivity meter for hemodialysis, each
E1560	Blood leak detector for hemodialysis, each, replacement
E1570	Adjustable chair, for ESRD patients
E1575	Transducer protectors/fluid barriers, for hemodialysis, any size, per 10
E1580	Unipuncuture control system for hemodialysis
E1590	Hemodialysis machine
E1592	Automatic intermittent peritoneal dialysis system
E1594	Cycler dialysis machine for peritoneal dialysis
E1600	Delivery and/or installation charges for hemodialysis equipment
E1610	Reverse osmosis water purification system, for hemodialysis
E1615	Deionizer water purification system, for hemodialysis
E1620	Blood pump for hemodialysis, replacement
E1630	Reciprocating peritoneal dialysis system
E1632	Wearable artificial kidney, each
E1635	Compact (portable) travel hemodialyzer system
E1636	Sorbent cartridges, for hemodialysis, per 10
E1637	Hemostats, each
E1639	Scale, each
E1699	Dialysis equipment, not otherwise specified
G8575	Developed postoperative renal insufficiency or required dialysis
G8576	No postoperative renal insufficiency/dialysis

Procedure Code	Description
J0120	Injection, tetracycline, up to 250 mg
J0290	Injection, ampicillin sodium, 500 mg
J0295	Injection, ampicillin sodium/sulbactam sodium, per 1.5 gram
J0690	Injection, cefazolin sodium, 500 mg
J0694	Injection, cefoxitin sodium, [Mefoxin], 1 gram
J0696	Injection, ceftriaxone sodium, [Rocephin], per 250 mg
J0697	Injection sterile cefuroxime sodium, [Ceftin, Kefurox, Zihacef injection], per 750 mg
J0698	Injection, cefotaxime sodium, [Claforan], per gram
J0710	Injection, cephapirin sodium, [Cefadyl], up to 1 gram
J0770	Injection, colistimethate sodium, [Coly-Mycin M], up to 150 mg
J0881	Injection, darbepoetin alfa, 1 microgram (non-ESRD use)
J0882	Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units
J0886	Injection, epoetin alfa, 1000 units (for ESRD on dialysis)
J0895	Injection, deferoxamine mesylate, [Desferal] 500 mg
J1570	Injection, ganciclovir sodium, [Cytovene], 500 mg
J1580	Injection, garamycin, gentamicin, up to 80 mg
J1642	Injection, heparin sodium, (heparin lock flush), per 10 units
J1890	Injection, cephalothin sodium, [Keflin], up to 1 gram
J1955	Injection, levocarnitine, per 1 gram
J2540	Injection, penicillin G potassium, [Pfizerpen], up to 600,000 units
J2700	Injection, oxacillin sodium, [Prostaphlin], up to 250 mg
J2920	Injection, methylprednisolone sodium succinate, [Solu-Medrol], up to 40 mg
J2930	Injection, methylprednisolone sodium succinate, [Solu-Medrol], up to 125 mg
J3260	Injection, tobramycin sulfate, [Nebcin], up to 80 mg
J3370	Injection, vancomycin HCl, 500 mg
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg
P7001	Culture, bacterial, urine; quantitative, sensitivity study
S1015	IV tubing extension set
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified. Identify product in "remarks."

ATTACHMENT 5
Wisconsin Chronic Disease Program Adult Cystic Fibrosis Procedure Codes

The following procedure codes are reimbursable for Wisconsin Chronic Disease Program adult cystic fibrosis services.

Procedure Code	Description
00160	Anesthesia for procedures on nose and accessory sinuses; not otherwise specified
00520	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified
00540	Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified
10021	Fine needle aspiration; without imaging guidance
10022	with imaging guidance
30110	Excision, nasal polyp(s), simple
30115	Excision, nasal polyp(s), extensive
31020	Sinusotomy, maxillary (antrotomy); intranasal
31200	Ethmoidectomy; intranasal, anterior
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
31255	with ethmoidectomy, total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31502	Tracheotomy tube change prior to establishment of fistula tract
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)
31625	with bronchial or endobronchial biopsy(s), single or multiple sites
31628	with transbronchial lung biopsy(s), single lobe
31629	with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
31630	with tracheal/bronchial dilation or closed reduction of fracture
32095	Thoracotomy, limited, for biopsy of lung or pleura
32100	Thoracotomy, major; with exploration and biopsy
32120	with postoperative complications
32999	Unlisted procedure, lungs and pleura
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family
36217	initial third order or more selective thoracic or brachiocephalic branch, within a vascular family
36415	Collection of venous blood by venipuncture
36600	Arterial puncture, withdrawal of blood for diagnosis
70210	Radiologic examination, sinuses, paranasal, less than 3 views
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views

Procedure Code	Description
71010	Radiologic examination, chest; single view, frontal
71020	Radiologic examination, chest, 2 views, frontal and lateral;
71035	Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)
71101	Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views
74000	Radiologic examination, abdomen; single anteroposterior view
74020	complete, including decubitus and/or erect views
75756	Angiography, internal mammary, radiological supervision and interpretation
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
78580	Pulmonary perfusion imaging, particulate
78585	Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath
78586	Pulmonary ventilation imaging, aerosol; single projection
78593	Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection
80198	Theophylline
80200	Tobramycin
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	non-automated, without microscopy
81003	automated, without microscopy
81015	Urinalysis; microscopic only
82040	Albumin; serum, plasma or whole blood
82150	Amylase
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82436	urine
82465	Cholesterol, serum or whole blood, total
82533	Cortisol; total
82565	Creatinine; blood
82570	other source
82670	Estradiol
82784	Gammaglobulin; IgA, IgD, IgG, IgM, each
82785	IgE

Procedure Code	Description
82787	immunoglobulin subclasses, (IgG1, 2, 3, or 4), each
82800	Gases, blood, pH only
82803	Gases, blood, any combination of pH, pCO_2, pO_2, CO_2, HCO_3 (including calculated O_2 saturation);
82947	Glucose; quantitative, blood, (except reagent strip)
82948	blood, reagent strip
82951	tolerance test (GTT), three specimens (includes glucose)
82977	Glutamyltransferase, gamma (GGT)
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	luteinizing hormone (LH)
83036	Hemoglobin; glycosylated (A1C)
83520	Immunoassay, analyte, quantitative; not otherwise specified
83525	Insulin; total
83540	Iron
83605	Lactate (lactic acid)
83615	Lactate dehydrogenase (LD), (LDH);
83690	Lipase
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83735	Magnesium
83930	Osmolality; blood
83935	urine
84075	Phosphatase, alkaline;
84100	Phosphorus inorganic (phosphate);
84132	Potassium; serum, plasma or whole blood
84133	urine
84134	Prealbumin
84155	Protein, total, except by refractometry; serum, plasma or whole blood
84165	Protein; electrophoretic fractionation and quantitation, serum
84295	Sodium; serum, plasma or whole blood
84300	urine
84436	Thyroxine; total
84439	free
84443	Thyroid stimulating hormone (TSH)
84446	Tocopherol alpha (Vitamin E)
84450	Transferase; aspartate amino (AST) (SGOT)
84460	alanine amino (ALT) (SGPT)
84478	Triglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
84590	Vitamin A

Procedure Code	Description
84703	Gonadotropin chorionic (hCG); qualitative
84999	Unlisted chemistry procedure
85002	Bleeding time
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	blood smear, microscopic examination without manual differential WBC count
85009	manual differential WBC count, buffy coat
85013	spun microhematocrit
85014	hematocrit (Hct)
85018	hemoglobin (Hgb)
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85032	manual cell count (erythrocyte, leukocyte, or platelet) each
85041	red blood cell (RBC), automated
85044	reticulocyte, manual
85045	reticulocyte, automated
85046	reticulocytes, automated, including one or more cellular parameters (eg, reticulocyte hemoglobin content [CHr], immature reticulocyte fraction [IRF], reticulocyte volume [mrv], RNA content), direct measurement
85048	leukocyte (WBC), automated
85049	platelet, automated
85610	Prothrombin time;
85651	Sedimentation rate, erythrocyte; non-automated
85730	Thromboplastin time, partial (PTT); plasma or whole blood
85999	Unlisted hematology and coagulation procedure
86140	C-reactive protein;
86225	Deoxyribonucleic acid (DNA) antibody; native or double
86255	Fluorescent noninfectious agent antibody; screen, each antibody
86256	titer, each antibody
86317	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86329	Immunodiffusion; not elsewhere specified
86430	Rheumatoid factor; qualitative
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87075	any source, except blood, anaerobic with isolation and presumptive identification of isolates
87076	anaerobic isolate, additional methods required for definitive identification, each isolate
87077	aerobic isolate, additional methods required for definitive identification, each isolate
87081	Culture, presumptive, pathogenic organisms, screening only;
87084	with colony estimation from density chart
87086	Culture, bacterial; quantitative colony count, urine

Procedure Code	Description
87102	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; other source (except blood)
87184	Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer disks)
87186	microdilution or agar dilution (minimum inhibitory concentration [MIC] or breakpoint), each multi-antimicrobial, per plate
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87206	fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87210	wet mount for infectious agents (eg, saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect
87253	tissue culture, additional studies or definitive identification (eg, hemabsorption, neutralization, immunofluorescence stain) each isolate
87999	Unlisted microbiology procedure
88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation
88106	simple filter method with interpretation
88107	smears and simple filter preparation with interpretation
88108	Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)
88125	Cytopathology, forensic (eg, sperm)
88130	Sex chromatin identification; Barr bodies
88140	peripheral blood smear, polymorphonuclear drumsticks
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)
88160	Cytopathology, smears, any other source; screening and interpretation
88161	preparation, screening and interpretation
88162	extended study involving over 5 slides and/or multiple stains
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)
88173	interpretation and report
88182	Flow cytometry; cell cycle or DNA analysis
88199	Unlisted cytopathology procedure
88300	Level I — Surgical pathology, gross examination only
88305	Level IV — Surgical pathology, gross and microscopic examination
88312	Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), each
88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody
88346	Immunofluorescent study, each antibody; direct method

Procedure Code	Description
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005	tracing only, without interpretation and report
93010	interpretation and report only
93224	Wearable electrocardiographic rhythm derived monitoring for 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation
93307	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiography imaging); complete
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)
93503	Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
94200	Maximum breathing capacity, maximal voluntary ventilation
94240	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94360	Determination of resistance to airflow, oscillatory or plethysmographic methods
94375	Respiratory flow volume loop
94720	Carbon monoxide diffusing capacity (eg, single breath, steady state)
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	multiple determinations (eg, during exercise)
94799	Unlisted pulmonary service or procedure
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a problem focused history; • a problem focused examination; • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused history; • an expanded problem focused examination; • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a detailed history; • a detailed examination; • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a comprehensive history; • a comprehensive examination; • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99221	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a detailed or comprehensive history; • a detailed or comprehensive examination; and • medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99222	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99223	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • a problem focused interval history; • a problem focused examination; • medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • an expanded problem focused interval history; • an expanded problem focused examination; • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: • a detailed interval history; • a detailed examination; • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.
99238	Hospital discharge day management; 30 minutes or less
99241	Office consultation for a new or established patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99242	Office consultation for a new or established patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Procedure Code	Description
99251	Inpatient consultation for a new or established patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.
99252	Inpatient consultation for a new or established patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.
99253	Inpatient consultation for a new or established patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

Procedure Code	Description
99255	Inpatient consultation for a new or established patient, which requires these three key components: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • a problem focused history; • a problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

Procedure Code	Description
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: • a detailed history; • a detailed examination; and • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour
A4306	Disposable drug delivery system, flow rate of less than 50 ml per hour
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500 ml = 1 unit
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

Procedure Code	Description
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit
E0430	Portable gaseous oxygen system, purchase; includes regulator flowmeter, humidifier, cannula or mask, and tubing
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or masks, tubing and refill adaptor
E0439	Stationary liquid oxygen system; rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0440	purchase, includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned), 1 month's supply = 1 unit
E0442	Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned), 1 month's supply = 1 unit
E0443	Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), 1 month's supply = 1 unit
E0444	Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), 1 month's supply = 1 unit
E0480	Percussor, electric or pneumatic, home model
E0570	Nebulizer; with compressor
E0575	Nebulizer, ultrasonic, large volume
E0776	IV pole
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0791	Parenteral infusion pump, stationary, single or multi-channel
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1399	Durable medical equipment, miscellaneous
J0120	Injection, tetracycline, up to 250 mg
J0290	Injection, ampicillin sodium, 500 mg
J0690	Injection, cefazolin sodium, 500 mg
J0694	Injection, cefoxitin sodium, [Mefoxin], 1 gram

Procedure Code	Description
J0696	Injection, ceftriaxone sodium, [Rocephin], per 250 mg
J0697	Injection sterile cefuroxime sodium, [Ceftin, Kefurox, Zihacef injection], per 750 mg
J0698	Injection, cefotaxime sodium, [Claforan], per gram
J0710	Injection, cephapirin sodium, [Cefadyl], up to 1 gram
J0713	Injection, ceftazidime, per 500 mg
J0720	Injection, chloramphenicol sodium succinate, [Chloromycetin Sodium Succinate], up to 1 gram
J0743	Injection, cilastatin sodium/imipenem, [Primaxin], per 250 mg
J0770	Injection, colistimethate sodium, [Coly-Mycin M], up to 150 mg
J1570	Injection, ganciclovir sodium, [Cytovene], 500 mg
J1580	Injection, garamycin, gentamicin, up to 80 mg
J1890	Injection, cephalothin sodium, [Keflin], up to 1 gram
J2540	Injection, penicillin G potassium, [Pfizerpen], up to 600,000 units
J2543	Injection, piperacillin sodium/tazobactam sodium, 1 gram/0.125 grams (1.125 grams)
J2700	Injection, oxacillin sodium, [Prostaphlin], up to 250 mg
J3260	Injection, tobramycin sulfate, [Nebcin], up to 80 mg
J3370	Injection, vancomycin HCl, 500 mg
J7620	Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded administered through DME
J7627	Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7650	Isoetharine HCl, inhalation solution, compounded product, administered through DME, unit dose form, per mg
J7670	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 mg
J7799	NOC drugs, other than inhalation drugs, administered through DME

ATTACHMENT 6
Wisconsin Chronic Disease Program Hemophilia Home Care Procedure Codes

The following procedure codes are reimbursable for Wisconsin Chronic Disease Program hemophilia home care services.

Procedure Code	Description
J7190	Factor VIII (antihemophilic factor, human), per IU
J7192	Factor VIII (antihemophilic factor, recombinant), per IU
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per IU
J7194	Factor IX, complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7197	Antithrombin III (human), per IU
J7198	Anti-inhibitor, per IU
J7199	Hemophilia clotting factor, not otherwise classified

ATTACHMENT 7
Wisconsin Chronic Disease Program Chronic Renal Disease Allowable Revenue Codes

The following are reimbursable revenue codes for Wisconsin Chronic Disease Program chronic renal disease services.

Revenue Code	Description
0100	All Inclusive Rate, All-Inclusive Room and Board Plus Ancillary
0101	All Inclusive Rate, All-Inclusive Room and Board
0110	Room & Board — Private (Medical or General), General Classification
0111	Room & Board — Private (Medical or General), Medical/Surgical/Gyn
0113	Room & Board — Private (Medical or General), Pediatric
0120	Room & Board — Semi-private Two Beds (Medical or General), General Classification
0121	Room & Board — Semi-private Two Beds (Medical or General), Medical/Surgical/Gyn
0123	Room & Board — Semi-private Two Beds (Medical or General), Pediatric
0130	Semi-private — three and Four Beds (Medical or General), General Classification
0131	Semi-private — three and Four Beds (Medical or General), Medical/Surgical/Gyn
0133	Semi-private — three and Four Beds (Medical or General), Pediatric
0150	Room & Board — Ward (Medical or General), General Classification
0151	Room & Board — Ward (Medical or General), Medical/Surgical/Gyn
0153	Room & Board — Ward (Medical or General), Pediatric
0160	Other Room & Board (Medical or General), General Classification
0167	Other Room & Board (Medical or General), Self Care
0200	Intensive Care, General Classification
0201	Intensive Care, Surgical
0202	Intensive Care, Medical
0203	Intensive Care, Pediatric
0240	All Inclusive Ancillary, General Classification
0249	All Inclusive Ancillary, Other All Inclusive Ancillary
0250	Pharmacy, General Classification
0251	Pharmacy, Generic Drugs
0252	Pharmacy, Non-generic Drugs
0254	Pharmacy, Drugs Incident to Other Diagnostic Services
0255	Pharmacy, Drugs Incident to Radiology
0256	Pharmacy, Experimental Drugs
0257	Pharmacy, Nonprescription
0258	Pharmacy, IV Solutions
0259	Pharmacy, Other DRUGS/OTHER

Revenue Code	Description
0260	IV Therapy, General Classification
0261	IV Therapy, Infusion Pump
0262	IV Therapy, IV Therapy/Pharmacy Services
0263	IV Therapy, IV Therapy/Drug/Supply/Delivery
0264	IV Therapy, IV Therapy/Supplies
0269	IV Therapy, Other IV Therapy
0270	Medical/Surgical Supplies, General Classification
0271	Medical/Surgical Supplies, Non-sterile Supply
0272	Medical/Surgical Supplies, Sterile Supply
0279	Medical/Surgical Supplies, Other Supplies/Devices
0300	Laboratory, General Classification
0301	Laboratory, Chemistry
0302	Laboratory, Immunology
0303	Laboratory, Renal Patient (Home)
0304	Laboratory, Non-routine Dialysis
0305	Laboratory, Hematology
0306	Laboratory, Bacteriology & Microbiology
0307	Laboratory, Urology
0309	Laboratory, Other Laboratory
0310	Laboratory Pathological, General Classification
0311	Laboratory Pathological, Cytology
0312	Laboratory Pathological, Histology
0314	Laboratory Pathological, Biopsy
0319	Laboratory Pathological, Other
0320	Radiology — Diagnostic, General Classification
0321	Radiology — Diagnostic, Angiocardiography
0322	Radiology — Diagnostic, Arthrography
0323	Radiology — Diagnostic, Arteriography
0324	Radiology — Diagnostic, Chest X-Ray
0329	Radiology — Diagnostic, Other
0340	Nuclear Medicine, General Classification
0341	Nuclear Medicine, Diagnostic Procedures
0342	Nuclear Medicine, Therapeutic Procedures
0349	Nuclear Medicine, Other
0360	Operating Room Services, General Classification
0361	Operating Room Services, Minor Surgery
0367	Operating Room Services, Kidney Transplant
0369	Operating Room Services, Other Operating Room Services

Revenue Code	Description
0370	Anesthesia, General Classification
0371	Anesthesia, Anesthesia Incident to RAD
0372	Anesthesia, Anesthesia Incident to Other Diagnostic Services
0379	Anesthesia, Other Anesthesia
0380	Blood, General Classification
0381	Blood, Packed Red Cells
0382	Blood, Whole Blood
0387	Blood, Other Derivatives (Cryopricipitates)
0389	Blood, Other Blood
0390	Blood Storage and Processing, General Classification
0391	Blood Storage and Processing, Blood Administration (e.g., Transfusions)
0399	Blood Storage and Processing, Other Processing and Storage
0400	Other Imaging Services, General Classification
0402	Other Imaging Services, Ultrasound
0409	Other Imaging Services, Other Imaging Services
0450	Emergency Room, General Classification
0459	Emergency Room, Other Emergency Room
0490	Ambulatory Surgical Care, General Classification
0499	Ambulatory Surgical Care, Other Ambulatory Surgical Care
0500	Outpatient Services, General Classification
0509	Outpatient Services, Other Outpatient Services
0510	Clinic, General Classification
0519	Clinic, Other Clinic
0520	Free-Standing Clinic, General Classification
0529	Free-Standing Clinic, Other Freestanding Clinic
0621	Medical/Surgical Supplies, Supplies Incident to Radiology
0622	Medical/Surgical Supplies, Supplies Incident to Other Diagnostic Services
0623	Medical/Surgical Supplies, Surgical Dressings
0630	Pharmacy, RESERVED
0631	Pharmacy, Single Source Drug
0632	Pharmacy, Multiple Source Drug
0634	Pharmacy, Erythropoietin (EPO) less than 10,000 units
0635	Pharmacy, Erythropoietin (EPO) 10,000 or more units
0636	Pharmacy, Drugs Requiring Detailed Coding (a)
0710	Recovery Room, General Classification
0730	Electrocardiogram (EKG/ECG), General Classification
0731	Electrocardiogram (EKG/ECG), Holter Monitor

Revenue Code	Description
0732	Electrocardiogram (EKG/ECG), Telemetry
0739	Electrocardiogram (EKG/ECG), Other EKG/ECG
0760	Treatment or Observation Room, General Classification
0761	Treatment or Observation Room, Treatment Room
0762	Treatment or Observation Room, Observation Room
0769	Treatment or Observation Room, Other Treatment Room
0800	Inpatient Renal Dialysis, General Classification
0801	Inpatient Renal Dialysis, Inpatient Hemodialysis
0802	Inpatient Renal Dialysis, Inpatient Peritoneal (Non-CAPD)
0803	Inpatient Renal Dialysis, Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804	Inpatient Renal Dialysis, Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0810	Organ Acquisition, General Classification
0811	Organ Acquisition, Living Donor
0812	Organ Acquisition, Cadaver Donor
0813	Organ Acquisition, Unknown Donor
0814	Organ Acquisition, Unsuccessful Organ Search Donor Bank Charge
0820	Hemodialysis — Outpatient or Home Dialysis, General Classification
0821	Hemodialysis — Outpatient or Home Dialysis, Hemodialysis/Composite or Other Rate
0822	Hemodialysis — Outpatient or Home Dialysis, Home Supplies
0823	Hemodialysis — Outpatient or Home Dialysis, Home Equipment
0824	Hemodialysis — Outpatient or Home Dialysis, Maintenance/100%
0825	Hemodialysis — Outpatient or Home Dialysis, Support Services
0829	Hemodialysis — Outpatient or Home Dialysis, Other Hemodialysis Outpatient
0830	Peritoneal Dialysis — Outpatient or Home, General Classification
0831	Peritoneal Dialysis — Outpatient or Home, Peritoneal/Composite or Other Rate
0832	Peritoneal Dialysis — Outpatient or Home, Home Supplies
0833	Peritoneal Dialysis — Outpatient or Home, Home Equipment
0834	Peritoneal Dialysis — Outpatient or Home, Maintenance/100%
0835	Peritoneal Dialysis — Outpatient or Home, Support Services
0839	Peritoneal Dialysis — Outpatient or Home, Other Peritoneal Dialysis
0840	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, General Classification
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, CAPD/Composite or Other Rate
0842	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, Home Supplies

Revenue Code	Description
0843	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, Home Equipment
0844	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, Maintenance/100%
0845	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, Support Services
0849	Continuous Ambulatory Peritoneal Dialysis (CAPD) — Outpatient or Home, Other CAPD Dialysis
0850	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, General Classification
0851	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, CCPD/Composite or Other Rate
0852	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, Home Supplies
0853	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, Home Equipment
0854	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, Maintenance/100%
0855	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, Support Services
0859	Continuous Cycling Peritoneal Dialysis (CCPD) — Outpatient, Other CCPD Dialysis
0920	Other Diagnostic Services, General Classification
0921	Other Diagnostic Services, Peripheral Vascular Lab
0929	Other Diagnostic Services, Other Diagnostic Service
0960	Professional Fees, General Classification
0963	Professional Fees, Anesthesiologist (MD)
0964	Professional Fees, Anesthesiologist (CRNA)
0969	Professional Fees, Other Professional Fees
0971	Professional Fees, Laboratory
0972	Professional Fees, Radiology — Diagnostic
0974	Professional Fees, Radiology — Nuclear Medicine
0975	Professional Fees, Operating Room
0981	Professional Fees, Emergency Room
0982	Professional Fees, Outpatient Services
0983	Professional Fees, Clinic
0985	Professional Fees, EKG
0987	Professional Fees, Hospital Visit
0988	Professional Fees, Consultation

ATTACHMENT 8
Wisconsin Chronic Disease Program Adult Cystic Fibrosis Allowable Revenue Codes

The following are reimbursable revenue codes for Wisconsin Chronic Disease Program adult cystic fibrosis services.

Revenue Code	Description
0100	All Inclusive Rate, All-Inclusive Room and Board Plus Ancillary
0101	All Inclusive Rate, All-Inclusive Room and Board
0110	Room & Board — Private (Medical or General), General Classification
0111	Room & Board — Private (Medical or General), Medical/Surgical/Gyn
0113	Room & Board — Private (Medical or General), Pediatric
0120	Room & Board — Semi-private Two Beds (Medical or General), General Classification
0121	Room & Board — Semi-private Two Beds (Medical or General), Medical/Surgical/Gyn
0123	Room & Board — Semi-private Two Beds (Medical or General), Pediatric
0130	Semi-private — three and Four Beds (Medical or General), General Classification
0131	Semi-private — three and Four Beds (Medical or General), Medical/Surgical/Gyn
0133	Semi-private — three and Four Beds (Medical or General), Pediatric
0150	Room & Board — Ward (Medical or General), General Classification
0151	Room & Board — Ward (Medical or General), Medical/Surgical/Gyn
0153	Room & Board — Ward (Medical or General), Pediatric
0160	Other Room & Board (Medical or General), General Classification
0167	Other Room & Board (Medical or General), Self Care
0200	Intensive Care, General Classification
0201	Intensive Care, Surgical
0202	Intensive Care, Medical
0203	Intensive Care, Pediatric
0240	All Inclusive Ancillary, General Classification
0249	All Inclusive Ancillary, Other All Inclusive Ancillary
0250	Pharmacy, General Classification
0251	Pharmacy, Generic Drugs
0252	Pharmacy, Non-generic Drugs
0254	Pharmacy, Drugs Incident to Other Diagnostic Services
0255	Pharmacy, Drugs Incident to Radiology
0256	Pharmacy, Experimental Drugs
0257	Pharmacy, Nonprescription
0258	Pharmacy, IV Solutions
0259	Pharmacy, Other DRUGS/OTHER

Revenue Code	Description
0260	IV Therapy, General Classification
0261	IV Therapy, Infusion Pump
0262	IV Therapy, Pharmacy Services
0263	IV Therapy, IV Therapy/Drug/Supply/Delivery
0264	IV Therapy, IV Therapy/Supplies
0269	IV Therapy, Other IV Therapy
0270	Medical/Surgical Supplies, General Classification
0271	Medical/Surgical Supplies, Non-sterile Supply
0272	Medical/Surgical Supplies, Sterile Supply
0273	Medical/Surgical Supplies, Take Home Supplies
0277	Medical/Surgical Supplies, Oxygen — Take Home
0290	Durable Medical Equipment (DME) (Other Than Rental), General Classification
0291	Durable Medical Equipment (DME) (Other Than Rental), Rental
0292	Durable Medical Equipment (DME) (Other Than Rental), Purchase of new DME
0293	Durable Medical Equipment (DME) (Other Than Rental), Purchase of used DME
0294	Durable Medical Equipment (DME) (Other Than Rental), Supplies/Drugs for DME Effectiveness (HHAs Only)
0299	Durable Medical Equipment (DME) (Other Than Rental), Other Equipment
0300	Laboratory, General Classification
0301	Laboratory, Chemistry
0302	Laboratory, Immunology
0305	Laboratory, Hematology
0306	Laboratory, Bacteriology & Microbiology
0307	Laboratory, Urology
0309	Laboratory, Other Laboratory
0310	Laboratory Pathological, General Classification
0311	Laboratory Pathological, Cytology
0312	Laboratory Pathological, Histology
0314	Laboratory Pathological, Biopsy
0319	Laboratory Pathological, Other
0320	Radiology — Diagnostic, General Classification
0321	Radiology — Diagnostic, Angiocardiography
0322	Radiology — Diagnostic, Arthrography
0323	Radiology — Diagnostic, Arteriography
0324	Radiology — Diagnostic, Chest X-Ray
0329	Radiology — Diagnostic, Other
0340	Nuclear Medicine, General Classification
0341	Nuclear Medicine, Diagnostic Procedures

Revenue Code	Description
0342	Nuclear Medicine, Therapeutic Procedures
0349	Nuclear Medicine, Other
0360	Operating Room Services, General Classification
0361	Operating Room Services, Minor Surgery
0369	Operating Room Services, Other Operating Room Services
0370	Anesthesia, General Classification
0371	Anesthesia, Anesthesia Incident to RAD
0372	Anesthesia, Anesthesia Incident to Other Diagnostic Services
0379	Anesthesia, Other Anesthesia
0400	Other Imaging Services, General Classification
0402	Other Imaging Services, Ultrasound
0409	Other Imaging Services, Other Imaging Services
0410	Respiratory Services, General Classification
0412	Respiratory Services, Inhalation Services
0413	Respiratory Services, Hyperbaric Oxygen Therapy
0419	Respiratory Services, Other Respiratory Services
0450	Emergency Room, General Classification
0459	Emergency Room, Other Emergency Room
0460	Pulmonary Function, General Classification
0469	Pulmonary Function, Other Pulmonary Function
0490	Ambulatory Surgical Care, General Classification
0499	Ambulatory Surgical Care, Other Ambulatory Surgical Care
0500	Outpatient Services, General Classification
0509	Outpatient Services, Other Outpatient Services
0510	Clinic, General Classification
0515	Clinic, Pediatric Clinic
0519	Clinic, Other Clinic
0520	Free-Standing Clinic, General Classification
0529	Free-Standing Clinic, Other Freestanding Clinic
0580	Other Visits (Home Health), General Classification
0581	Other Visits (Home Health), Visit Charge
0582	Other Visits (Home Health), Hourly Charge
0589	Other Visits (Home Health), Other Home Health Visits
0600	Oxygen (Home Health), General Classification
0601	Oxygen (Home Health), Oxygen — State/Equip/Suppl or Cont
0602	Oxygen (Home Health), Oxygen — Stat/Equip/Suppl Under 1 LPM
0603	Oxygen (Home Health), Oxygen — Stat/Equip/Over 4 LPM
0604	Oxygen (Home Health), Oxygen — Portable Add-on

Revenue Code	Description
0621	Medical/Surgical Supplies, Supplies Incident to Radiology
0622	Medical/Surgical Supplies, Supplies Incident to Other Diagnostic Services
0630	Pharmacy, RESERVED
0631	Pharmacy, Single Source Drug
0632	Pharmacy, Multiple Source Drug
0710	Recovery Room, General Classification
0760	Treatment or Observation Room, General Classification
0761	Treatment or Observation Room, Treatment Room
0762	Treatment or Observation Room, Observation Room
0769	Treatment or Observation Room, Other Treatment Room
0920	Other Diagnostic Services, General Classification
0921	Other Diagnostic Services, Peripheral Vascular Lab
0929	Other Diagnostic Services, Other Diagnostic Service
0960	Professional Fees, General Classification
0963	Professional Fees, Anesthesiologist (MD)
0964	Professional Fees, Anesthetist (CRNA)
0969	Professional Fees, Other Professional Fees
0971	Professional Fees, Laboratory
0972	Professional Fees, Radiology — Diagnostic
0974	Professional Fees, Radiology — Nuclear Medicine
0975	Professional Fees, Operating Room
0976	Professional Fees, Respiratory Therapy
0981	Professional Fees, Emergency Room
0982	Professional Fees, Outpatient Services
0983	Professional Fees, Clinic
0985	Professional Fees, EKG
0987	Professional Fees, Hospital Visit
0988	Professional Fees, Consultation

ATTACHMENT 9
Wisconsin Chronic Disease Program Hemophilia Home Care Allowable Revenue Codes

The following are reimbursable revenue codes for Wisconsin Chronic Disease Program hemophilia home care services.

Revenue Code	Description
0270	Medical/Surgical Supplies, General Classification
0271	Medical/Surgical Supplies, Non-sterile Supply
0387	Blood, Other Derivatives (Cryopricipitates)