CHAPTER 520 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PODIATRY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 520.8	Prior Authorization Requirements	01/06/06	February 15, 2006
Attachment I	Level II Alpha Procedure Codes	01/05/06	February 15, 2006
Section 520.5.7	Inserts/Modifications/Repairs/ Replacements/Inlays for Therapeutic Shoes for Diabetes	01/03/06	February 15, 2006
Section 520.5.6	Therapeutic Shoes For Diabetes	01/03/06	February 15, 2006
Section 520.8	Prior Authorization Requirements	10/24/05	Postponed
Section 520.8	Prior Authorization Requirements	9/27/05	11/01/05
Section 520.8.1	Prior Authorization Requirements for Outpatient Services	9/27/05	10/01/05

JANUARY 06, 2006

SECTION 520.8

Introduction: The Bureau for Medical Services will require prior authorization beginning February 15, 2006. WVMI will begin prior authorizing services on January 16, 2006 for scheduled procedures on or after February 15, 2006.

Old Policy: All surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005.

New Policy: Certain surgeries performed in place of services 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. These surgeries are listed in Attachment 3.

Change: First paragraph to read, certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 3, along with the PA form that may be utilized.

Directions: Replace pages.

JANUARY 05, 2006

ATTACHMENT I

Introduction: CMS changes to covered procedure codes.

Change: Procedure code K0628 was deleted, and it was replaced by code A5512. Description stayed the same. Procedure code K0629 was deleted, and it was replaced by procedure code A5513. This procedure code had a small description change.

Directions: Replace pages.

JANUARY 03, 2006

SECTION 520.5.7

Introduction: Implementing changes in policy for prior authorization for inserts for diabetic shoes.

Change: In the first bullet, put a period behind the word “shoes”. Delete the words, “and the inserts are prior authorized”.

Directions: Replace pages.

JANUARY 03, 2006

SECTION 520.5.6

Introduction: Implementing changes in policy for prior authorization to diabetic shoes effective 2/15/06.

Change: Take out the comma after the word “met”, put in the word “and” after the word “met”, and put a semicolon after the word documented. The words “and prior authorized” should be deleted.

Directions: Replace pages.

OCTOBER 24, 2005

SECTION 520.8

The outpatient surgery prior authorization review through WVMI that was to become effective November 1, 2005 has been postponed until further notice. PA for imaging services is still required as of October 1, 2005.

SEPTEMBER 27, 2005

SECTION 520.8

Introduction: Implementing changes in policy for outpatient surgery effective 11/01/05.

Change: Added sentence, “All surgeries performed in place of service 22 (Outpatient hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective November 1, 2005”. Added “alpha” to second sentence which now reads “alpha procedures requiring prior authorization are listed in Attachment 1”.

Directions: Replace pages.

SECTION 520.8.1

Introduction: Implementing changes in policy for imaging procedures effective 10/01/05.

Change: Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Directions: Replace pages.

CHAPTER 520—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR PODIATRY SERVICES

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CHAPTER 520–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PODIATRY SERVICES

INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

The policies and procedures set forth herein are promulgated as regulations governing the provision of foot and ankle care services in the Medicaid Program administered by the Bureau for Medical Services, West Virginia Department of Health and Human Resources, under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

This chapter sets forth the Bureau for Medical Services requirements for reimbursement of services provided by independently practicing and licensed podiatrists to eligible West Virginia Medicaid members.

IMPORTANT: The fact that a provider prescribes, recommends or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided.

520.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for reimbursement of foot and ankle care services described in this chapter.

Podiatric Services - The foot and ankle services provided by a podiatrist licensed to provide such services in the State of West Virginia. For provision of ankle surgery, the podiatrist must have hospital privileges granted by the hospital's medical staff credentialing committee.

Podiatrist - An individual currently licensed under West Virginia law to practice podiatry, or under the laws of the State where the practice is conducted, and is eligible to participate in the West Virginia Medicaid Program.

Prior Authorization - Prior approval is necessary before a service can be rendered. A utilization management method used to control certain services, which are limited in amount, duration, or scope.

Referral - The transfer of total or specific care of a West Virginia Medicaid-eligible member from one practitioner to another and does not constitute a consultation.

Routine Foot Care - Any service performed involving the foot in the absence of localized illness, injury, or symptoms. Routine foot care includes, but is not limited to, such services as: cutting or removal of corns, calluses or warts (excluding plantar warts); treatment of a fungal (mycotic) toenail infection; the trimming of nails, including mycotic nails; cleaning and soaking of feet; applications of topical medication or skin creams; and other hygienic and preventive maintenance care in the realm of self care.

Subluxation Of The Foot - The partial dislocation or displacement of joint surfaces, tendons, ligaments or muscles.

Under The Active Care Of A Practitioner/Physician - The member has seen a practitioner/physician for treatment and/or evaluation of the complicating disease during the six-month period prior to the performance of the routine foot care services.

520.2 PROVIDER PARTICIPATION

In order to participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau, podiatrists must:

- Meet and maintain all applicable licensing as required by the state in which the practice is located.
- Meet and maintain all Bureau provider enrollment requirements. (Chapter 300 and Section 520.5.1 of this chapter.)
- Have a valid signed provider enrollment application/agreement on file.

520.3 MEMBER ELIGIBILITY

Reimbursement for foot and ankle care services is available on behalf of all eligible West Virginia Medicaid members subject to the conditions and limitations that apply to these services.

520.4 DESCRIPTION OF COVERED SERVICES

The Bureau will reimburse podiatrists for the following medically necessary and appropriate foot and ankle care services provided to eligible West Virginia Medicaid members:

- Treatment services for acute conditions such as infections, inflammations, and ulcers
- Surgeries for such conditions as bunions, exostoses, hammertoes, neuromas, and ingrown toenails.
- Reduction of fractures and dislocations of the foot and ankle, if specific requirements outlined in Section 520.5.1 are met
- Surgical correction of a subluxated foot structure is covered if:
  - It is an integral part of the treatment of a foot injury
  - It is performed to improve function of the foot
  - It alleviates an induced or associated symptomatic condition.
- Treatments of symptomatic conditions associated with partial displacement of the foot are covered. Symptomatic conditions include:
  - Osteoarthritis
  - Bursitis
  - Bunions
  - Tendonitis
- Treatment of sprains and strains.
- Treatment of plantar warts.
- Orthotics necessary for treatment of the feet and limited to the following items:
  - Footrest, removable, molded to member model
  - Orthopedic footwear, custom molded shoe, removable inner mold, orthotic shoe, and modifications
  - Therapeutic shoes and inserts for members with severe diabetic foot disease and provided for the purpose of averting amputation.
- Consultations for further evaluation and management of the member as requested by a licensed practitioner, including a written report to the requesting practitioner (usually the member's attending

practitioner).

- Evaluation and management services and covered treatment services provided to members who are inpatients of a hospital.
- Covered treatment/surgical services provided to members who are residents of a nursing home except screening services.
- Non-invasive peripheral vascular studies are covered for pre-operative evaluation of members with diabetes or other signs of peripheral vascular disease (93922, 93923, 93925, 93926).

520.5 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

The following limitations apply to the requirements for reimbursement of foot and ankle care services described in this chapter.

520.5.1 SPECIFIC REQUIREMENTS FOR ANKLE PROCEDURES

In order to participate in the West Virginia Medicaid Program and receive reimbursement from the Bureau for ankle surgical procedures, podiatrists must:

- Meet the requirements of Chapter 30, Article 3, Section 4 of the West Virginia Code.
- Provide a copy of their current hospital privileges sheet outlining the ankle surgery procedures that they can perform in that facility upon request by the Bureau for Medical Services. The chairperson, who is a practitioner, must sign the hospital privilege sheet.
- Provide a list of the procedure codes within the provider's scope of practice as outlined in their hospital privileges related to the ankle and for which he/she plans to submit a claim upon request by the Bureau for Medical Services.

520.5.2 ROUTINE FOOT CARE SERVICES

Reimbursement for medically necessary and medically appropriate routine foot care services is limited and contingent on the following:

- Must have referral from treating practitioner who has treated patient within six months.
- The member, under the active care of a practitioner, including inpatient hospital and nursing home residents, must have one or more of the following diseases or systemic conditions, along with documented evidence that unskilled care would be harmful to the member:
  - Diabetes mellitus.
  - Chronic thrombophlebitis.
  - Peripheral neuropathies involving the feet related to malnutrition, alcoholism, malabsorption (celiac disease, tropical sprue) or pernicious anemia, carcinoma, diabetes mellitus, drugs and toxins, multiple sclerosis, chronic renal disease, traumatic injury, neurosyphilis, hereditary sensory radicular neuropathy, angiokeratoma corporis diffusum and amyloid neuropathy.
  - Arteriosclerosis of the extremities.

- Thromboangiitis obliterans or Buerger's disease.

- In addition to the above covered diagnoses, the severity of the condition must be established and supported by clinical findings in conjunction with the practitioner, as follows:

  Class A:

  - A finding of "non-traumatic amputation of foot or integral skeletal portion."

  Class B:

  - Or, any two findings of:
    - Absent posterior tibial pulse
    - Advanced tropic changes, such as decrease in hair growth, nail thickening, discolorations, thin or shiny texture and reddening of skin color (three of these required)
    - Absent dorsalis pedis pulse.

  Class C:

  - Combination of one from Class B and two from Class C or, one finding from the preceding list and two findings of:
    - Claudication
    - Temperature changes, such as cold feet
    - Edema
    - Abnormal spontaneous sensations in the feet
    - Burning

  When billing for the above services, use the appropriate modifier from the list below:

  Q7 One Class A finding.

  Q8 Two Class B findings.

  Q9 One Class B and two Class C findings.

- Podiatrists must obtain and document:
  - The name of the practitioner who has seen the member within the last six months, and with a diagnosis previously provided.
  - The name of the practitioner presently in charge of the member's care if not the same as the referring practitioner.

520.5.3 MYCOTIC NAIL SERVICES

Reimbursement for debridement of mycotic nails is limited as follows:

- Clinical evidence of mycosis of the toenail, and
- Medical evidence documenting the member has a marked limitation of ambulation requiring active treatment of the nails, or
- Medical evidence documenting a non-ambulatory member has a condition that is likely to result in significant medical complications in the absence of such treatment.

Medical record documentation must include:

- Evidence of mycosis for both ambulatory and non-ambulatory members, and
- A detailed description of the affected nails, or
- A photograph of the affected nails, or
- A culture report from an approved and participating laboratory that states the specific organism identified. "Positive for fungus, mycosis, or onychomycosis" is not an acceptable culture report for reimbursement purposes.

520.5.4 NON-INVASIVE PERIPHERAL VASCULAR STUDIES

Reimbursements for non-invasive peripheral vascular studies are covered for feet only subject to a diagnosis of diabetes or peripheral vascular disease. These studies include:

93922 Non-invasive physiologic studies of lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement).

93923 Non-invasive physiologic studies of lower extremity arteries, multiple levels or with provocative functions maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmorgraphy, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia).

93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study.

93926 Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study.

Medical record documentation must include, but is not limited to a clinical summary of the member's condition and a copy of the test results and any other pertinent information documenting the need for non-invasive peripheral vascular studies.

520.5.5 ORTHOPEDIC FOOTWEAR

Custom Orthopedic Shoes: Shoes that are custom molded and manufactured according to the member's specifications and prescribed by a practitioner, doctor of osteopathy, nurse practitioner, or podiatrist.

- **Coverage Guidelines:** Custom shoes are covered for diagnosis of foot deformity. Prior to submitting a request for prior approval, the practitioner must document the nature and severity of the deformity, evidence of pain, indication of tissue breakdown or high probability of tissue breakdown, a description of any limitation on walking, and a practitioner/physician or podiatrist order. Custom shoes must also have a copy of the materials and labor cost itemized.

  A custom molded shoe is covered when the foot deformity cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the supplier's records and submitted to the Bureau for Medical Services' contracted agency for prior authorization. If there is insufficient justification for the custom-molded shoe, but the general coverage criteria are met, reimbursement will be based on the allowance for the least costly medically appropriate alternative.

Stock Orthopedic Shoes: An orthopedic shoe that is not built to a person's individual specifications, as prescribed by a practitioner, podiatrist or other practitioner acting within their licensure.

520.5.6 THERAPEUTIC SHOES FOR DIABETES

Therapeutic shoes, inserts and modifications are covered by West Virginia Medicaid when the following coverage standards are met and documented:

- The member has diabetes (ICD-9-CM diagnosis code required on claims)
- The member has one or more of the following conditions:
  - Previous amputation of a foot, or part of either foot
  - History of previous foot ulceration of either foot
  - History of pre-ulcerative calluses of either foot
  - Peripheral neuropathy with evidence of callous formation of either foot
  - Foot deformity of either foot; and/or
  - Poor circulation of either foot.

520.5.7 INSERTS/MODIFICATIONS/REPAIRS/REPLACEMENTS/INLAYS FOR THERAPEUTIC SHOES FOR DIABETES:

- Separate inserts are covered when the patient has covered diabetic custom-molded or depth shoes. Inserts used in non-covered shoes are not covered.
- Shoe modifications can be substituted for an insert. Common shoe modifications are: rigid rocker bottoms, roller bottoms, wedges, metatarsal bars, or offset heels.
- A podiatrist knowledgeable in the fitting of diabetic shoes and inserts must prescribe shoe inserts and modifications. The footwear must be fitted and furnished by a podiatrist or other qualified individuals such as a pedorthist, orthotist, or prosthetist.
- Replacement will be considered when adequate documentation is provided which supports the medical justification for replacement.
- The practitioner shall be responsible to document the need for replacement. Replacement is not automatic. The current therapeutic shoes for members with a diagnosis of diabetes may still be serviceable.
- The member's current shoes will need to be evaluated for repair and/or modification prior to considering replacement. Medical necessity should indicate why present shoes cannot be repaired or modified.

520.6 NON-COVERED SERVICES

In addition to the exclusions listed in Chapter 100, General Information of the Provider Manual, the following services are not covered:

- Treatment and supportive devices for flat foot conditions, regardless of underlying pathology.
- Treatment of subluxations of the foot; i.e., correcting a subluxated structure in the foot as an isolated entity.
- Routine foot care performed in the absence of localized illness, injury, or symptoms involving the foot. (See 520.5.2)
- Therapeutic shoes, inserts and/or modifications that are provided to members who do not meet the coverage criteria.
- Consultations or visits when the sole purpose of the encounter is to dispense or fit the shoes.
- Deluxe features of any kind.

- Telephone calls/consultations, including but not limited to, information or services provided to a member or on her/his behalf.
- Services/items for the convenience of the patient or caretaker.
- Failed appointments, including, but not limited to, missed or canceled appointments.
- Time spent in preparation of reports.
- A copy of medical report when the DHHR or the Bureau paid for the original service.
- Experimental services or drugs.
- Research/study projects.
- Services/items that are not least costly that will meet patient's medical needs.
- Services rendered outside the scope of a provider's license.
- Treatment in podiatrist's office, etc. when patient is able to do self care at home.
- Denial of services by a primary payer for "not medically necessary" or "deemed not medically necessary."
- Conscious sedation, local anesthesia, regional anesthesia, IV sedation are non-covered. These are included in the procedure/service being provided.

520.7 MANAGED CARE

- If the individual is a member of a Health Maintenance Organization (HMO), the providers must follow the HMO's prior authorization requirements and applicable rules related to podiatry services and bill the HMO.
- If the individual is a Physician Assured Access System (PAAS) member, authorization/referral is required from the Primary Care Provider (PCP) for reimbursement of services.
- Medicaid will not reimburse for services provided when requirements of the HMO/PAAS Program are not followed.

520.8 PRIOR AUTHORIZATION REQUIREMENTS

Certain surgeries performed in place of service 22 (Outpatient Hospital) and 24 (Ambulatory Surgical Center) will require prior authorization, effective February 15, 2006. The selected surgeries that require prior authorization through the BMS review contractor are listed in Attachment 3, along with the PA form that may be utilized.

Alpha procedures requiring prior authorization are listed in Attachment I.

- Prior authorization requests must be completed according to the instructions contained in Attachment 2 to this chapter. The form to be completed follows the instructions in Attachment 2. The form may be duplicated.
- Prior authorization requests must be submitted at a minimum 10 days prior to providing or continuing services that require approval by the Bureau's contracted agency.
- Podiatrists may order and substantiate the need for medical equipment by completing the Certificate of Medical Necessity. However, the item/service must be related to their specialty area.
- If a procedure requires prior authorization, the prior authorization is necessary before the service is

provided. If it is not obtained, reimbursement for the service provided will not be made. The member cannot be billed.

- Requests for prior authorization must be submitted to:

  West Virginia Medical Institute
  Podiatry Review
  3001 Chesterfield Place
  Charleston, West Virginia 25304
  Fax: 304-346-8185

Disclaimer: Prior authorization does not guarantee reimbursement.

520.8.1 Prior Authorization Requirements for Outpatient Services

Effective 10/01/05, prior authorization will be required on all outpatient radiological services that include Computerized Tomography (CT), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Positron Emission Tomography Scans (PET), and Magnetic Resonance Cholangiopancreatography (MRCP). Prior authorization requirements governing the provisions of all West Virginia Medicaid services will apply pursuant to Chapter 300 General Provider Participation Requirements, provider manual. Diagnostic services required during an emergency room episode will not require prior authorization. It is the responsibility of the ordering provider to obtain the prior authorization. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

Prior authorization must be obtained from West Virginia Medical Institute (WVMI) prior to the provision of the service. Failure to obtain prior authorization will result in denial of the service; the Medicaid member cannot be billed for failure to receive authorization for these services.

520.9 GENERAL DOCUMENTATION REQUIREMENTS

- Providers must maintain a specific record for all services provided for each West Virginia Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, referral from the member's attending practitioner, pertinent diagnostic information, a current treatment plan signed by the practitioner, documentation of services provided, the dates the services were provided, and the date and signature of individuals providing the service and their titles. Documentation must substantiate medical necessity of the service provided.
- Podiatrists must also comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 00, General Administration of the Provider Manual.

520.10 BILLING PROCEDURES/CODING

- "A" (Alpha) procedure codes for inserts or modifications is used for items related to therapeutic shoes for members with a diagnosis of diabetes. Prior authorization is required.
- Inserts and modifications for footwear other than for diabetes must be coded using the appropriate "L" codes. Prior authorization is required.
- Procedure code A5507 (for diabetics only not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe) requires prior approval. A narrative description of the feature to be provided and the cost invoice is required before authorization will be considered.

Procedure code A5507 is not to be used for deluxe upgrades to therapeutic shoes for members with a diagnosis of diabetes. Deluxe features of any kind are considered a non-covered service for Medicaid.

- When billing for shoes, follow unit description in code book. Enter the correct unit(s) and the prior authorization number on the claim. The PAAS approval number must appear on the claim if the patient has a PAAS provider.
- Podiatrists should refer to Chapter 100, General Information of the Provider Manual for a list of Medicaid Contacts to obtain additional information.

520.11 REIMBURSEMENT LIMITATIONS

- The cost of drugs dispensed by a podiatrist is considered to be included in the podiatric service charge and is not payable as an additional item of service.
- All codes for orthoses or repairs of orthoses billed with the same date of service must be submitted on the same claim.
- Reimbursement may be made for a visit to determine a need for therapeutic shoes, inserts, or modifications if the podiatrist documents that the purpose of such visit was not solely to fit or dispense the shoe, insert, or modification. A podiatrist called in (e.g., nursing facility) by the attending practitioner should bill specific codes for services rendered, i.e. consultation, minor surgeries, etc.
- For custom fabricated orthoses, there must be documentation in the podiatrist's records to support the medical necessity of that type of device rather than a prefabricated orthosis. This information must be available to the Bureau for Medical Services on request.
- There is no separate reimbursement for fitting, evaluation, measurement, casting, fabrication, follow-up, or adjustment of therapeutic shoes, inserts or modifications, or for the certification of need or prescription of the footwear.

520.12 LABORATORY SERVICES

Laboratory services within scope of podiatry state licensure may be ordered. An order for medically necessary laboratory services can be given to the Medicaid member who will present the order with his/her Medicaid card to a participating laboratory or hospital outpatient department.

520.13 PHARMACY SERVICES

When medically necessary, the licensed medical practitioner within the scope of their licensure may write a prescription for their Medicaid patient. The patient presents the prescription to the pharmacy of their choice and the pharmacy will bill the Medicaid Program for covered prescription services.

520.14 RADIOLOGICAL SERVICES

The Medicaid Program provides coverage of radiological services, including interpretation and taking, for eligible members; radiological services must be provided by practitioners/facilities properly licensed and/or certified as required by state law and practicing within the scope of their licensure.

An order for radiological services may be given to the member to be taken to an approved and participating radiological facility or outpatient hospital. The radiological facility and/or outpatient hospital bills the Medicaid Program directly for services provided.

520.15 INPATIENT HOSPITAL SERVICES

All inpatient hospital services covered under the program are subject to the utilization review process, which determines medical necessity for admission and continued stay. This certification is the responsibility of the Bureau for Medical Services' contracted agency.

520.16 ADDITIONAL INFORMATION

For general information concerning procedure codes and diagnosis codes, please refer to Chapter 100, General Information of the Provider Manual. In addition, please refer to the following attachment for procedure codes and prior authorization:

- For detailed information regarding procedure codes for orthopedic/therapeutic footwear, see **Attachment 1**.
- Refer to **Attachment 2** for the instructions and form for "Certificate of Medical Necessity" for Orthotics and Prosthetics.

CHAPTER 520
PODIATRY SERVICES
JULY 1, 2004

ATTACHMENT 1:
LEVEL II "ALPHA"
PROCEDURE CODES FOR
PODIATRY SERVICES
Page 1 of 6

Revised February 15, 2006

West Virginia Department of Health and Human Resources

Bureau For Medical Services

HCPCS Level II

Podiatry Procedure Codes

HCPCS CODE	DESCRIPTION	REPLACES	SERVICE LIMIT	NOT COVERED BY MEDICARE	SPECIAL INSTRUCTIONS
A5500	For diabetics only, fitting (including follow up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5501	For diabetics only, fitting (including follow up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5503	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth inlay shoe with wedge(s), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5506	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe		2 per year		Diagnosis Requirements: 250.00 - 250.93
A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe		2 per year Cost Invoice		Diagnosis Requirements: 250.00 - 250.93
A5512	For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer of 3/16 inch material of shore a 40 (or higher), prefabricated, each	A5509	6 per year		Diagnosis Requirements: 250.00 - 250.93
A5513	For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom	A5511	2 per year		Diagnosis Requirements: 250.00 - 250.93

	fabricated, each				
J0702	Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg				
J0704	Injection, betamethasone sodium phosphate, per 4 mg				
J1094	Injection, dexamethasone acetate, 1 mg				
J1100	Injection, dexamethosone sodium phosphate, 1 mg				
J1885	Injection, ketorolac tromethamine, per 15 mg				
J2001	Injection, lidocaine HCI for intravenous infusion, 10 mg				
J3301	Injection, triamcinolone acetonide, per 10 mg				
J3302	Injection, triamcinolone, diacetate, per 5 mg				
J3303	Injection, triamcinolone hexacetonide, per 5 mg				
J3490	Unclassified drugs				
L1902	AFO; ankle gauntlet, prefabricated, includes fitting and adjustment		4 per year		
L1906	multiligamentus ankle support, prefabricated, includes fitting and adjustment		4 per year		
L1930	Ankle foot orthosis; plastic or other material, prefabricated, includes fitting and adjustment		2 per year		
L1970	plastic with ankle joint, custom fabricated		2 per year		
L2112	soft, prefabricated, includes fitting and adjustment		4 per year		
L2114	semi-rigid, prefabricated, includes fitting and adjustment		4 per year		
L3000	Foot, insert, removable, molded to patient model; "UCB" type, Berkeley Shell, each		4 per year Prior Authorization		
L3001	Spenco, each		2 per year		
L3002	plastazote or equal, each		4 per year		
L3003	silicone gel, each		2 per year		
L3010	longitudinal arch support, each		2 per year		
L3020	longitudinal/metatarsal support, each		4 per year		
L3030	Foot, insert, removable, formed to patient foot each		2 per year	X	
L3040	Foot, arch support, removable, premolded; longitudinal, each		4 per year		
L3050	metatarsal, each		2 per year		
L3060	longitudinal/metatarsal, each		2 per year		**Not** covered for diagnosis 250.00 thru 250.93

L3170	Foot, plastic heel stabilizer		2 per year		
L3201	Orthopedic shoe, oxford with supinator or pronator; infant		6 units per year		
L3202	child		6 units per year		
L3203	junior		6 units per year		
L3204	Orthopedic shoe, hightop with supinator or pronator; infant		6 units per year		
L3206	child		6 units per year		
L3207	junior		6 units per year		
L3208	Surgical boot, each; infant		6 units per year		
L3209	child		6 units per year		
L3211	junior		6 units per year		
L3212	Benesch boot, pair; infant		3 pair per year		
L3213	child		3 pair per year		
L3214	junior		3 pair per year		
L3215	Orthopedic footwear, ladies shoes; oxford		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3216	depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3217	hightop, depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3219	Orthopedic footwear, mens shoes; oxford		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3221	depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3222	shoes, hightop, depth inlay		2 pair per year	X	**Not** covered for diagnosis 250.00 thru 250.93
L3224	Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)		4 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3225	Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)		4 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3230	Orthopedic footwear, custom shoes, depth inlay		2 pair per year		**Not** covered for diagnosis 250.00 thru 250.93

L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each		4 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3251	Foot, shoe molded to patient model; silicone shoe, each		2 per year Prior Authorization Cost Invoice		**Not** covered for diagnosis 250.00 thru 250.93
L3252	plastazole (or similar), custom fabricated, each		2 per year Prior Authorization		**Not** covered for diagnosis 250.00 thru 250.93
L3253	Foot, molded shoe plastazote (or similar) custom fitted, each		2 units per year		**Not** covered for diagnosis 250.00 thru 250.93
L3254	Non-standard size or width		2 units per year		
L3255	Non-standard size or length		2 units per year		
L3257	Orthopedic footwear, additional charge for split size		1 unit per year		
L3260	Surgical boot/shoe, each		2 units per year		
L3265	Plastazote sandal, each		2 units per year	X	
L3300	Lift, elevation; heel, tapered to metatarsal, per inch		6 units per year		
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch		6 units per year		
L3350	Heel wedge		4 units per year		
L3450	Heel, SACH, cushion type		2 units per year		
L3480	Heel, pad and depression for spur		2 units per year		
L3485	Heel, pad, removable for spur		2 units per year		
L3580	Orthopedic shoe addition, convert instep to velcro closure		8 units per year		
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified		Prior Authorization Cost Invoice		
L4350	Ankle control orthosis, stirrup style, rigid, includes any type interface (eg., pneumatic gel), prefabricated, includes fitting and adjustment		4 per year		
L4360	Walking boot, pneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment		4 per year		
L4392	Replacement, soft interface material; static AFO		4 per year		
L4394	Replace soft interface material, foot drop splint		4 per year		
L4396	Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and		2 per year		

	adjustment				
L4398	Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment		2 per year		
Q4037	Cast supplies, short leg cast, adult (11 years +), plaster				
Q4038	Cast supplies, short leg cast, adult (11 years +), fiberglass				
Q4039	Cast supplies, short leg cast, pediatric (0-10 years), plaster				
Q4040	Cast supplies, short leg cast, pediatric (0-10 years), fiberglass				
Q4045	Cast supplies, short leg splint, adult (11 years +), plaster				
Q4046	Cast supplies, short leg splint, adult (11 years +), fiberglass				
Q4047	Cast supplies, short leg splint, pediatric (0-10 years), plaster				
Q4048	Cast supplies, short leg splint, pediatric (0-10 years), fiberglass				
S9981 *	Medical records copying fee, administrative				

***** This code (S9981) is to be used for copying medical reports for eligibility purposes (diagnosis code (V68.0). Reimbursement is made only for reports relevant to eligibility determination for the Medicaid Program. (Reports requested for review of claims for payment, auditing, etc. must be provided free of charge.) DFS Form from the local office of the West Virginia Department of Health and Human Resources requesting the medical report must be attached to the claim. If paid without the DFS Form, monies will be recouped.

CHAPTER 520

PODIATRY SERVICES

JULY 1, 2004

ATTACHMENT 2

CERTIFICATE OF MEDICAL NECESSITY

INSTRUCTIONS AND APPLICATION

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity
Orthotics and Prosthetics

Form Completion Instructions:

Section I

Member Data

- Complete Member identification number
- Complete Member full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone number (include area code).

Servicing Provider

- Complete provider number (10 digits)
- Complete provider name
- Complete name of contact person to call if BMS has questions.

CMN Status

- Check appropriate box.

Section II

Member Information

- Check all boxes that apply.
- Identify functional limitations related to Member and need for DME service.
- If requesting oxygen, the results of PO2 saturation levels (room air) must be submitted.
- Date last examined by practitioner.
- Clinical diagnosis/narrative diagnosis must be clearly identified and item(s) requested must be related to diagnosis.
- ICD 9 code (optional).
- Check appropriate line for date of on-set for each diagnosis.

Section III

- Begin service date (month, day, year).
- Item(s) ordered description. Must be narrative description of item (DME vendor may identify by HCPCS code).
- Length of time needed. Length of time item will be needed for all durable equipment.
- Quantity ordered. Identify quantity ordered. For expendable supplies, designate supplies needed for 1 month. If items are required greater than 1 month, note time frame in the length of time needed column.
- Quantity/frequency of use. Justification/comments. Practitioner's order for frequency of use must be identified.

Section IV

Practitioner Certification

- Practitioner's full name (print)
- Must be personally signed and fully dated by practitioner. (Note: Attached practitioner's prescription will not be accepted in lieu of practitioner's signature on this form)
- If orders for DME services are written on both sides of form, practitioner must sign/date both sides of form
- Complete practitioner Medicaid provider number (optional)
- Telephone number (include area code).

The Certificate of Medical Necessity form to complete follows this page. The form may be duplicated.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Certificate of Medical Necessity For Orthotics and Prosthetics

SECTION I

MEMBER DATA	**SERVICING PROVIDER**	**CMN STATUS**
ID#_____	**Provider #**_____	____**Initial**
Name_____	**Provider Name**_____	____**Revised**
D.O.B._____	**Contact Person**_____	____**Renewed**
Phone # (___)_____	**Phone #** (____)_____	

SECTION II - MEMBER INFORMATION

Answer all questions that are applicable to **ORTHOTIC / PROSTHETIC** services being requested. If answer is Yes, you must describe/ attach additional information to support medical justification. (Additional Space on Reverse).

DOES PATIENT:	YES	NO
1. Have impaired mobility?	____	____
2. Have impaired endurance?	____	____
3. Have restricted activity?	____	____
4. Have skin break down? (Describe site, Size, Depth, and Drainage on reverse side of form)	____	____
5. Have impaired respiration? (Identify most recent PO2/ saturation level for Pts. on O2) (Room air)	____	____
6. Require assistance with ADL'S ?	____	____
7. Have impaired speech?	____	____
8. Is item suitable for use in home and does the Patient/Care giver demonstrate willingness and ability to use the equipment?	____	____

ICD 9- CODES **CLINICAL DIAGNOSIS** **DATE OF ONSET**

_____

_____

_____

_____

DATE PATIENT LAST EXAMINED BY PRACTITIONER: _____/_____/_____

FUNCTIONAL LEVEL: (As per Medicare standard classification for specific prosthetic components) Attach supporting documentation.

_____Level – 0 ____Level – I __Level - II __Level - III __Level - IV

SECTION III (Additional space on reverse side)

Begin Service Date	HCPCS Code	Description of HCPCS Code	Length of Time Needed	Quantity Ordered	Frequency of Use	Dollar Amount

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective," and is not a convenience item for the recipient, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

_____ _____ ____/____/_____ _____ (___)_____

Prescribing Practitioner's Name Practitioner's Signature Date ID# Phone #

(Please Print)

CHAPTER 520

PODIATRY SERVICES

JULY 1, 2004

ATTACHMENT 3

OUTPATIENT SURGERY PA REQUIREMENTS

Confidential

WVMI Medicaid Outpatient Services Authorization Request Form

Fax: 304- 344-2580 **or** 1-800- 891-0016 **Phone:** 304-414-2551 or (Toll Free) 1-800-296-9849

Request Date: _____ Member's Medicaid ID #:_____

A. **Member** Name: _____ Date of Birth: _____
Last First MI

Member Address: _____
Street City State Zip

B. **Surgical Procedure** Requested: _____

CPT Code **(Required)**: _____ ICD-9-CM Code **(Required)**: _____ Assistant surgeon? ⎸Yes ⎸No

Diagnosis Related to Surgical Procedure: _____

C. **Facility** Performing Surgical Procedure: _____
Facility ID # (10 digits): _____ Facility is: □ In WV □ Outside WV

Referring Physician Name: _____
Mailing Address: _____
Street City State Zip

Surgeon Name: _____
Mailing Address: _____
Street City State Zip

Contact Name: _____ Phone# (_____)_____-_____ Ext: _____
Fax # (_____)_____-_____

D. **Clinical Reasons for Surgery:** (e.g. signs and symptoms): _____
_____
_____
_____ Date of Onset: _____

E. **Relative Diagnostic and Outpatient Studies: (Include results of studies and attach photographs if** indicated):_____
_____
_____

F. **Related Medications, Treatments, and Therapies (include duration): _____**
_____
_____
_____

G. If procedure routinely performed in office, please document need for OP surgical setting: _____
_____

*****THIS FORM WILL BE RETURNED TO ORDERING PHYSICIAN WITH DETERMINATION*****

For <u>WVMI Use Only:</u>
Approved: ___ Authorization Number: _____ Date*: _____

***(Authorization expires 90 days from this date)**

Denied: ____ Detailed letter to follow

*** REMINDER: Preauthorization for medical necessity does not guarantee payment*

CPT/ HCPCS	Description	Medical Necessity	Place of Service
10040	Acne surgery	X	
10060	Drainage of skin abscess		X
10061	Drainage of skin abscess		X
10080	Drainage of pilonidal cyst	X	X
10081	Drainage of pilonidal cyst	X	X
10120	Remove foreign body		X
10121	Remove foreign body		X
10140	Drainage of hematoma/fluid	X	X
10160	Puncture drainage of lesion	X	X
10180	Complex drainage, wound	X	X
11055	Trim skin lesion	X	X
11056	Trim skin lesions, 2 to 4	X	X
11057	Trim skin lesions, over 4	X	X
11100	Biopsy, skin lesion	X	X
11101	Biopsy, skin add-on	X	X
11200	Removal of skin tags	X	X
11201	Remove skin tags add-on	X	X
11300	Shave skin lesion	X	X
11301	Shave skin lesion	X	X
11302	Shave skin lesion	X	X
11303	Shave skin lesion	X	X
11305	Shave skin lesion	X	X
11306	Shave skin lesion	X	X
11307	Shave skin lesion	X	X
11308	Shave skin lesion	X	X
11310	Shave skin lesion	X	X
11311	Shave skin lesion	X	X
11312	Shave skin lesion	X	X
11313	Shave skin lesion	X	X
11400	Exc tr-ext b9+marg 0.5 < cm	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm	X	X
11406	Exc tr-ext b9+marg > 4.0 cm	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm	X	X
11440	Exc face-mm b9+marg 0.5 < cm	X	X
11441	Exc face-mm b9+marg 0.6-1 cm	X	X
11442	Exc face-mm b9+marg 1.1-2 cm	X	X
11443	Exc face-mm b9+marg 2.1-3 cm	X	X
11444	Exc face-mm b9+marg 3.1-4 cm	X	X
11446	Exc face-mm b9+marg > 4 cm	X	X
11450	Removal, sweat gland lesion	X	X
11451	Removal, sweat gland lesion	X	X
11462	Removal, sweat gland lesion	X	X
11463	Removal, sweat gland lesion	X	X
11470	Removal, sweat gland lesion	X	X
11471	Removal, sweat gland lesion	X	X

11600	Exc tr-ext mlg+marg 0.5 < cm	X	X
11601	Exc tr-ext mlg+marg 0.6-1 cm	X	X
11602	Exc tr-ext mlg+marg 1.1-2 cm	X	X
11603	Exc tr-ext mlg+marg 2.1-3 cm	X	X
11604	Exc tr-ext mlg+marg 3.1-4 cm	X	X
11606	Exc tr-ext mlg+marg > 4 cm	X	X
11620	Exc h-f-nk-sp mlg+marg 0.5 <	X	X
11621	Exc h-f-nk-sp mlg+marg 0.6-1	X	X
11622	Exc h-f-nk-sp mlg+marg 1.1-2	X	X
11623	Exc h-f-nk-sp mlg+marg 2.1-3	X	X
11624	Exc h-f-nk-sp mlg+marg 3.1-4	X	X
11626	Exc h-f-nk-sp mlg+mar > 4 cm	X	X
11640	Exc face-mm malig+marg 0.5 <	X	X
11641	Exc face-mm malig+marg 0.6-1	X	X
11642	Exc face-mm malig+marg 1.1-2	X	X
11643	Exc face-mm malig+marg 2.1-3	X	X
11644	Exc face-mm malig+marg 3.1-4	X	X
11646	Exc face-mm mlg+marg > 4 cm	X	X
11719	Trim nail(s)		X
11720	Debride nail, 1-5		X
11721	Debride nail, 6 or more		X
11730	Removal of nail plate		X
11732	Remove nail plate, add-on		X
11740	Drain blood from under nail		X
11750	Removal of nail bed		X
11752	Remove nail bed/finger tip		X
11755	Biopsy, nail unit		X
11760	Repair of nail bed		X
11762	Reconstruction of nail bed		X
11765	Excision of nail fold, toe		X
11900	Injection into skin lesions	X	X
11901	Added skin lesions injection	X	X
11960	Insert tissue expander(s)	X	X
11970	Replace tissue expander	X	X
11971	Remove tissue expander(s)	X	X
11975	Insert contraceptive cap		X
11976	Removal of contraceptive cap		X
11980	Implant hormone pellet(s)		X
12001	Repair superficial wound(s)	X	X
12002	Repair superficial wound(s)	X	X
12004	Repair superficial wound(s)	X	X
12011	Repair superficial wound(s)	X	X
12013	Repair superficial wound(s)	X	X
12014	Repair superficial wound(s)	X	X
12015	Repair superficial wound(s)	X	X
12031	Layer closure of wound(s)	X	X
12032	Layer closure of wound(s)	X	X
12041	Layer closure of wound(s)	X	X
12042	Layer closure of wound(s)	X	X
12051	Layer closure of wound(s)	X	X
12052	Layer closure of wound(s)	X	X
12053	Layer closure of wound(s)	X	X
14000	Skin tissue rearrangement	X	
14001	Skin tissue rearrangement	X	
14020	Skin tissue rearrangement	X	

14021	Skin tissue rearrangement	X	
14040	Skin tissue rearrangement	X	
14041	Skin tissue rearrangement	X	
14060	Skin tissue rearrangement	X	
14061	Skin tissue rearrangement	X	
15786	Abrasion, lesion, single	X	X
15787	Abrasion, lesions, add-on	X	X
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	X	
15831	Excise excessive skin tissue	X	
15850	Removal of sutures		X
15851	Removal of sutures		X
15852	Dressing change not for burn		X
17000	Destroy benign/premlg lesion	X	
17003	Destroy lesions, 2-14	X	
17004	Destroy lesions, 15 or more	X	
17106	Destruction of skin lesions	X	
17107	Destruction of skin lesions	X	
17108	Destruction of skin lesions	X	
17110	Destruct lesion, 1-14	X	
17111	Destruct lesion, 15 or more	X	
17250	Chemical cautery, tissue	X	
17260	Destruction of skin lesions	X	
17261	Destruction of skin lesions	X	
17262	Destruction of skin lesions	X	
17263	Destruction of skin lesions	X	
17264	Destruction of skin lesions	X	
17266	Destruction of skin lesions	X	
17270	Destruction of skin lesions	X	
17271	Destruction of skin lesions	X	
17272	Destruction of skin lesions	X	
17273	Destruction of skin lesions	X	
17274	Destruction of skin lesions	X	
17276	Destruction of skin lesions	X	
17280	Destruction of skin lesions	X	
17281	Destruction of skin lesions	X	
17282	Destruction of skin lesions	X	
17283	Destruction of skin lesions	X	
17284	Destruction of skin lesions	X	
17286	Destruction of skin lesions	X	
17304	1 stage mohs, up to 5 spec	X	X
17305	2 stage mohs, up to 5 spec	X	X
17306	3 stage mohs, up to 5 spec	X	X
17307	Mohs addl stage up to 5 spec	X	X
17310	Mohs any stage > 5 spec each	X	X
19140	Mastectomy for gynecomastia	X	
19180	Prophylactic, simple, complete	X	
19182	Mastectomy, subcutaneous	X	
19316	Mastopexy	X	
19318	Reduction mammaplasty	X	
19324	Mammaplasty, augmentation; without prosthetic implant	X	
19325	Mammaplasty, augmentation; with prosthetic implant	X	
19328	Removal intact mammary implant	X	
19330	Removal mammary implant material	X	
19340	Immediate insertion breast prosthesis after reconstruction	X	
19342	Delayed breast prosthesis	X	

19350	Nipple/areola reconstruction	X	
19355	Correction of inverted nipples	X	
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	X	
19361	Breast reconstruction with lat. flap	X	
19364	Breast reconstruction with free flap	X	
19366	Breast reconstruction other technique	X	
19367	Breast reconsturction with TRAM	X	
19368	with microvascular anastaomosis	X	
19369	with TRAM double pedicle	X	
19370	Open periprosthetic capsulotomy, breast	X	
19371	Periprosthetic capsulectomy, breast	X	
19380	Revision of reconstructed breast	X	
19396	Prep for custom implant	X	
19499	Unlisted procedure, breast	X	
21060	Meniscectomy TMJ (<21)	X	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	X	
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	X	
21143	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, without bone	X	
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	X	
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	X	
21147	Reconstruction midface, LeFort I; three or more pieces, segment move in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	X	
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	X	
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	X	
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts) with LeFort I	X	
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); without LeFort I	X	
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc) requiring bone grafts (includes obtaining autografts); with LeFort I	X	
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	X	
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	X	
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	X	
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	X	
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	X	
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	X	
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	X	

21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	X	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	X	
21198	Osteotomy, mandible, segmental	X	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	X	
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	X	
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	X	
21209	Osteoplasty, facial bones; reduction	X	
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	X	
21215	Graft, bone; mandible (includes obtaining graft)	X	
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	X	
21240	Arthroplasty, temporomandibular joint (TMJ), with or without autograft (includes obtaining graft) for <21 years.	X	
21240	Reconstruction of jaw joint	X	
21242	Arthroplasty, temporomandibular joint (TMJ), with allograft for <21 years	X	
21242	Reconstruction of jaw joint	X	
21243	Arthroplasty, temporomandibular joint (TMJ), with prosthetic joint replacement for <21 years	X	
21243	Reconstruction of jaw joint	X	
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)	X	
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	X	
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	X	
21247	Reconstruction of mandibular condyle with bone and cartilage autogra fts (includes obtaining grafts) (e.g. for hemifacial microsomia)	X	
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial	X	
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete	X	
21270	Malar augmentation, prosthetic material	X	
21280	Medial canthopexy (separate procedure)	X	
21282	Lateral canthopexy	X	
21299	Unlisted craniofacial and maxillofacial procedure	X	
21310	Treatment of nose fracture	X	
21315	Treatment of nose fracture	X	
21320	Treatment of nose fracture	X	
21325	Treatment of nose fracture	X	
21330	Treatment of nose fracture	X	
21335	Treatment of nose fracture	X	
21499	Unlisted musculoskeletal procedure, head	X	
21685	Hyoid myotomy and suspension	X	
21740	Reconstructive repair of pectus excavatum or carinatum; open	X	
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) without thoracoscopy	X	
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure) with thoracoscopy	X	
22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic	X	
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; lumbar	X	
22522	Each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure	X	
22523	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); thoracic	X	

22524	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); lumbar	X	
22525	Percutaneous vertebroplasty augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, Kyphoplasty); each additional thoracic or lumbar vertebral body (listed separately in addition to code for primary procedure)	X	
22899	Unlisted procedure, spine (to be used for kyphoplasty with dates of service prior to 01/01/2006)	X	
23412	Release shoulder joint	X	
23415	Drain shoulder lesion	X	
23420	Drain shoulder bursa	X	
23450	Exploratory shoulder surgery	X	
23455	Biopsy shoulder tissues	X	
23460	Biopsy shoulder tissues	X	
23462	Removal of shoulder lesion	X	
23470	Reconstruct shoulder joint	X	
23472	Reconstruct shoulder joint	X	
24351	Release elbow joint	X	
24352	Biopsy arm/elbow soft tissue	X	
24354	Biopsy arm/elbow soft tissue	X	
24356	Remove arm/elbow lesion	X	
24360	Reconstruct elbow joint	X	
24361	Reconstruct elbow joint	X	
24362	Reconstruct elbow joint	X	
24363	Replace elbow joint	X	
24365	Reconstruct head of radius	X	
24366	Reconstruct head of radius	X	
25000	Incision of tendon sheath	X	
25001	Incise flexor carpi radialis	X	
25111	Remove wrist tendon lesion	X	
25112	Reremove wrist tendon lesion	X	
25332	Revise wrist joint	X	
25441	Reconstruct wrist joint	X	
25442	Reconstruct wrist joint	X	
25443	Reconstruct wrist joint	X	
25444	Reconstruct wrist joint	X	
25445	Reconstruct wrist joint	X	
25446	Wrist replacement	X	
25447	Repair wrist joint(s)	X	
26010	Drainage of finger abscess		X
26055	Incise finger tendon sheath	X	
26121	Release palm contracture	X	
26123	Release palm contracture	X	
26125	Release palm contracture	X	
26160	Remove tendon sheath lesion	X	
26530	Revise knuckle joint	X	
26531	Revise knuckle with implant	X	
26531	Revise knuckle with implant	X	
26535	Revise finger joint	X	
26535	Revise finger joint	X	
26536	Revise/implant finger joint	X	
26536	Revise/implant finger joint	X	
26560	Repair of web finger	X	
26561	Repair of web finger	X	

26562	Repair of web finger	X	
26568	Lengthen metacarpal/finger	X	
26580	Repair hand deformity	X	
26587	Reconstruct extra finger	X	
26590	Repair finger deformity	X	
26989	Hand/finger surgery	X	
27096	Inject sacroiliac joint	X	
27200	Treat tail bone fracture	X	
27332	Removal of knee cartilage	X	
27333	Removal of knee cartilage	X	
27403	Repair of knee cartilage	X	
27405	Repair of knee ligament	X	
27407	Repair of knee ligament	X	
27409	Repair of knee ligament	X	
27437	Revise kneecap	X	
27437	Revise kneecap	X	
27438	Revise kneecap with implant	X	
27438	Revise kneecap with implant	X	
27440	Revision of knee joint	X	
27440	Revision of knee joint	X	
27441	Revision of knee joint	X	
27441	Revision of knee joint	X	
27442	Revision of knee joint	X	
27442	Revision of knee joint	X	
27443	Revision of knee joint	X	
27443	Revision of knee joint	X	
27445	Arthroplasty of knee	X	
27445	Revision of knee joint	X	
27446	Revision of knee joint	X	
27446	Revision of knee joint	X	
27447	Total knee arthroplasty	X	
27487	Revise/replace knee joint	X	
27613	Biopsy lower leg soft tissue	X	
27700	Arthroplasty, ankle	X	
27700	Ankle arthroplasty	X	
27702	With implant	X	
27703	Revision, total ankle	X	
27704	Removal of ankle implant	X	
28035	Decompression of tibia nerve	X	
28070	Removal of foot joint lining	X	
28072	Removal of foot joint lining	X	
28080	Removal of foot lesion	X	
28108	Removal of foot lesions	X	
28110	Part removal of metatarsal	X	
28111	Part removal of metatarsal	X	
28112	Part removal of metatarsal	X	
28113	Part removal of metatarsal	X	
28114	Removal of metararsal heads	X	
28116	Revision of foot	X	
28118	Removal of heel bone	X	
28119	Removal of heel spur	X	
28190	Removal of foot foreign body	X	
28192	Removal of foot foreign body	X	
28193	Removal of foot foreign body	X	
28238	Revision of foot tendon for medical necessity	X	

28240	Release of big toe	X	
28250	Revision of foot fascia	X	
28280	Fusion of toes	X	
28285	Repair of hammertoe	X	
28286	Repair of hammertoe	X	
28288	Partial removal of foot bone	X	
28289	Repair hallux rigidus	X	
28290	Correction of bunion	X	
28292	Correction of bunion	X	
28293	Correction of bunion	X	
28293	Correction of bunion with implant	X	
28294	Correction of bunion	X	
28296	Correction of bunion	X	
28297	Correction of bunion	X	
28298	Correction of bunion	X	
28299	Correction of bunion	X	
28300	Incision of heel bone	X	
28310	Revision of big toe	X	
28312	Revision of toe	X	
28313	Repair deformity of toe	X	
28315	Removal of sesamoid bone	X	
29800	Jaw arthroscopy/surgery	X	
29806	Shoulder arthroscopy/surgery	X	
29807	Shoulder arthroscopy/surgery	X	
29819	Shoulder arthroscopy/surgery	X	
29822	Shoulder arthroscopy/surgery	X	
29823	Shoulder arthroscopy/surgery	X	
29824	Shoulder arthroscopy/surgery	X	
29826	Shoulder arthroscopy/surgery	X	
29827	Arthroscop rotator cuff repr	X	
29848	Wrist endoscopy/surgery	X	
29855	Tibial arthroscopy/surgery	X	
29856	Tibial arthroscopy/surgery	X	
29870	Knee arthroscopy, dx	X	
29871	Knee arthroscopy/drainage	X	
29873	Knee arthroscopy/surgery	X	
29874	Knee arthroscopy/surgery	X	
29875	Knee arthroscopy/surgery	X	
29876	Knee arthroscopy/surgery	X	
29877	Knee arthroscopy/surgery	X	
29879	Knee arthroscopy/surgery	X	
29880	Knee arthroscopy/surgery	X	
29881	Knee arthroscopy/surgery	X	
29882	Knee arthroscopy/surgery	X	
29883	Knee arthroscopy/surgery	X	
29885	Knee arthroscopy/surgery	X	
29886	Knee arthroscopy/surgery	X	
29887	Knee arthroscopy/surgery	X	
29888	Knee arthroscopy/surgery	X	
29889	Knee arthroscopy/surgery	X	
29893	Scope, plantar fasciotomy	X	
29999	Arthroscopy of joint	X	
30150	Rhinectomy; partial	X	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	X	

30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	X	
30420	Rhinoplasty, primary; including major septal repair	X	
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	X	
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	X	
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	X	
30465	Repair of nasal stenosis	X	
30520	Repair of nasal septum	X	
30540	Repair nasal defect	X	
30545	Repar nasal defect	X	
31299	Unlisted procedure, accessory sinuses	X	
31513	Injection into vocal cord	X	
31570	Laryngoscopy with injection	X	
31571	Laryngoscopy with injection	X	
36299	Unlisted procedure, vascular injection	X	
36468	Inj. Sclerosing solution	X	
36469	face	X	
36470	single vein	X	
36471	multiple veins, same leg	X	
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	X	
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	X	
37501	Unlisted vascular endoscopy procedure	X	
37700	Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	X	
37718	Ligation division and stripping short saphenous vein	X	
37722	Ligation divisin and stripping , long greater saphenous viens from saphenofemoral junction to knee or below	X	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	X	
37760	Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open	X	
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	X	
37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	X	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	X	
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg	X	
37799	Unlisted procedure, vascular surgery	X	
39502	Repair paraesophageal hiatus hernia, transabdominal, with or without fundoplasty, vagotomy, and/or pyloroplasty, exceptional	X	
40806	Incision of lip fold	X	
40819	Excise lip or cheek fold	X	
41520	Reconstruction, tongue fold	X	
42145	Repair palate, pharynx/uvula	X	
42810	Excision of nect cyst	X	
42815	Excision of nect cyst	X	
42820	Remove tonsils and adenoids	X	
42821	Remove tonsils and adenoids	X	
42825	Removal of tonsils	X	
42826	Removal of tonsils	X	
42830	Removal of adenoids	X	
42831	Removal of adenoids	X	
42835	Removal of adenoids	X	
42836	Removal of adenoids	X	

43201	Esophagoscopy with injections	X	
43280	Lap, esophagus	X	
43289	Lap, esophagus	X	
43644	Lap, gastric bypass	X	
43645	Lap, gastric bypass	X	
43651	Lap, vagotomy	X	
43652	Lap, vagotomy	X	
43659	Lap, gastric, unlisted	X	
44970	Lap, appendectomy	X	
44979	Lap, appendix unlisted	X	
46505	Chemodenervation of internal and sphincter if coupled with J0585 pr K0587	X	
47562	Lap cholecystectomy	X	
47563	Lap cholecystectomy	X	
47564	Lap cholecystectomy	X	
47570	Lap cholecystoenterostomy	X	
47579	Lap, unlisted biliary	X	
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure	X	
49329	Lap, abd, peritoneum, omen, unlisted	X	
49560	Repair initial incisional or rentrel hernia	X	
49561	Incarcerated or strangulated	X	
49565	Repair recurrentincisional or rentrel hernia, reducible	X	
49566	Incarcerated or strangulated	X	
49568	Hernia repair with mesh	X	
49569	Lap, hernia, unlisted	X	
49570	Repair epigashric hiernia, reducible	X	
49572	Repair epigashric hiernia, blocked	X	
49585	Repair umbilical hernia, reducible > 5 years	X	
49587	Repair umbilical hernia, blocked+C379+C411 > 5 years	X	
49650	Lap, inguinal hernia	X	
49651	Lap, inguinal hernia	X	
49904	Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects)	X	
51999	Lap, bladder, unlisted	X	
51999	Lap, bladder, unlisted	X	
53440	Correct bladder function	X	
53442	Remove perineal prosthesis	X	
53445	Insert uro/ves nck sphincter	X	
53447	Remove/replace ur sphincter	X	
53448	Removal/replacement of sphincter pump	X	
53505	Repair of urethra injury no pa--no pink	X	
54400	Insert semi-rigid prosthesis	X	
54401	Insert self-contd prosthesis	X	
54405	Insert multi-comp penis pros	X	
54406	Removal of inflatable penile prosthesis	X	
54409	Removal of inflatable penile prosthesis	X	
54410	Remove/replace penis prosth	X	
54416	Remv/repl penis contain pros	X	
54699	Lap, testicle unlisted	X	
55550	Lap, ligation spermatic veins	X	
55559	Lap, spermatic cord, unlisted	X	
55866	Lap. Prostatectomy	X	
57265	Extensive repair of vagina	X	
57284	Repair paravaginal defect	X	
57287	Revise/remove sling repair	X	
57288	Repair bladder defect	X	

57425	Lap colpopexy	X	
58150	Hyst and BSO	X	
58180	Hyst and BSO	X	
58200	Hyst and BSO	X	
58260	Vag Hyst	X	
58262	removal of tubes/ovaries	X	
58263	Vag Hyst	X	
58267	Vag Hyst	X	
58270	Vag Hyst	X	
58275	Vag Hyst	X	
58280	Vag Hyst	X	
58285	Vag Hyst	X	
58290	Vag Hyst	X	
58291	Vag Hyst	X	
58292	Vag Hyst	X	
58293	Vag Hyst	X	
58294	Vag Hyst	X	
58550	Laparoscopy, surgical with vaginal hysterectomy	X	
58552	Laparoscopy, surgical with vaginal hysterectomy	X	
58553	Laparoscopy, surgical with vaginal hysterectomy	X	
58554	Laparoscopy, surgical with vaginal hysterectomy	X	
58555	Hysteroscopy, diagnostic	X	
58558	Hysteroscopy, surgical	X	
58559	With lysis of cohesions	X	
58560	With division or resection of intrauterine septum	X	
58561	With removal of leiomyoma	X	
58562	With removal of impacted foreign body	X	
58563	With endometrial ablation	X	
58565	Hysteroscopy, sterilization	X	
58578	Lap, uterus unlisted	X	
58579	Unlisted hysteroscopy procedure, uterus	X	
58679	Lap, ovary unlisted	X	
59898	Lap, unlisted, maternity	X	
61885	Implant neurostim one array	X	
61886	Implant neurostim arrays	X	
62360	Implantation or replacement of device for intrathreal or epidural drug infusion; subcutaneous.	X	
62361	Implant spine infusion pump	X	
62362	Implant spine infusion pump	X	
63650	Implant neuroelectrodes	X	
63655	Implant neuroelectrodes	X	
63685	Implant neuroreceiver	X	
64553	Implant neuroelectrodes	X	
64555	Implant neuroelectrodes	X	
64560	Implant neuroelectrodes	X	
64561	Implant neuroelectrodes	X	
64565	Implant neuroelectrodes	X	
64573	Implant neuroelectrodes	X	
64575	Implant neuroelectrodes	X	
64577	Implant neuroelectrodes	X	
64580	Implant neuroelectrodes	X	
64581	Implant neuroelectrodes	X	
64585	Revision or removal of peripheral stimulator electrodes	X	
64590	Implant neuroreceiver	X	
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)	X	

64613	Chemodenervation, neck muscles	X	
64614	Extremity or trunk	X	
64650	Chemodenervation of eccrineglands	X	
64653	Other areas when coupled with J0585 or J0587	X	
65772	Corneal relaxing incision for correction of surgically induced astigmatism	X	
65775	Corneal wedge resection for correction of surgically inducted astigmatism	X	
67345	Chemodenervation of extraocular muscle	X	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	X	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	X	
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)	X	
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	X	
67904	Repair of blepharoptosis; (tarso) Levator resection or advancement, external approach	X	
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	X	
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)	X	
67909	Reduction of overcorrection of ptosis	X	
67911	Correction of lid retraction	X	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)	X	
67914	Repair of ectropion, suture	X	
67915	Repair of ectropion; thermocauterization	X	
67916	Repair of ectropion; excision tarsal wedge	X	
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)	X	
67921	Repair of entropion; suture	X	
67922	Repair of entropion; thermocauterization	X	
67923	Repair of entropion; excision tarsal wedge	X	
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)	X	
67950	Canthoplasty	X	
67999	Unlisted eyelid procedure	X	
69300	Otoplasty	Not covered	
69399	Unlisted procedure, external ear	X	
69420	Incision of eardrum	X	
69421	Incision of eardrum	X	
69610	Repair of eardrum	X	
69620	Repair of eardrum	X	
69631	Repair eardrum structures	X	
69632	Rebuild eardrum structures	X	
69633	Rebuild eardrum structures	X	
69635	Rebuild eardrum structures	X	
69636	Rebuild eardrum structures	X	
69637	Rebuild eardrum structures	X	
69650	Release middle ear bone	X	
69660	Revise middle ear bone	X	
69661	Revise middle ear bone	X	
69662	Revise middle ear bone	X	
69930	Cochlear device implantation, with or without mastoidectomy	X	
69949	Unlisted procedure, inner ear	X	
76012	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body	X	

76013	Radiological supervision and interpretation, percutaneous vertebroplasty or vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance	X	
76499	Unlisted diagnostic radiographic procedure (to be used for dates of service prior to 01/01/2006 for radiological sueprvision and interpretation, kyphoplasty under fluoroscopic or CT guidance).	X	
91110	GI tract imaging, capsulte endoscopy	X	
95873	Electrical stimulation/chemodenervation	X	
13100-13152	Keloid Revision	X	
21182-21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g. fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	X	
43770-43774	Lap, gastric band	X	
47560-47561	Lap, transhepatic cholangiography	X	
49320-49323	Lap, abd, peritoneium, omentum	X	
51990-51992	Lap, for stress incontinence	X	
54690-54692	Lap, testicle	X	
58545-58546	Lap myomectomy	X	
58550-58554	Lap hysterectomy	X	
58660-58673	Lap, ovary	X	
58970-58976	Lap, in vitro	X	
67971-67975	Reconstruction of eyelid	X	
68320-68340	Conjunctivoplasty	X	
69310-69320	Reconstruction external auditory canal	X	