

CPT Code Changes for 2006

There are 527 code changes (278 new codes, 110 deleted codes, 125 revisions and 14 recycled codes) to *Current Procedural Terminology (CPT®)* for 2006 in addition to numerous changes to the coding guidelines. There are 74 new genetic testing code modifiers. This summary provides a high-level overview of the additions, revisions and deletions to codes for CPT® in 2006, but does not address or imply coverage or reimbursement of a procedure or service, unless noted. A final decision to pay or deny a claim will not be made until a claim has been received and processed according to the member's certificate of coverage and/or the provider contract. Medica accepts all the listed codes. Please consult the 2006 CPT® manual for descriptions, definitions and further directive for claim submission.

Symbols

- Indicates a new procedure number was added to CPT
- ▶ ◀ Indicates revised guidelines, cross-references, and or explanatory test
- ↗ Indicates a code for a vaccine that is pending FDA approval

Appendix – New

Appendix J – Electrodiagnostic Medicine Listing of Sensory, Motor and Mixed Nerves

This summary assigns each sensory, motor, and mixed nerve with its appropriate nerve conduction study code in order to enhance accurate reporting of 95900, 95903 and 95904 (Nerve Conduction Studies).

Appendix K – Product Pending FDA Approval

Some vaccine products have been assigned a CPT Category I code in anticipation of future approval from the FDA. This appendix includes 6 codes that are identified in the CPT book with the ↗ symbol. Upon notification of the approval status by the FDA, notation of the revision will be provided via the AMA and subsequent publications of the CPT codebook. Codes: 90649, 90680, 90698, 90710, 90715, 90736

Appendix L – Vascular Families

This appendix includes an assignment of the branches of a vascular family by first order, second order, third order and beyond third order branches.

Evaluation and Management

Consultations - 99241 - 99255

- If initiated by patient and/or family, and not requested by a physician, codes are **not** reported using the consultation codes, but the office visit codes (99212 – 99205).

Inpatient Consultations – 99251 - 99255

- Submitted *once* by the reporting physician or physician specialty group, for an individual hospital or nursing facility patient for a particular episode of care (length of stay).

Follow-up Inpatient Consultations – 99261 - 99263

- Deleted as they were redundant since other more specific E/M codes are available, e.g., subsequent hospital visit codes 99231 - 99233 and subsequent nursing facility care codes 99307 – 99310.

Confirmatory Consultations – 99271 - 99275

- Deleted as they were redundant as other more specific E/M consultation codes are available, e.g., 99241 - 99245, 99251 – 99255.

Inpatient Neonatal and Pediatric Critical Care Services – 99293 - 99296

- Guidelines revised to include codes 36400, 36405 and 36406 in the list of bundled services.
- Provides consistency among the critical care reporting guidelines.

Continuing Intensive Care Services - 99298 - 99300

- Noncritical care codes for low birth weight infants requiring intensive observation, frequent interventions or other intensive management services.
- 99300 was added for infants weighing 2501 - 5000 grams; NICUs do not limit care to low birth weight premature infants; (>5000 g - reported using subsequent hospital codes 99231 - 99233).

Nursing Facility Services – 99304 - 99310

- Better reflect current practices.
- Driven by various regulations mandated for the care of patient receiving convalescent, rehabilitative, long-term care or psychiatric care in nursing or residential facilities.
- Codes are now consistent in format with other E/M codes.
- Time component has been excluded from the new codes.
- 99318 is for reporting of the comprehensive annual assessment and **cannot** be performed by mid-level providers, must be MD / DO or equivalent.

Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services - 99324 - 99328; 99334 - 99337

- More consistent with other E/M codes.
- Better capture of the level of care provided.
- Can also be used for visits to assisted living facilities.

Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services – 99339 - 99340

- Describes reporting of services for patients with special health care needs and chronic medical conditions provided by primary care physicians who coordinate the medical care management with other medical and nonmedical service providers and family.
- Patient may be located in their home, in a domiciliary site, assisted living facility, etc.
- **Cannot** be submitted if the patient is under the care of a home health agency, a hospice program or a nursing facility resident.
- May encompass oversight of work or school programs the patient may be attending where therapy is provided.
- Billed *once / month*.

ANESTHESIA - 01965 - 01966

- Distinguishes anesthesia services for two different types of abortion procedures, due to potential reimbursement implications for both -
 - Spontaneous (incomplete or missed)
 - Induced

SURGERY

Skin, Subcutaneous and Accessory Structures

- Parenthetical note added under the add-on code 11008 noting that code 49568 is allowed to be submitted for insertion of mesh for closure and repair associated with necrotizing soft tissue infection.

Skin Replacement Surgery and Skin Substitutes, 15040; 15110 - 15431

- Renamed subsection with numerous verbiage revisions to the introductory notes (previous subsection was entitled “Free Skin Grafts”).
- 45 new codes added to this subsection due to technological advancements of materials and grafts for the treatment of skin wounds and for definition synchronization of skin replacements and substitutes.
- Clarification of body areas/sites, size of graft/replacement and consistency with percent of total body surface area involved.

Spine (Vertebral Column) – 22010 - 22015

- Reported for incision and drainage of posterior deep spinal abscesses, by site.

Vertebral Body, Embolization or Injection – 22523 - 22525

- Describes percutaneous vertebral augmentation, including cavity creation using a mechanical device at a single vertebral body.
- Fracture reduction and bone biopsy are incidental and not separately reported.
- 22525 is an add-on code for each additional vertebral body, by site.
- Procedures designed to treat vertebral body compression fractures (VCF) commonly caused by osteoporosis, multiple myeloma, osteolytic metastatic disease, benign lesions, and traumatic fractures.
- **Note:** Medica policy *Percutaneous Vertebroplasty and Kyphoplasty* is available on www.medica.com, Provider Resources, then Medical Policies.

Foot and Toes - 28890

- Identifies additional physician effort required to perform extracorporeal shockwave (ESW) of the plantar fascia versus other ESW procedures.
- Includes ultrasound guidance.
- **Note:** Medica policy *Extracorporeal Shock Wave Treatment for Musculoskeletal Indications* is available on www.medica.com, Provider Resources, then Medical Policies.

Endoscopy / Arthroscopy – 29866 - 29868

- Exclusionary notes added giving instructions as to when arthroscopic removal of foreign bodies (29874) and/or debridement or shaving of articular cartilage (29877) may not be reported with this range of codes.

Nose - 30130; 30140; 30801; 30802; 30930

- Revised to clarify usage specific to the inferior turbinates and primary reporting for procedures performed for the treatment of inferior turbinate hypertrophy causing nasal airway obstruction.
- Eliminates confusion with middle and superior turbinates when other intra-nasal surgeries are performed, i.e., endoscopic sinus surgery.
- Inferior turbinate removal is considered integral to the ethmoidectomy codes (31200 – 31205 and 31254 – 31255) and not separately reported.
- Cross references have also been made regarding nasal hemorrhage control and fracture, cautery or ablation of the turbinates.
- Cross references regarding the appropriate submission of codes 30130 and 30140 at the same session as 30801 or 30802 and 30930.
- **Note:** Medica's coverage policy on *Radiofrequency Volumetric Tissue Reduction (RFVTR) for Breathing Disorders* may have impact on submission of these codes. This policy can be located at www.medica.com, Provider Resources, Medical Policies, then Coverage Policies.

Larynx – 31585 - 31586

- Instructional parenthetical added to report the appropriate E/M when a closed treatment of a larynx fracture without manipulation is performed.
- Codes were deleted as infrequently performed.

Lungs and Pleura - 32002; 32020; 32100; 32503 - 32504

- Parenthetical notes added for codes 32002; 32020; 32100 stating these are not separately reported with codes 19260, 19271, 19272, 32503 and 32504.
- 32503 - 32504 were added for reporting of apical lung resection tumors that typically include lobectomy with resection of the ribs in the thoracic inlet and dissection of the tumor away from the brachial plexus and subclavian artery.

Heart and Pericardium – 33507; 33548; 33768; 33880 – 33891; 33886; 33891; 33925 - 33926

- 33507 was added for repair of coronary artery from an anomalous origin of the aorta (differs from 33502 which is from the pulmonary artery origin).
- 33548 is for an alternative to cardiac transplantation for patients with end-stage cardiac disease with advanced stages of heart failure -
 - bypass surgery frequently performed in addition and is separately reported;
 - codes 32020, 33210 – 33211 and 33310 – 33315 are inherent to 33548;
 - reporting of a Batista or pachopexy procedure, usually performed for nonischemic cardiomyopathy, is submitted with the unlisted code of 33999 (description of procedure required on the CMS-1500 claim form).
- 33768 is an add-on code for treatment of bilateral superior venae cavae at the same session as the complex cardiac anomaly repair procedures 33478, 33617 or 33767 -
 - component procedures (32020, 33210 and 33211) are *not* separately reported.
- 33880 – 33891 = replace Category III codes 0033T – 0040T -
 - codes include all device introduction, manipulation, positioning and deployment and balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, before or after endograft deployment;
 - Balloon angioplasty and/or stent deployment outside the target zone is reported separately;
 - Other codes allowed as separately reportable – 34812, 34820, 34833, 34834, 36200 – 36218, 36140, 75956 and 75957.
- 33886 is reported *once* regardless of the number of graft extensions placed.
- 33891 includes the bypass graft codes 35509 and 35601.

- 33925 – 33926, more accurately describe repair of the pulmonary artery arborization anomalies with or without cardiopulmonary bypass -
 - appending of modifier 63 (procedure on infants <4 kg) is appropriate when performed on neonates and infants up to 4 kg due to the significantly increased complexity.

Arteries and Veins – 36598; 37184 – 37188; 37718 - 37722

- 36598 is commonly provided in the maintenance of central venous access –
 - intended for reporting of evaluation of the position and function of an existing central venous access device;
 - performed more by interventional radiologists.
- 37184 - 37188 are distinguished (from code 35470 – treats diseased vessel wall due to plaque or intimal hyperplasia, without removal of clot) by provision of arterial or venous therapy -
 - thrombus removal, from vessel lumen, is performed for acute limb ischemia, pulmonary embolus or venous occlusion due to thrombus or emboli;
 - code 37201 (pharmacological thrombolysis) is separately reportable when performed same date.
- 37718; 37722 = replace deleted codes 37720 and 37730 respectively -
 - describe the excision of the long or short saphenous veins;
 - unilateral codes, use of modifier 50 (bilateral procedure) is appropriate, when indicated;
 - unusual, but in the off chance that the greater and short saphenous veins are *excised at the same session*, modifier 59 should be utilized;
 - code 37785 is separately reportable with these codes;
 - code 37700 is a component of these codes and not separately reportable.

Digestive System - 43770 – 43774; 43886 – 43888 for Bariatric Surgery

- New subheading in CPT.
- Widely performed procedure entailing placement of a silicone band, via laparoscopic technique, around the upper stomach just below the gastroesophageal junction.
- Patients are usually seen frequently for the gradual serial adjustments to tighten the band until optimal function is obtained.
- Guidelines state that the subsequent band adjustments are included as part of the procedure’s postoperative period and are *not separately reported*.
- **Note: Medica policy *Gastrointestinal Surgery for Morbid Obesity* is published on www.medica.com, Provider Resources then Utilization Management. This service requires prior authorization. Medica allows code S2083 to be submitted for band adjustments necessary after the postoperative period.**

Intestines (Except Rectum) and Rectum - 44180; 44186 – 44188; + 44213; 44227; 45395; 45397; 45400; 45402; 45499; 45990

- Identification of laparoscopic performance of various services.
- Previously only open codes were available and an unlisted needed to be submitted if performed laparoscopically.
- Each code has a corresponding “open” code.
- Subsections are further divided into areas of –
 - excision;
 - repair, and;
 - enterostomy - external fistulization of intestines.
- 45499 is an unlisted code that replaces deleted code 44239 and requires description of service to be documented on the CMS-1500 for processing.
- 45990 includes -
 - external perineal exam;
 - digital rectal exam;
 - pelvic exam (when performed);
 - diagnostic anoscopy;
 - diagnostic rigid proctoscopy;
 - If, during the exam, another procedure is initiated (i.e., colonoscopy), then only the procedure code would be reported.

Anus – 46505; 46710 - 46712

- 46505 is for reporting of a Botox injection into the internal anal sphincter area as another type of medical therapy before surgical intervention -
 - usually results in an equivalent of a surgical lateral internal sphincterotomy;
 - drug code is separately reported.

- 46710 - 46712 allow reporting of circumferential transanal pouch advancement to repair a pouch-vaginal or pouch-perineal fistula or a long exit conduit of an S-pouch.

Kidney – 50250; 50382 – 50389; 50592

- 50250 is a potential treatment option that may result in decreased morbidity and rapid recovery for renal cell cancer patients and will edit for case-by-case review.
- 50382 – 50389 = new subsection in CPT with two sub-headings, *Internally Dwelling* and *Externally Accessible* -
 - codes are differentiated by approach (percutaneous / transurethral);
 - by type (internally / externally dwelling);
 - by removal or removal-replacement;
 - commonly performed for the treatment of ureteral strictures and obstructions.
- 50387 and 50389 – stent removals not requiring fluoroscopic guidance are considered inherent in the E/M.
- 50592 is frequently performed for the treatment of renal masses for inoperative stage IV renal cell carcinoma –
 - will edit for case-by-case review;
 - includes moderate sedation;
 - differs, by approach than the other radiofrequency ablation (RFA) codes (50542, 49200 – 49201);
 - unilateral procedure, use of modifier 50 (bilateral) is appropriate, when indicated.

Bladder – 51999

- New unlisted laparoscopic procedure, bladder that requires description of the procedure to be documented on the CMS-1500.

Vagina – 57295; 57421

- 57295 is performed when a complication (i.e., infection) occurs and the graft material needs to be dealt with surgically -
 - includes removal of the graft (*not* separately reported).
- 57421 is revised to clarify that endometrial biopsies are not included in this code.

Corpus Uteri - 58110

- A new add-on code to be used with codes 57420 – 57421, 57452 – 57461, for reporting of endometrial sampling during a colposcopy.

Skull, Meninges, and Brain – 61630 – 61642

- Intended to treat impaired cerebral circulation.
- 61630 and 61635 include -
 - all related radiological supervision / interpretation;
 - confirmation of the need for angioplasty or stent placement via diagnostic arteriogram (including imaging and selective cath);
 - *do not* report these codes when angioplasty or stenting are *not* performed unless performed in separate vessels;
 - codes *would not* be reported together as 61630 is a component of 61635.
- 61640 – 61642 includes -
 - all selective vascular cath of the target vessel;
 - contrast injection(s);
 - vessel measurement;
 - roadmapping;
 - post-dilatation angiography;
 - fluoroscopic guidance for balloon dilatation;
 - *none* of these services are to be separately reported.

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System – 64613; 64650 - 64653

- 64613 is revised to specify neck muscle(s) rather than cervical spinal muscle(s) for treatment of spasmodic dysphonia.
- 64650 - 64653 were created as existing codes did not adequately describe structures like eccrine sweat glands.
- 64653 is *per day*, regardless of the number of injections per session.
- **Note:** Medica policy *Botulinum Toxin (BTX) Treatment for Non-Cosmetic Indications* can be accessed via www.medica.com, Provider Resources, Medical Policies, then Coverage Policies.

Ocular Adnexa - 67901 - 67902

- Revised to reflect use of banked fascial strips, which requires harvesting of the fascia with a fascial stripper from the same patient (autologous) for repair of an eyelid defect (i.e., brow ptosis, blepharoptosis).

RADIOLOGY

- **Therapeutic transcatheter supervision and interpretation codes:**
 - **75958** is reported one time for placement of **each** proximal graft extension.
 - **75959** is reported **one time**, regardless of the number of graft extensions placed during a session and is *not reported* in addition to 75956 or 75957.
- **76376 - 76377** were added to report current technology of 3-dimensional imaging.
- **77422 – 77423** allow tracking and monitoring of neutron therapy and the ability to differentiate the type of radiation therapy reported.

LABORATORY

- **80195** is new test to monitor drug levels of Sirolimus, which is a medication for solid organ transplants.
- **82270** (revised) = reporting of evaluation of triple sample specimens with single determination, which is essential for proper screening -
 - reported once regardless of number of specimens sent to lab
- **82271** replaces deleted code 82273 (same as 82270 only from other sources).
- **82272** is for single specimen reporting, usually performed in office at time of exam (guaiac).
- **83037** is used when an FDA approved Hgb A1C device (usually used at home) is utilized for an immediate result during a face-to-face encounter in a clinic or outpatient setting.
- **83631** is used to -
 - determine the presence of intestinal inflammation;
 - differentiate inflammatory from non-inflammatory GI disease;
 - monitor patient response to therapy;
 - predict inflammatory bowel disease recurrence.
- **83695; 83700; 83701; 83704** are indicators for -
 - increased risk for myocardial infarction;
 - stroke;
 - coronary artery disease;
 - vein graft restenosis;
 - retinal arterial occlusions when present in elevated blood concentrations.
- **83900; 83901; 83907; 83908; 83909** are new and revised codes used in a wide variety of clinical diagnostic tests for -
 - infectious agents;
 - DNA-based disease markers;
 - therapy selection in oncology;
 - predictors of inherited genetic disorders.
- **83914** is used to report mutation identification.
- **86200** aids in the diagnosis of rheumatoid arthritis.
- **86355; 86357; 86367** are new and relocated replacement codes for Category III codes.
- **86480** replaces deleted category III code 0010T -
 - describes TB testing by cell-mediated immunity measurement of gamma interferon antigen response (blood test).
- **86923** is for reporting of a pretransfusion electronic crossmatch test for reporting services when lab information system verifies ABO compatibility of the unit of blood with the intended recipient.
- **86960** is for volume reduction routinely done to reduce the amount of ABO incompatible plasma from the platelets (or rarely a red blood cell component) that are to be transfused.
- **87209** is added to describe complex special stains for ova and parasites.
- **87900** replaces deleted category III code 0023T -
 - used in the management of HIV patient on antiretroviral therapy.
- **88333 - 88334** are for reporting of intraoperative cytologic exam (via touch or squash prep) *and consultation* to provide immediate diagnosis during an intraoperative consultation without the involvement of frozen section.
- **88384 - 88386** are for reporting array-based evaluation of multiple molecular probes.
- **89049** is for identification of individuals who are susceptible to malignant hyperthermia (MH) which becomes evident upon exposure to certain common anesthetic agents during surgery.

MEDICINE

Vaccines and Immunizations – 90649; 90736

- 90649 is a vaccine product intended for use in individuals 9 - 26 yrs of age -
 - developed to offer protection against the common types of human papilloma virus (HPV);
 - currently not FDA approved (**not billable at this time**).
- 90736 is a vaccine provided to reduce the occurrence, severity, and duration of shingles pain -
 - expected to be administered to older adults;
 - currently not FDA approved (**not billable at this time**).

Hydration – 90760 - 90761

- For reporting of an IV infusion consisting of a pre-packaged fluid and electrolytes.
- Require direct physician supervision.

Therapeutic, Prophylactic and Diagnostic Injections and Infusions - 90765 - 90779

- Used for the administration of substances / drugs.
- Typically require direct physician supervision.
- IV or intra-arterial push is defined as -
 - an injection in which the provider who administers the substance/drug is continuously present to administer the injection and observe the patient;
 - an infusion of 15 minutes or less (reported with code 90744 or 90775).
- Please see separate document on “*Therapeutic, Prophylactic and Diagnostic Injection Policy Update*”, posted on this website under “2006 1st Quarter CPT Code Update”.

Gastroenterology - 91022

- Indicated in pediatric and adult patients with unexplained nausea / vomiting, particularly when gastric emptying is normal or equivocal.
- Or when severe symptoms persist despite therapeutic trials.

Ophthalmology

- 92330 - 92335; 92390 - 92396 have been deleted.
- If prescription, fitting and/or medical supervision of ocular prosthetic adaptation by a physician is provided, submit the E/M (99212 – 99205) or the ophthalmological (92002 – 92014) codes.
- HCPCS "V" codes (V2020 – V2790) should be submitted for the supply of lenses, spectacles and other visual aids and prosthetics.

Special ENT Services – 92506 - 92507; 92520; 92626 - 92633

- 92506 is intended for use by speech language pathologists for assessment of speech-reading (lip reading) abilities.
- 92507 is intended to be reported for services provided for the hearing impaired individual who does not use a hearing aid or cochlear implant and needs assistance to improve listening under adverse environmental conditions.
- 92520 was revised to clarify code is for aerodynamic testing (measures average airflow, peak airflow, vocal efficiency and subglottal pressure) and acoustic testing (measures pitch, loudness, jitter, shimmer, signal-to-noise ratio and spectral analysis) -
 - append modifier -52 (reduced services) if only one test done.
- 92626 – 92627 is to determine -
 - current abilities to instruct the use of residual hearing provided by a cochlear implant or hearing aid;
 - assessment addresses (in children and adults) dimensions of impairment;
 - activity limitation;
 - participation restriction;
 - applicable environmental and contextual factors;
 - invalid for Medicare submission when performed by an audiologist, as the codes represent therapeutic services rather than diagnostic services (Medicare allows audiologists to submit diagnostic, not therapeutic services – *Federal Register, Nov 21, 2005, pg 70281*).
- 92630 - 92633 is performed primarily for pediatric patients -
 - with no prior experience with hearing and are learning to hear through the use of hearing aids or cochlear implants;
 - can also be reported for rehabilitation of adults who have received a cochlear implant after a long period of time during which they had no functional hearing to assist in achieving speech understanding and identification of sound in a shorter time span.

Endocrinology

- **95251** is for the reporting the physician interpretation and report component of the glucose monitoring service (92550).

Neurology and Neuromuscular Procedures

- **95865** reported for diagnosing laryngeal nerve and muscle disorders, for intraoperative monitoring and during botox injections in the laryngeal muscles.
- **95866** reported for diagnosing respiratory muscle disorders and (less frequently) for intraoperative monitoring.
- **95873 - 95874** are add on codes sometimes necessary to perform a more precise localization for needle placement before the chemical is injected.

Central Nervous System Assessments/Tests

- **96101** is a test administration by psychologist or psychiatrist with subsequent interpretation and report.
- **96102** is reported for the technician-administered testing -
 - 96101 is reported in addition for the physician interpretation and report.
- **96103** is reported for the computer-administered testing –
 - 96101 is reported in addition for the physician interpretation and report
- **96116** is for performance of gathering information to provide an important first analysis of brain dysfunction and the progression and changes in the symptoms over time.
- **96118** is the test administration by the psychologist or psychiatrist with subsequent interpretation and report.
- **96119** is reported for the technician administered neuropsychological testing –
 - 96118 is reported in addition for the physician interpretation and report.
- **96120** is reported for the computer-assisted neuropsychological testing -
 - 96118 is reported in addition for the physician interpretation and report.

Chemotherapy Administration – 96401 - 96523

- Apply to parenteral administration of –
 - non-radionuclide anti-neoplastic drugs;
 - anti-neoplastic agents provided for the treatment of noncancer diagnosis(es);
 - substances such as monoclonal antibody agents and other biologic response modifiers.
- Can be provided and billed by any physician type.
- Requires direct physician supervision.
- If multiple infusions, only **one initial** service code may be submitted, *unless* there are 2 or more separate IV sites *or* the patient is seen in 2 or more separately identifiable encounters on the same date of service.
- Separate codes for each parenteral method of administration are allowed when employed for chemotherapy administered by different techniques.
- Please see separate document on “*Drug Administration Services Code Changes*”, posted on this website under “2006 1st Quarter CPT Code Update”.

Orthotic Management and Prosthetic Management – 97760 - 97762

- Includes assessing the patient; determining the most appropriate orthotic (e.g., static vs dynamic); and designing, selecting and fabricating the orthotic.
- 97760 – 97761 allow further orthotic/prosthetic training during follow-up visits including exercises performed in the orthotic/prosthetic, instruction in skin care and orthotic/prosthetic wearing time.
- 97762 is the replacement for deleted code 97703 –
 - reported for the assessment for determination of an established patient's response to the orthotic/prosthetic including redness and/or pressure areas and making any necessary adjustments.

Education and Training for Patient Self-Management - 98960 - 98962

- For the reporting of educational and training services designed to teach patients how to effectively self-manage illness(es) or disease(es).
- Performed by a *qualified nonphysician health care professional* using a standardized curriculum.
- Must be prescribed by a physician but performed by a nonphysician.
- Qualifications of the nonphysician health care professional and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society or nonphysician health care professional society or association or other appropriate source.
- **Note: Medica will allow these codes for *diabetes diagnoses only* (ICD 9 codes 250.00 – 250.93) for Commercial and Medicaid products. Other conditions and diagnoses submitted will be denied 031 – services not covered per benefit package.**

- **NOTE: non-covered for Medicare as other codes exist for Diabetes Self-Management Services** – *Federal Register, November 21, 2005, pg 70282.*

Moderate Sedation - 99143 - 99150

- Drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.
- No interventions are required to maintain a patent airway and spontaneous ventilation is adequate.
- Cardiovascular function is usually maintained.
- Not to be submitted for average risk patient undergoing standard upper and lower endoscopic procedures per publicly published statements from the Gastroenterological Associations and Societies.
- **CCI edits will apply, if applicable.**
- Also see separate document on “*Moderate / Conscious Sedation Services*” posted on www.medica.com, **Tools and Forms, Reimbursement/Claims Policies.**

Category II Codes

- **0001F - 4018F** are used for data collection by many national committees reviewing performance and quality of care measurements.
- There are no revenue codes designated for Category II; therefore, expectation is these codes would not be submitted on a UB-92 by a facility.
- Medica will be denying these codes, reason 059 (included in primary service).

Category III Codes 0141T – 0153T

These codes do not appear in the CPT manual, however, per the American Medical Association (<http://www.ama-assn.org/ama/pub/category/3885.html>), these codes are valid and active, effective January 1, 2006.

- 0141T – 0143T are a member certificate of coverage exclusion and should deny reason 031 – noncovered service per benefit package and will deny as member liability.
- 0144T requires prior authorization;
 - **Note: Medica Utilization Management Policy *Computed Tomography (CT), Including Electron Beam (EBCT), Helical, Multi-Detector (MDCT) and Multi-Row (MRCT) for Coronary Artery Calcium Scoring (CACS)* can be accessed at www.medica.com, Provider Resources, Medical Policies, then Utilization Management.**
- 0145T – 0151T are considered investigational;
 - **Note: Medica Policy *Non-Invasive Coronary Angiography* can be accessed at www.medica.com, Provider Resources, Medical Policies, then Coverage Policies.**
- 0152T is a physician only service that will deny reason 059 – included in primary service.
- 0153T will edit for manual review.
- 0154T is a physician only service that will deny reason 059 – included in primary service. (Note: effective date is being determined as it was released in the 2006 AMA CPT code release, however, the above AMA website has it listed as being effective 7/1/06. Verification is pending.)