CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10557	**Date: January 8, 2021**
	Change Request 12129

Transmittal 10546, dated December 31, 2020, is being rescinded and replaced by Transmittal 10557, dated, January 8, 2021 to correct Attachment B with the addition of missing existing HCPCS J0390, J0745, J2560, 0583T, and Q5118. All other information remains the same.

SUBJECT: January 2021 Update of the Ambulatory Surgical Center (ASC) Payment System

I. SUMMARY OF CHANGES: This recurring update notification describes changes to and billing instructions for various payment policies implemented in the January 2021 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 10557	Date: January 8, 2021	Change Request: 12129

Transmittal 10546, dated December 31, 2020, is being rescinded and replaced by Transmittal 10557, dated, January 8, 2021 to correct Attachment B with the addition of missing existing HCPCS J0390, J0745, J2560, 0583T, and Q5118. All other information remains the same.

SUBJECT: January 2021 Update of the Ambulatory Surgical Center (ASC) Payment System

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

I. GENERAL INFORMATION

A. Background: This recurring update notification describes changes to and billing instructions for various payment policies implemented in the January 2021 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Calendar Year (CY) 2021 payment rates for separately payable procedures/services, drugs and biologicals, including descriptors for newly created Current Procedural Terminology (CPT) and Level II HCPCS codes, are included in this notification. A January 2021 Ambulatory Surgical Center Fee Schedule (ASCFS) File, January 2021 Ambulatory Surgical Center Payment Indicator (ASC PI) File, a January 2021 Ambulatory Surgical Center Drug File, a January 2021 ASC Code Pair file, and a revised July 2020 ASC Code Pair file will be issued through this transmittal.

B. Policy: 1. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the Outpatient Prospective Payment System (OPPS), categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3) years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. This policy was implemented in the 2008 revised ASC payment system. Therefore, additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the OPPS.

We are establishing three new device pass-through categories as of January 1, 2021. Table 1, describes these categories. (see Attachment A: Policy Section Tables).

a. Device Offset from Payment:

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices in the OPPS an amount that reflects the device portion of the Ambulatory Payment Classification (APC) payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device. This policy was implemented in the 2008 revised ASC payment system.

We have determined that there are device offset amounts associated with each of the new device pass-through categories effective January 1, 2021, that are included in table 1. (see Attachment A: Policy Section Tables).

There are also device offset amount changes associated with existing device pass-through HCPCS C1839, C1748, and C1982.

i. We have determined the device offset amounts for OPPS APC 5491 Level 1 Intraocular Procedures and OPPS APC 5492 Level 2 Intraocular Procedures that are associated with the costs of the device category described by HCPCS code C1839 (Iris prosthesis). The device in the category described by HCPCS code C1839 should always be billed by ASCs with one of the following CPT codes:

- CPT code 0616T - Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens, which is assigned to OPPS APC 5491 for CY 2021;

- CPT code 0617T - Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens, which is assigned to OPPS APC 5492 for CY 2021;

- CPT code 0618T - Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange, which is assigned to OPPS APC 5492 for CY 2021;

ii. We have determined the device offset amount for OPPS APC 5465 (Level 5 Neurostimulator and Related Procedures) that is associated with the cost of the device category described by HCPCS code C1825 (Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)). The device in the category described by HCPCS code C1825 should be billed by ASCs with the following CPT code:

- CPT code 0266T (Implt/rpl crtd sns dev total), which is assigned to OPPS APC 5465 for CY 2021;

iii. We have determined the device offset amounts for OPPS APC 5302 (Level 2 Upper Gastrointestinal (GI) Procedures) and OPPS APC 5312 (Level 2 Lower GI Procedures) that are associated with the cost of the device category described by HCPCS code C1052 (Hemostatic agent, gastrointestinal, topical). The device in the category described by HCPCS code C1052 should always be billed by ASCs with one of the following CPT codes:

- CPT code 43227 (Esophagoscopy control bleed), which is assigned to OPPS APC 5302 for CY 2021;

- CPT code 43255 (Egd control bleeding any), which is assigned to OPPS APC 5302 for CY 2021;

- CPT code 44366 (Small bowel endoscopy), which is assigned to OPPS APC 5302 for CY 2021;

- CPT code 44378 (Small bowel endoscopy), which is assigned to OPPS APC 5302 for CY 2021;
- CPT code 44391 (Colonoscopy for bleeding), which is assigned to OPPS APC 5312 for CY 2021;
- CPT code 45334 (Sigmoidoscopy for bleeding), which is assigned to OPPS APC 5312 for CY 2021;
- CPT code 45382 (Colonoscopy w/control bleed), which is assigned to OPPS APC 5312 for CY 2021;

iv. We have determined the device offset amount for OPPS APC 5114 (Level 4 Musculoskeletal Procedures) that is associated with the cost of the device category described by HCPCS code C1062 (Intravertebral body fracture augmentation with implant (e.g., metal, polymer). The device in the category described by HCPCS code C1062 should always be billed with one of the following CPT codes:

- CPT code 22513 (Perq vertebral augmentation), which is assigned to OPPS APC 5114 for CY 2021;
- CPT code 22514 (Perq vertebral augmentation), which is assigned to OPPS APC 5114 for CY 2021;

v. On July 1, 2020, we determined that an offset would apply to HCPCS code C1748 (Endoscope, single-use, (i.e. disposable), Upper GI, imaging/illumination device (insertable)) because OPPS APC 5303 (Level 3 Upper GI Procedures) and OPPS APC 5331 (Complex GI Procedures) already contain costs associated with the device described by HCPCS code C1748. HCPCS code C1748 should always be billed with the CPT codes listed below. The device offset is a deduction from pass-through payments for HCPCS code C1748. After further review, we have determined that the costs associated with HCPCS code C1748 are not already reflected in OPPS APCs 5303 or 5331. Therefore, we are not applying a device offset to HCPCS code C1748. This determination to not apply the device offset from payment will be retroactive to July 1, 2020. Effected claims shall be reprocessed by the Medicare Administrative Contractors (MACs).

- CPT code 43260 (Ercp w/specimen collection), which is assigned to OPPS APC 5303 for CY 2021;
- CPT code 43261 (Endo cholangiopancreatograph), which is assigned to OPPS APC 5303 for CY 2021;
- CPT code 43262 (Endo cholangiopancreatograph), which is assigned to OPPS APC 5303 for CY 2021;
- CPT code 43263 (Ercp sphincter pressure meas), which is assigned to OPPS APC 5303 for CY 2021;
- CPT code 43264 (Ercp remove duct calculi), which is assigned to OPPS APC 5303 for CY 2021;

- CPT code 43265 (Ercp lithotripsy calculi), which is assigned to OPPS APC 5331 for CY 2021;
- CPT code 43274 (Ercp duct stent placement), which is assigned to OPPS APC 5331 for CY 2021;
- CPT code 43275 (Ercp remove forgn body duct), which is assigned to OPPS APC 5303 for CY 2021;
- CPT code 43276 (Ercp stent exchange w/dilate), which is assigned to OPPS APC 5331 for CY 2021;
- CPT code 43277 (Ercp ea duct/ampulla dilate), which is assigned to OPPS APC 5303 for CY 2021;
- CPT code 43278 (Ercp lesion ablate w/dilate), which is assigned to OPPS APC 5303 for CY 2021;

vi. We have determined the device offset amount for APC 2025 (Cath, pressure, valve-occlu) that is associated with the cost of the device category described by HCPCS code C1982 (Cath, pressure, valve-occlu). The device in the category described by HCPCS code C1982 may be billed with the following CPT code:

- CPT code 37242 (Vasc embolize/occlude artery), which is assigned to APC 5193 for CY 2021

2. Device Pass-Through Payments

Per transmittal 1325, communicated December 7, 2007, ASC pass-through device pricing is based on acquisition cost or invoice. Provider education regarding ASC pass-through device pricing, as well as billing guidance associated with MAC processing of pass-through device claims, shall be posted to the MAC websites.

3. New HCPCS Code Describing the Administration of Subretinal Therapies Requiring Vitrectomy

CMS is establishing a new HCPCS code C9770, to describe a vitrectomy, mechanical, pars plana approach, with subretinal injection of a pharmacologic or biologic agent. Table 2, lists the HCPCS, short descriptor, long descriptor, and ASC PI. (see Attachment A: Policy Section Tables).

4. New HCPCS Code Describing Nasal Endoscopy with Cryoablation of Nasal Tissue(s) and/or Nerve(s)

CMS is establishing HCPCS code C9771 to describe the technology associated with nasal endoscopy with cryoablation of nasal tissues and/or nerves. Table 3, lists the HCPCS, short descriptor, long descriptor, and ASC PI. (see Attachment A: Policy Section Tables).

5. New HCPCS Codes Describing Peripheral Intravascular Lithotripsy (IVL) Procedures

For the January 2021 update, CMS is establishing four additional new HCPCS codes to describe the technology associated with the IVL procedure, which has integrated lithotripsy emitters and is designed to enhance percutaneous transluminal angioplasty by enabling delivery of the calcium disrupting capability of lithotripsy prior to full balloon dilatation at low pressures. The application of lithotripsy mechanical pulse waves alters the structure of an occlusive vascular deposit (stenosis) prior to low-pressure balloon dilation of the stenosis and facilitates the passage of blood and is used for the treatment of Peripheral Artery Disease (PAD). Specifically, CMS is establishing HCPCS code C9772, C9773, C9774, and C9775 to describe the surgical procedures

utilizing IVL. Table 4, lists the HCPCS, short descriptors, long descriptors, and ASC PIs. (see Attachment A: Policy Section Tables).

6. Removal of Selected National Coverage Determinations Effective January 1, 2021

As stated in the CY 2021 Physician Fee Schedule (PFS) final rule with comment period, effective January 1, 2021, CMS removed certain National Coverage Determinations (NCD). See Table 5, for the NCD name and manual citation. (see Attachment A: Policy Section Tables).

As a result of this change, the coverage determinations for the procedures, services, and items associated with the NCDs listed above will be made by the local MAC. In addition, we revised the ASC PIs for the codes listed in Table 6, from ASC PI = "Y5" (Non-Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) to the ASC PIs listed in Table 6. (see Attachment A: Policy Section Tables).

7. Existing HCPCS Codes for Certain Drugs and Biologicals That Will Start to Receive Separate Payment

There is 1 existing HCPCS codes for certain drugs and biologicals in the ASC setting that will start to receive separate payment beginning on January 1, 2021. The HCPCS code is listed below in Table 7. (see Attachment A: Policy Section Tables).

8. Newly Established HCPCS Codes for Drug and Biologicals Effective January 1, 2021

Fifteen (15) new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment effective January 1, 2021. These HCPCS codes are listed in Table 8. The HCPCS codes listed in the "old HCPCS codes" column, are deleted effective January 1, 2021. (see Attachment A: Policy Section Tables).

9. Retroactive Correction for HCPCS J1097 Effective October 1, 2020

Effective October 2020, HCPCS J1097 (Phenylep ketorolac opth soln), brand name Omidria, became separately payable in the ASC payment system. A payment rate was not available to the MACs as part of the October release in the ASC payment system. Consequently, ASCs that may have submitted claims for this drug, may not have been paid correctly.

Retroactively, HCPCS J1097 is separately payable for ASC claims with dates of service beginning October 1, 2020.

Suppliers who think they may have previously received an incorrect payment or incorrect disposition associated with this correction for J1097, for claims beginning October 1, 2020, may request contractor adjustment of the previously processed claims.

10. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2021, payment for nonpass-through drugs and biologicals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In addition, in CY 2021, a single payment of ASP + 6 percent continues to be made for OPPS pass-through drugs, and biologicals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective

January 1, 2021, can be found in the January 2021 update of ASC Addendum BB on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html

a. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals with payment rates based on the ASP methodology may have their payment rates corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the CMS Web site on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request contractor adjustment of the previously processed claims.

11. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for hospital Outpatient Orospective Payment System (OPPS) pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. High cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT code 15271-15278. Please note that the final rule skin substitute table incorrectly assigned Q4222 (Progenamatrix, per sq cm) to the low cost group when it should have been assigned to the high cost group for January. This correction is currently reflected in all relevant January ASC payment files and tables.

Table 9, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. (see Attachment A: Policy Section Tables).

Note that ASCs should not separately bill for packaged skin substitutes (ASC PI=N1) since packaged codes are not reportable under the ASC payment system.

12. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12129.1	Contractors shall download the January 2021 ASC Fee Schedule (FS) from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY21.FS.JANA.V1204 NOTE: The January 2021 ASCFS is a full update. **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC
12129.2	Medicare contractors shall download and install the January 2021 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY21.DRUG.JANA.V1218 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC
12129.3	Medicare contractors shall download and install the January 2021 ASC Payment Indicator (PI) file. FILENAME: MU00.@BF12390.ASC.CY21.PI.JANA.V1211 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12129.4	Medicare contractors shall download and install the January 2021 ASC Code Pair file. FILENAME: MU00.@BF12390.ASC.CY21.CP.JANA.V1204 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC
12129.5	Medicare contractors shall download and install the July 2020 ASC Code Pair file. FILENAME: MU00.@BF12390.ASC.CY20.CP.JULB.V1218 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC
12129.6	Contractors and Common Working File (CWF) shall add Type of Service (TOS) F, as appropriate, for HCPCS included in attachment A, tables 1-4, and 6-8 effective for services January 1, 2021 and later payable in the ASC setting.		X						X	
12129.7	Contractors and CWF shall end date, as appropriate, the CY 2020 HCPCS/CPT codes in table 8 in their systems, effective December 31, 2020.		X						X	
12129.8	CWF, as appropriate, shall remove the TOS F records as appropriate, the CY 2020 HCPCS/CPT codes in table 8, effective December 31, 2020.								X	
12129.9	If released by CMS, Medicare contractors shall download and install the revised October 2020 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY20.DRUG.OCTB.V1218		X							VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: Date of retrieval will be provided in a separate email communication from CMS.									
12129.9.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service October 1, 2020 - December 31, 2020 and; 2) Were originally processed prior to the installation of the revised October 2020 ASC DRUG File.		X							
12129.10	If released by CMS, Medicare contractors shall download and install the revised July 2020 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY20.DRUG.JULC.V1218 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC
12129.10.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service July 1, 2020 - October 31, 2020 and; 2) Were originally processed prior to the installation of the revised July 2020 ASC DRUG File.		X							
12129.11	If released by CMS, Medicare contractors shall download and install the revised April 2020 ASC DRUG file.		X							VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	FILENAME: MU00.@BF12390.ASC.CY20.DRUG.APRD.V1218 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**									
12129.11.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service April 1, 2020 - June 30, 2020 and; 2) Were originally processed prior to the installation of the revised April 2020 ASC DRUG File.		X							
12129.12	If released by CMS, Medicare contractors shall download and install the revised January 2020 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY20.DRUG.JAND.V1218 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDC
12129.12.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service January 1, 2020 - March 31, 2020 and;		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2) Were originally processed prior to the installation of the revised January 2020 ASC DRUG File.									
12129.13	Contractors shall search for and reprocess within 30 days, as appropriate, claims with C1748 that resulted in the code pair procedure offset, for claims with dates of service beginning July 1, 2020 through implementation of this transmittal.		X						X	
12129.14	Contractors shall make January 2021 ASCFS fee data for their ASC payment localities available on their web sites.		X							
12129.15	Contractors shall notify CMS of successful receipt via e-mail to price_file_receipt@cms.hhs.gov stating the name of the file received, (e.g., CLAB, ASP, etc.) and the entity for which it was received (i.e., include states, carrier numbers, quarter, and if Part A, Part B, or both).		X							VDC
12129.16	Common Working File (CWF) shall add Type of Service (TOS) F, as appropriate, for HCPCS included in attachment B, effective for services January 1, 2021 and later payable in the ASC setting. NOTE: attachment B is included in this transmittal to support this business requirement. NOTE: this separate CWF requirement is to be implemented in addition to other requirements already appearing in this transmittal with CWF responsibility.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12129.17	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.		X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
1-4, 6-8	Attachment A: POLICY SECTION TABLES
16	Attachment B: BUSINESS REQUIREMENT 12129.16 TABLE

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Chuck Braver, 410-786-6719 or chuck.braver@cms.hhs.gov (ASC Payment Policy) , Yvette Cousar, 410-786-2160 or yvette.cousar@cms.hhs.gov (B MAC Claims Processing Issues)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Attachment A − Policy Section Tables

Table 1. — New Device Pass-Through Codes Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C1825	Gen, neuro, carot sinus baro	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	J7
C1052	Hemostatic agent, gi, topic	Hemostatic agent, gastrointestinal, topical	J7
C1062	Intravertebral fx aug impl	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	J7

Table 2. — New HCPCS Code Describing the Administration of Subretinal Therapies Requiring Vitrectomy Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9770	Vitrec/mech pars, subret inj	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent	G2

Table 3. — New Nasal Endoscopy with Cryoablation of Nasal Tissues and/or Nerves HCPCS Code Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9771	Nsl/sins cryo post nasal tis	Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral	J8

Table 4. — New HCPCS Codes Describing Peripheral Intravascular Lithotripsy (IVL) Procedures Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9772	Revasc lithotrip tibi/perone	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	J8
C9773	Revasc lithotr-stent tib/per	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	J8
C9774	Revasc lithotr-ather tib/per	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	J8
C9775	Revasc lith-sten-ath tib/per	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	J8

Table 5. ─ Elimination of Selected National Coverage Determinations (NCDs)

Effective January 1, 2021

NCD Manual Citation	Name of NCD
20.5	Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
30.4	Electrosleep Therapy
100.9	Implantation of Gastroesophageal Reflux Device
110.19	Abarelix for the Treatment of Prostate Cancer
220.2.1	Mangenetic Resonance Spectroscopy
220.6.16	FDG PET for Inflammation and Infection

Table 6. ─ Revised ASC PIs for Designated NCDs

HCPCS	Short Descriptor	Long Descriptor	ASC PI
76390	Mr spectroscopy	Magnetic resonance spectroscopy	Z2
0609T	Mrs disc pain acquisj data	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	Z2
0611T	Mrs disc pain alg alys data	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	Z2
G0235	Pet not otherwise specified	Pet imaging, any site, not otherwise specified	Z2

Table 7. ─ Existing HCPCS Codes for Certain Drugs and Biologicals That Will Start to Receive Separate Payment

HCPCS	Short Descriptor	Long Descriptor	ASC PI
J9198	Inj. infugem, 100 mg	Gemcitabine hydrochloride, (infugem), 100 mg	K2

Table 8. ─ Newly Established HCPCS Codes for Drug and Biologicals Effective January 1, 2021

New HCPCS Code	Old HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
A9591	C9060	Fluoroestradiol f 18	Fluoroestradiol F 18, diagnostic, 1 millicurie	K2
C9068	N/A	Copper cu-64, dotatate, dx	Copper Cu-64, dotatate, diagnostic, 1 millicurie	K2
C9069	N/A	Belantamab mafodontin-blmf	Injection, belantamab mafodontin-blmf, 0.5 mg	K2
C9070	N/A	Injection, tafasitamab-cxix	Injection, tafasitamab-cxix, 2 mg	K2
C9071	N/A	Injection, viltolarsen	Injection, viltolarsen, 10 mg	K2
C9072	N/A	Inj, imm glob asceniv	Injection, immune globulin (asceniv), 500 mg	K2
J0693	N/A	Inj., cefiderocol, 5 mg	Injection, cefiderocol, 5 mg	K2

New HCPCS Code	Old HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
J1823	N/A	Inj. inebilizumab-cdon, 1 mg	Injection, inebilizumab-cdon, 1 mg	K2
J7212	N/A	Factor viia recomb sevenfact	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	K2
J7352	N/A	Afamelanotide implant, 1 mg	Afamelanotide implant, 1 mg	K2
J9144	C9062	Daratumumab, hyaluronidase	Injection, daratumumab, 10 mg and hyaluronidase-fihj	K2
J9223	N/A	Inj. lurbinectedin, 0.1 mg	Injection, lurbinectedin, 0.1 mg	K2
J9281	C9064	Mitomycin instillation	Mitomycin pyelocalyceal instillation, 1 mg	K2
J9316	N/A	Pertuzu, trastuzu, 10 mg	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	K2
J9317	C9066	Sacituzumab govitecan-hziy	Injection, sacituzumab govitecan-hziy, 2.5 mg	K2

Table 9. — Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2021

CY2021 HCPCS Code	CY2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
C1849	Skin substitute, synthetic	High	High
C9363	Integra meshed bil wound mat	High	High*
Q4100	Skin substitute, nos	Low	Low
Q4101	Apligraf	High	High
Q4102	Oasis wound matrix	Low	Low
Q4103	Oasis burn matrix	High	High*
Q4104	Integra bmwd	High	High
Q4105	Integra drt or omnigraft	High	High
Q4106	Dermagraft	High	High
Q4107	Graftjacket	High	High
Q4108	Integra matrix	High	High*
Q4110	Primatrix	High	High*
Q4111	Gammagraft	Low	Low
Q4115	Alloskin	Low	Low
Q4116	Alloderm	High	High
Q4117	Hyalomatrix	Low	Low
Q4121	Theraskin	High	High*
Q4122	Dermacell, awm, porous sq cm	High	High
Q4123	Alloskin	High	High
Q4124	Oasis tri-layer wound matrix	Low	Low
Q4126	Memoderm/derma/tranz/integup	High	High
Q4127	Talymed	High	High*
Q4128	Flexhd/allopatchhd/matrixhd	High	High
Q4132	Grafix core, grafixpl core	High	High
Q4133	Grafix stravix prime pl sqcm	High	High
Q4134	Hmatrix	Low	Low
Q4135	Mediskin	Low	Low

CY2021 HCPCS Code	CY2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
Q4136	Ezderm	Low	Low
Q4137	Amnioexcel biodexcel, 1 sq cm	High	High
Q4138	Biodfence dryflex, 1cm	High	High
Q4140	Biodfence 1cm	High	High
Q4141	Alloskin ac, 1cm	High	High*
Q4143	Repriza, 1cm	High	High
Q4146	Tensix, 1cm	High	High
Q4147	Architect ecm px fx 1 sq cm	High	High
Q4148	Neox neox rt or clarix cord	High	High
Q4150	Allowrap ds or dry 1 sq cm	High	High
Q4151	Amnioband, guardian 1 sq cm	High	High
Q4152	Dermapure 1 square cm	High	High
Q4153	Dermavest, plurivest sq cm	High	High
Q4154	Biovance 1 square cm	High	High
Q4156	Neox 100 or clarix 100	High	High
Q4157	Revitalon 1 square cm	High	High*
Q4158	Kerecis omega3, per sq cm	High	High*
Q4159	Affinity 1 square cm	High	High
Q4160	Nushield 1 square cm	High	High
Q4161	Bio-connekt per square cm	High	High
Q4163	Woundex, bioskin, per sq cm	High	High
Q4164	Helicoll, per square cm	High	High
Q4165	Keramatrix, kerasorb sq cm	Low	Low
Q4166	Cytal, per square centimeter	Low	Low
Q4167	Truskin, per square centimeter	Low	High
Q4169	Artacent wound, per sq cm	High	High
Q4170	Cygnus, per sq cm	Low	Low
Q4173	Palingen or palingen xplus	High	High
Q4175	Miroderm	High	High
Q4176	Neopatch, per sq centimeter	High	High
Q4178	Floweramniopatch, per sq cm	High	High
Q4179	Flowerderm, per sq cm	High	High
Q4180	Revita, per sq cm	High	High
Q4181	Amnio wound, per square cm	High	High
Q4182	Transcyte, per sq centimeter	Low	High
Q4183	Surgigraft, 1 sq cm	High	High
Q4184	Cellesta or duo per sq cm	High	High*
Q4186	Epifix 1 sq cm	High	High
Q4187	Epicord 1 sq cm	High	High
Q4188	Amnioarmor 1 sq cm	Low	High
Q4190	Artacent ac 1 sq cm	Low	High
Q4191	Restorigin 1 sq cm	Low	Low
Q4193	Coll-e-derm 1 sq cm	Low	High
Q4194	Novachor 1 sq cm	High	High*
Q4195	Puraply 1 sq cm	High	High
Q4196	Puraply am 1 sq cm	High	High
Q4197	Puraply xt 1 sq cm	High	High
Q4198	Genesis amnio membrane 1 sqcm	Low	High
Q4200	Skin te 1 sq cm	Low	High

CY2021 HCPCS Code	CY2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
Q4201	Matrion 1 sq cm	Low	Low
Q4203	Derma-gide, 1 sq cm	High	High*
Q4204	Xwrap 1 sq cm	Low	Low
Q4205	Membrane graft or wrap sq cm	High	High
Q4208	Novafix per sq cm	High	High
Q4209	Surgraft per sq cm	Low	High
Q4210	Axolotl graf dualgraf sq cm	Low	Low
Q4211	Amnion bio or axobio sq cm	Low	High
Q4214	Cellesta cord per sq cm	Low	Low
Q4216	Artacent cord per sq cm	Low	Low
Q4217	Woundfix biowound plus xplus	Low	Low
Q4218	Surgicord per sq cm	Low	Low
Q4219	Surgigraft dual per sq cm	Low	High
Q4220	Bellacell hd, surederm sq cm	Low	Low
Q4221	Amniowrap2 per sq cm	Low	Low
Q4222	Progenamatrix, per sq cm	Low	High
Q4226	Myown harv prep proc sq cm	High	High
Q4227	Amniocore per sq cm	Low	High
Q4228	Bionextpatch, per sq cm	Low	Low
Q4229	Cogenex amnio memb per sq cm	Low	Low
Q4232	Corplex, per sq cm	Low	High
Q4234	Xcellerate, per sq cm	High	High
Q4235	Amniorepair or altiply sq cm	Low	Low
Q4236	Carepatch per sq cm	Low	Low
Q4237	Cryo-cord, per sq cm	Low	High
Q4238	Derm-maxx, per sq cm	Low	High
Q4239	Amnio-maxx or lite per sq cm	Low	High
Q4247	Amniotext patch, per sq cm	Low	Low
Q4248	Dermacyte amn mem allo sq cm	Low	Low
Q4249	Amniply, per sq cm	Low	High
Q4250	AmnioAMP-MP per sq cm	Low	Low
Q4254	Novafix dl per sq cm	Low	Low
Q4255	Reguard, topical use per sq	Low	Low

* These products do not exceed either the proposed MUC or PDC threshold for CY 2021, but are assigned to the high cost group because they were assigned to the high cost group in CY 2020.

Attachment B: BUSINESS REQUIREMENT 12129.16 TABLE

CY 2021 CPT/ HCPCS Code	CY 2021 Long Descriptor
19307	Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle
20100	Exploration of penetrating wound (separate procedure); neck
20101	Exploration of penetrating wound (separate procedure); chest
20102	Exploration of penetrating wound (separate procedure); abdomen/flank/back
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
21049	Excision of benign tumor or cyst of maxilla; requiring extra-oral osteotomy and partial maxillectomy (eg, locally aggressive or destructive lesion[s])
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, c, or l osteotomy; without bone graft
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21346	Open treatment of nasomaxillary complex fracture (lefort ii type); with wiring and/or local fixation
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches
21385	Open treatment of orbital floor blowout fracture; transantral approach (caldwell-luc type operation)
21386	Open treatment of orbital floor blowout fracture; periorbital approach
21387	Open treatment of orbital floor blowout fracture; combined approach
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft)

21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
21601	Excision of chest wall tumor including rib(s)
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (nuss procedure), with thoracoscopy
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical
22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
24150	Radical resection of tumor, shaft or distal humerus
24935	Stump elongation, upper extremity
25170	Radical resection of tumor, radius or ulna
25909	Amputation, forearm, through radius and ulna; re-amputation
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)
27027	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral
27057	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27179	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (heyman type procedure)
27235	Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27412	Autologous chondrocyte implantation, knee
27477	Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)
27722	Repair of nonunion or malunion, tibia; with sliding graft
28360	Reconstruction, cleft foot
28805	Amputation, foot; transmetatarsal
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery
31292	Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall

31293	Nasal/sinus endoscopy, surgical, with orbital decompression; medial and inferior wall
31294	Nasal/sinus endoscopy, surgical, with optic nerve decompression
31584	Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed
31587	Laryngoplasty, cricoid split, without graft placement
31600	Tracheostomy, planned (separate procedure);
31601	Tracheostomy, planned (separate procedure); younger than 2 years
31610	Tracheostomy, fenestration procedure with skin flaps
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes
31785	Excision of tracheal tumor or carcinoma; cervical
32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)
32560	Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)
32561	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day
32562	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day
32601	Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy
32604	Thoracoscopy, diagnostic (separate procedure); pericardial sac, with biopsy
32606	Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy
32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
32609	Thoracoscopy; with biopsy(ies) of pleura
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction
33272	Removal of subcutaneous implantable defibrillator electrode
34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision
34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision
34203	Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision
34421	Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision

34471	Thrombectomy, direct or with catheter; subclavian vein, by neck incision
34501	Valvuloplasty, femoral vein
34510	Venous valve transposition, any vein donor
34520	Cross-over vein graft to venous system
34530	Saphenopopliteal vein anastomosis
35011	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision
35045	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery
35180	Repair, congenital arteriovenous fistula; head and neck
35184	Repair, congenital arteriovenous fistula; extremities
35190	Repair, acquired or traumatic arteriovenous fistula; extremities
35201	Repair blood vessel, direct; neck
35206	Repair blood vessel, direct; upper extremity
35226	Repair blood vessel, direct; lower extremity
35231	Repair blood vessel with vein graft; neck
35236	Repair blood vessel with vein graft; upper extremity
35256	Repair blood vessel with vein graft; lower extremity
35261	Repair blood vessel with graft other than vein; neck
35266	Repair blood vessel with graft other than vein; upper extremity
35286	Repair blood vessel with graft other than vein; lower extremity
35321	Thromboendarterectomy, including patch graft, if performed; axillary-brachial
35860	Exploration for postoperative hemorrhage, thrombosis or infection; extremity
35879	Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty
35881	Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition
35883	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, dacron, eptfe, bovine pericardium)
35884	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft
35903	Excision of infected graft; extremity
36460	Transfusion, intrauterine, fetal
36838	Distal revascularization and interval ligation (dril), upper extremity hemodialysis access (steal syndrome)
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (tips) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recannulization/dilatation, stent placement and all associated imaging guidance and documentation)

37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
37195	Thrombolysis, cerebral, by intravenous infusion
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation
37565	Ligation, internal jugular vein
37600	Ligation; external carotid artery
37605	Ligation; internal or common carotid artery
37606	Ligation; internal or common carotid artery, with gradual occlusion, as with selverstone or crutchfield clamp
37615	Ligation, major artery (eg, post-traumatic, rupture); neck
37619	Ligation of inferior vena cava
38120	Laparoscopy, surgical, splenectomy
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage
38208	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor
38209	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor
38210	Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, t-cell depletion

38211	Transplant preparation of hematopoietic progenitor cells; tumor cell depletion
38212	Transplant preparation of hematopoietic progenitor cells; red blood cell removal
38213	Transplant preparation of hematopoietic progenitor cells; platelet depletion
38214	Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion
38215	Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer
38240	Hematopoietic progenitor cell (hpc); allogeneic transplantation per donor
38531	Biopsy or excision of lymph node(s); open, inguinofemoral node(s)
38720	Cervical lymphadenectomy (complete)
39401	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed
39402	Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)
42842	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with local flap (eg, tongue, buccal)
43020	Esophagotomy, cervical approach, with removal of foreign body
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, nissen, toupet procedures)
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
43420	Closure of esophagostomy or fistula; cervical approach
43510	Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (eg, celestin or mousseaux-barbin)
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43651	Laparoscopy, surgical; transection of vagus nerves, truncal
43652	Laparoscopy, surgical; transection of vagus nerves, selective or highly selective
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43830	Gastrostomy, open; without construction of gastric tube (eg, stamm procedure) (separate procedure)
43831	Gastrostomy, open; neonatal, for feeding

44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)
44186	Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)
44950	Appendectomy;
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (list separately in addition to code for primary procedure)
44970	Laparoscopy, surgical, appendectomy
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical
47490	Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation
49185	Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed
49323	Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity
49405	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
49491	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; reducible
49492	Repair, initial inguinal hernia, preterm infant (younger than 37 weeks gestation at birth), performed from birth up to 50 weeks postconception age, with or without hydrocelectomy; incarcerated or strangulated
50020	Drainage of perirenal or renal abscess, open
50541	Laparoscopy, surgical; ablation of renal cysts
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed
50543	Laparoscopy, surgical; partial nephrectomy
50544	Laparoscopy, surgical; pyeloplasty
50945	Laparoscopy, surgical; ureterolithotomy
51060	Transvesical ureterolithotomy
51845	Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, stamey, raz, modified pereyra)
51860	Cystorrhaphy, suture of bladder wound, injury or rupture; simple
51990	Laparoscopy, surgical; urethral suspension for stress incontinence
53500	Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)
54332	1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

54336	1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54535	Orchiectomy, radical, for tumor; with abdominal exploration
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, fowler-stephens)
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
57106	Vaginectomy, partial removal of vaginal wall;
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57109	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)
57284	Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach
57292	Construction of artificial vagina; with graft
57330	Closure of vesicovaginal fistula; transvesical and vaginal approach
57335	Vaginoplasty for intersex state
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)
57555	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58770	Salpingostomy (salpingoneostomy)
58920	Wedge resection or bisection of ovary, unilateral or bilateral

58925	Ovarian cystectomy, unilateral or bilateral
59030	Fetal scalp blood sampling
59409	Vaginal delivery only (with or without episiotomy and/or forceps);
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid
60271	Thyroidectomy, including substernal thyroid; cervical approach
60502	Parathyroidectomy or exploration of parathyroid(s); re-exploration
60512	Parathyroid autotransplantation (list separately in addition to code for primary procedure)
60520	Thymectomy, partial or total; transcervical approach (separate procedure)
61623	Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion
61626	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)
61720	Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus
62000	Elevation of depressed skull fracture; simple, extradural
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; thoracic
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar

63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (list separately in addition to code for primary procedure)
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (list separately in addition to code for primary procedure)
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment
63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (list separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)
63741	Creation of shunt, lumbar, subarachnoid-peritoneal, -pleural, or other; percutaneous, not requiring laminectomy
64804	Sympathectomy, cervicothoracic
64911	Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve
69725	Decompression facial nerve, intratemporal; including medial to geniculate ganglion
69955	Total facial nerve decompression and/or repair (may include graft)
69960	Decompression internal auditory canal
69970	Removal of tumor, temporal bone
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch

C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel
C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)
C9751	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-d rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)
C9758	Blinded procedure for nyha class iii/iv heart failure; transcatheter implantation of interatrial shunt or placebo control, including right heart catheterization, trans-esophageal echocardiography (tee)/intracardiac echocardiography (ice), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, tems), including muscularis propria (ie, full thickness)
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)

0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (egj), with implantation of pulse generator, includes programming
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
0453T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface
0454T	Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode
0457T	Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface
0458T	Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode
0460T	Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode
0499T	Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only
0518T	Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left ventricular pacing
0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)
0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode

J0390	Injection, chloroquine hydrochloride, up to 250 mg
J0745	Injection, codeine phosphate, per 30 mg
J2560	Injection, phenobarbital sodium, up to 120 mg
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia
Q5118	Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10 mg