Medicare National Coverage Determination Policy

Policies in this MLCP Reference Guide apply to testing performed at a Quest Diagnostics facility and apply to Medicare National Coverage Determination Policy. This diagnosis code reference guide is provided as an aid to physicians and office staff in determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. Quest Diagnostics does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

Please note this document has been updated with National Medicare changes effective 7/1/2015

Medicare National Coverage Determination Policy

190.25 Alpha-Fetoprotein

Data Source: http://www.cms.gov

CPT Code: 82105

NCD Description:. Alpha-fetoprotein (AFP) is a polysaccharide found in some carcinomas. It is effective as a biochemical marker for monitoring the response of certain malignancies to therapy.

ICD-9-CM Codes that Support Medical Necessity

The Alpha-fetoprotein (AFP) is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

070.22-070.23	Chronic viral hepatitis B with hepatic coma, with or without mention of hepatitis delta
070.32-070.33	Chronic viral hepatitis B without mention of hepatic coma, with or without mention of hepatitis delta
070.44	Chronic hepatitis C with hepatic coma
070.54	Chronic hepatitis C without mention of hepatic coma
095.3	Syphilis of liver
121.1	Clonorchiasis
121.3	Fascioliasis
155.0-155.2	Malignant neoplasm of the liver and intrahepatic bile ducts
164.2-164.9	Malignant neoplasm of the mediastinum
183.0	Malignant neoplasm, ovary
186.0	Malignant neoplasm of undescended testis
186.9	Malignant neoplasm, other and unspecific testis
197.1	Secondary malignant neoplasm of mediastinum
197.7	Secondary malignant neoplasm of liver
198.6	Secondary malignant neoplasm of ovary
198.82	Secondary malignant neoplasm, genital organs
209.20-209.27, 209.29	Malignant carcinoid tumors of other and unspecified sites
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone
209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites
211.5	Benign neoplasm of liver and biliary passages
235.3	Neoplasm of uncertain behavior of liver and biliary passages
272.2	Mixed hyperlipidemia
273.4	Alpha-1-antitrypsin deficiency
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
275.1	Disorder of copper metabolism
277.00	Cystic Fibrosis without mention of meconium ileus
277.03	Cystic fibrosis with gastrointestinal manifestations
277.6	Other deficiencies of circulating enzymes
285.0	Sideroblastic Anemia
338.3	Neoplasm related pain (acute) (chronic)
414.4	Coronary atherosclerosis due to calcified coronary lesion
444.01	Saddle embolus of abdominal aorta
444.09	Other arterial embolism and thrombosis of abdominal aorta
571.2	Alcoholic cirrhosis of liver
571.40	Chronic hepatitis, unspecified
571.41	Chronic persistent hepatitis
571.42	Autoimmune hepatitis
571.49	Other chronic hepatitis
571.5	Cirrhosis of liver without mention of alcohol
573.5	Hepatopulmonary syndrome
608.89	Other specified disorders of male genital organs
793.11	Solitary pulmonary nodule
793.19	Other nonspecific abnormal finding of lung field
793.2	Non-specific (abnormal) findings on radiological and other examination of other intrathoracic organs
793.3	Non-specific (abnormal) findings on radiological and other examination of biliary tract
793.6	Non-specific (abnormal) findings on radiological and other examination of abdominal area, including retroperitoneum
795.89	Other abnormal tumor markers
V10.07	Personal history of malignant neoplasm, liver
V10.43	Personal history of malignant neoplasm, ovary
V10.47	Personal history of malignant neoplasm, testis
V86.0	Estrogen receptor positive status [ER+]
V86.1	Estrogen receptor negative status [ER-]

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.15 Blood Counts (1 of 5)

Data Source: http://www.cms.gov

CPT Codes: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

NCD Description: Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

ICD-9-CM Codes that Support Medical Necessity are not provided

ICD-9-CM codes that ***do not*** support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

ICD-9-CM Codes That Do Not Support Medical Necessity

078.10 – 078.19	Viral warts
210.0-210.9	Benign neoplasm of lip, oral cavity, and pharynx
214.0	Lipoma, skin and subcutaneous tissue of face
216.0-216.9	Benign neoplasm of skin
217	Benign neoplasm of breast
222.0-222.9	Benign neoplasm of male genital organs
224.0	Benign neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid
230.0	Carcinoma in situ of lip, oral cavity and pharynx
232.0-232.9	Carcinoma in situ of skin
300.00-300.09	Neurotic disorders
301.0-301.9	Personality disorders
302.0-302.9	Sexual and gender identity disorders
307.0	Stuttering
307.20-307.23	Tics
307.3	Stereotypic movement disorder
307.80-307.89	Pain disorders related to psychological factors
312.00-312.9	Disturbance of conduct, not elsewhere classified
313.0-313.9	Disturbance of emotions specific to childhood and adolescence
314.00-314.9	Hyperkinetic syndrome of childhood
338.0	Central pain syndrome
338.11	Acute pain due to trauma
338.12	Acute post-thoracotomy pain
338.18	Other acute postoperative pain
338.19	Other acute pain
338.21	Chronic pain due to trauma
338.22	Chronic post-thoracotomy pain
338.28	Other chronic postoperative pain
338.29	Other chronic pain
338.4	Chronic pain syndrome
363.30-363.35	Chorioretinal scars
363.40-363.43	Choroidal degeneration
363.50-363.57	Hereditary choroidal dystrophies
363.70-363.9	Choroidal detachment
366.00-366.9	Cataract
367.0-367.9	Disorders of refraction and accommodation
371.00-371.9	Corneal opacity and other disorders of cornea
373.00-373.9	Inflammation of eyelids
375.00-375.9	Disorders of lacrimal system
376.21-376.22	*Endocrine exophthalmos
376.40-376.47	*Deformity of orbit
376.50-376.52	*Enophthalmos
376.6	*Retained (old) foreign body following penetrating wound of orbit
376.81-376.82	*Orbital cysts; myopathy of extraocular muscles
376.89	*Other orbital disorders
376.9	*Unspecified disorder of orbit
377.10-377.16	Optic atrophy
377.21-377.24	Other disorders of optic disc
384.20-384.25	Perforation of tympanic membrane
384.81-384.82	Other specified disorders of tympanic membrane
385.00-385.9	Other disorders of middle ear and mastoid
387.0-387.9	Otosclerosis
388.00-388.32	Degenerative and vascular disorders of ear; noise effects on inner ear; sudden hearing loss, unspecified; and tinnitus
388.40-388.45	Other abnormal auditory perception
388.5	Disorders of acoustic nerve
389.00-389.06, 389.08	Conductive hearing loss
389.10-389.18	Sensorineural hearing loss
389.20-389.22	Mixed hearing loss
389.7	Deaf, non-speaking, not elsewhere classifiable
389.8, 389.9	Hearing loss
440.0-440.1	Atherosclerosis of aorta and renal artery

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.15 Blood Counts (2 of 5)

Data Source: http://www.cms.gov

CPT Codes: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

NCD Description: Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

ICD-9-CM Codes that Support Medical Necessity are not provided

ICD-9-CM codes that ***do not*** support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

ICD-9-CM Codes That Do Not Support Medical Necessity

443.81-443.9 Other and unspecified peripheral vascular disease
448.1 Capillary nevus, non neoplastic
457.0 Postmastectomy lymphedema syndrome
470 Deviated nasal septum
471.0-471.9 Nasal polyps
478.0 Hypertrophy of nasal turbinates
478.11 Nasal mucositis (ulcerative)
478.19 Other disease of nasal cavity and sinuses
478.4 Polyp of vocal cord or larynx
520.0-520.9 Disorders of tooth development and eruption
521.00-521.15, 521.20-521.25, 521.30-521.35, 521.40-521.42,521.49, 521.5-521.7, 521.81, 521.89, 521.9 Diseases of hard tissues of teeth
524.00-524.9 Dentofacial anomalies, including malocclusion
525.0, 525.10-525.13, 525.19, 525.20-525.26, 525.3, 525.40-525.44, 525.50-525.54, 525.60- 525.67, 525.69 Other diseases and conditions of teeth and supporting structures
525.71 Osseointegration failure of dental implant
525.72 Post-osseointegration biological failure of dental implant
525.73 Post-osseointegration mechanic failure of dental implant
525.8 Other specified disorders of the teeth and supporting structures
525.9 Unspecified disorder of the teeth and supporting structures
526.0-526.3 Diseases of the jaws
526.61 Perforation of root canal space
526.62 Endodontic overfill
526.63 Endodontic underfill
526.69 Other periradicular pathology associated with previous endodontic treatment
527.6-527.9 Diseases of salivary glands
575.6 Cholesterolosis of gallbladder
600.00-600.91 Hyperplasia of prostate
603.0 Encysted hydrocele
603.8 Other specified types of hydrocele
603.9 Hydrocele, unspecified
605 Redundant prepuce and phimosis
606.0-606.1 Infertility, male azoospermia and oligospermia
608.1 Spermatocele
608.20 Torsion of testis, unspecified
608.21 Extravaginal torsion of spermatic cord
608.22 Intravaginal torsion of spermatic cord
608.23 Torsion of appendix testis
608.24 Torsion of appendix epididymis
608.3 Atrophy of testis
610.0-610.9 Benign mammary dysplasia
611.1-611.6 Other disorders of breast
611.9 Unspecified breast disorder
616.2 Cyst of Bartholin's gland
616.2 Cyst of Bartholin's gland
618.00-618.05, 618.09, 618.1-618.7, 618.81-618.83, 618.84, 618.89, 618.9 Genital prolapse
620.0-620.3 Noninflammatory disorders of ovary, fallopian tube, & broad ligament
621.6-621.7 Malposition or chronic inversion of uterus
627.2-627.9 Menopausal and post menopausal disorders
628.0-628.9 Infertility, female
676.00-676.94 Other disorders of breast associated with childbirth and disorders of lactation
691.0-691.8 Atopic dermatitis and related disorders
692.0-692.9 Contact dermatitis and other eczema
700 Corns and callosities
701.0-701.9 Other hypertrophic and atrophic conditions of skin
702.0-702.8 Other dermatoses
703.9 Unspecified disease of nail
706.0-706.9 Diseases of sebaceous glands

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.15 Blood Counts (3 of 5)

Data Source: http://www.cms.gov

CPT Codes: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

NCD Description: Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

ICD-9-CM Codes that Support Medical Necessity are not provided

ICD-9-CM codes that ***do not*** support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

ICD-9-CM Codes That Do Not Support Medical Necessity

709.00-709.4	Other disorders of skin and subcutaneous tissue
715.00-715.98	Osteoarthrosis
716.00-716.99	Other and unspecified arthropathies
718.00- 718.99	Other derangement of joint
726.0-726.91	Peripheral enthesopathies and allied syndromes
727.00-727.9	Other disorders of synovium, tendon, and bursa
728.10-728.85	Disorders of muscle ligament and fascia
732.0-732.9	Osteochondropathies
733.00-733.09	Osteoporosis
734	Flat foot
735.0-735.9	Acquired deformities of toe
736.00-736.9	Other acquired deformities of limb
737.0-737.9	Curvature of spine
738.0-738.9	Other acquired deformity
739.0-739.9	Nonallopathic lesions, not elsewhere classified
799.81	Decreased libido
830.0-832.19	Dislocation of jaw, shoulder, and elbow
832.2	Nursemaid's elbow
833.00-833.19	Dislocation of wrist
834.00-834.12	Dislocation of finger
835.00-835.13	Dislocation of hip
836.0-836.69	Dislocation of knee
837.0-837.1	Dislocation of ankle
838.00-838.19	Dislocation of foot
839.00-839.9	Other, multiple and ill-defined dislocations
840.0-848.9	Sprains and strains of joints and adjacent muscles
905.0-909.9	Late effects of musculoskeletal and connective tissue injuries
910.0-919.9	Superficial injuries
930.0-932	Foreign body on external eye, in ear, in nose
955.0-957.9	Injury to peripheral nerve
V03.0-V06.9	Need for prophylactic vaccination
V11.0-V11.3	Personal history of mental disorder; schizophrenia, affective disorders, neurosis, and alcoholism
V11.4	Personal history of combat and operational stress reaction
V11.8-V11.9	Personal history of other and unspecified mental disorders
V14.0-V14.8	Personal history of allergy to medicinal agents
V16.0	Family history of malignant neoplasm, gastrointestinal tract
V16.3	Family history of malignant neoplasm, breast
V21.0-V21.9	Constitutional states in development
V25.01-V25.04, V25.09	Encounter for contraceptive management; general counseling and advice
V25.11	Encounter for insertion of intrauterine contraceptive device
V25.12	Encounter for removal of intrauterine contraceptive device
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device
V25.2-V25.3, V25.40-V25.43, V25.49, V25.5, V25.8, V25.9	Encounter for sterilization; menstrual extraction; surveillance of previously prescribed contraceptive methods; and insertion of implantable subdermal contraceptive; other specified and unspecified contraceptive management
V26.0-V26.39	Procreative management
V26.41	Other procreative counseling and advice using natural family planning
V26.42	Encounter for fertility preservation counseling
V26.49	Other procreative management, counseling and advice
V26.51	Tubal ligation status
V26.52	Vascectomy status
V26.81	Encounter for assisted reproductive fertility procedure cycle
V26.82	Encounter for fertility preservation procedure
V26.89-V26.9	Other specified and unspecified procreative management
V40.0-V40.9	Mental and behavioral problems
V41.0-V41.9	Problems with special senses and other special functions

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.15 Blood Counts (4 of 5)

Data Source: http://www.cms.gov

CPT Codes: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

NCD Description: Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

ICD-9-CM Codes that Support Medical Necessity are not provided

ICD-9-CM codes that ***do not*** support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

ICD-9-CM Codes That Do Not Support Medical Necessity

V43.0-V43.1 Organ or tissue replaced by other means, eye globe or lens
V44.0-V44.9 Artificial opening status
V45.00-V45.02, V45.09 Other post surgical states
V45.11 Renal dialysis status
V45.12 Non-compliance with renal dialysis
V45.2-V45.4, V45.51, V45.52, V45.59, V45.61, V45.69, V45.71-V45.79, V45.81-V45.85, V45.86, V45.89 Other post surgical states
V48.0-V48.9 Problems with head, neck, and trunk
V49.0 - V49.85 Other conditions influencing health status
V49.86 Do not resuscitate status
V49.87 Physical restraints status
V49.89 - V49.9 Other specified and unspecified conditions influencing health status
V51.0 Encounter for breast reconstruction following mastectomy
V51.8 Other aftercare involving the use of plastic surgery
V52.0-V52.9 Fitting and adjustment of prosthetic device and implant
V53.01-V53.09 Fitting and adjustment of devices related to nervous system & special senses
V53.1 Fitting and adjustment of spectacles and contact lenses
V53.31-V53.39 Fitting and adjustment of cardiac device
V53.4 Fitting and adjustment of orthodontic devices
V53.50 Fitting and adjustment of intestinal appliance and device
V53.51 Fitting and adjustment of gastric lap band
V53.59 Fitting and adjustment of other gastrointestinal appliance and device
V53.6 Fitting and adjustment of urinary devices
V53.7 Fitting and adjustment of orthopedic devices
V53.8 Fitting and adjustment of wheelchair
V53.90-V53.99 Fitting and adjustment of other and unspecified device
V54.01-V54.9 Other orthopedic aftercare
V55.0-V55.9 Attention to artificial openings
V57.0-V57.2 Care involving use of rehabilitation procedures
V57.3 Care involving speech-language therapy
V57.4-V57.9 Orthoptic training, other specified, and unspecified rehabilitation procedure
V58.5 Orthodontics
V59.01-V59.9 Donors
V61.01 Family disruption due to family member on military deployment
V61.02 Family disruption due to return of family member from military deployment
V61.03 Family disruption due to divorce or legal separation
V61.04 Family disruption due to parent-child estrangement
V61.05 Family disruption due to child in welfare custody
V61.06 Family disruption due to child in foster care or in care of non-parental family member
V61.07 Family disruption due to death of family member
V61.08 Family disruption due to other extended absence of family member
V61.09 Other family disruption
V61.10 Counseling for marital and partner problems, unspecified
V61.11 Counseling for victim of spousal and partner abuse
V61.12 Counseling for perpetrator of spousal and partner abuse
V61.20 Counseling for parent-child problem
V61.21 Counseling for victim of child abuse
V61.22 Counseling for perpetrator of parental child abuse
V61.23 Counseling for parent-biological child problem
V61.24 Counseling for parent-adopted child problem
V61.25 Counseling for parent (guardian)-foster child problem
V61.29 Other parent-child problems
V61.3 Problems with aged parents or in-laws
V61.41 Alcoholism in family
V61.42 Substance abuse in family
V61.49, V61.5-V61.9 Other specified and unspecified family problems

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.15 Blood Counts (5 of 5)

Data Source: http://www.cms.gov

CPT Codes: 85004, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85032, 85048, 85049

NCD Description: Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

ICD-9-CM Codes that Support Medical Necessity are not provided

ICD-9-CM codes that ***do not*** support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

ICD-9-CM Codes That Do Not Support Medical Necessity

V62.21 Personal current military deployment status
V62.22 Personal history of return from military deployment
V62.29 Other occupational circumstances or maladjustment
V62.3-V62.84 Educational circumstances; other psychological or physical stress, not elsewhere classified; suicidal ideation
V62.85 Homicidal ideation
V62.89-V62.9 Other psychological or physical stress, not elsewhere classified; and unspecified psychosocial circumstances
V65.2 Person feigning illness
V65.3 Dietary surveillance and counseling
V65.40-V65.49 Other counseling, not elsewhere classified
V65.5 Person with feared complaint in whom no diagnosis was made
V65.8 Other reasons for seeking consultation
V65.9 Unspecified reason for consultation
V66.0-V66.9 Convalescence and palliative care
V67.3 Follow-up examination following psychotherapy
V67.4 Follow-up examination following treatment of healed fracture
V69.3 Problems related to lifestyle, gambling and betting
V71.01 - V71.09 Observation and evaluation for suspected conditions not found, mental
V72.0 Examination of eyes and vision
V72.11 - V72.12; V72.19 Encounter for hearing conservation and treatment; other examination of ears and hearing
V72.2 Dental examination
V72.40, V72.41, V72.42 Pregnancy examination or test; pregnancy unconfirmed; negative result; positive result.
V72.5 Radiological examination, not elsewhere classified
V72.60 Laboratory examination, unspecified
V72.61 Antibody response examination
V72.62 Laboratory examination ordered as part of a routine general medical examination
V72.63 Pre-procedural laboratory examination
V72.69 Other laboratory examination
V72.7 Diagnostic skin and sensitization tests
V72.9 Unspecified examination
V76.10-V76.19 Special screening for malignant neoplasms, breast
V76.2 Special screening for malignant neoplasms, cervix
V76.44 Special screening for malignant neoplasms, other sites, prostate
V76.51 Special screening for malignant neoplasms, Intestine, colon
V77.1 Special screening for diabetes mellitus
V81.0-V81.2 Special screening for cardiovascular diseases

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.20 Blood Glucose Testing (1 of 3)

Data Source: http://www.cms.gov

CPT Codes: 82947, 82948, 82962

NCD Description:. This policy is intended to apply to blood samples used to determine glucose levels.

ICD-9-CM Codes that Support Medical Necessity

The Blood Glucose Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

011.00-011.96	Tuberculosis
038.0, 038.10-038.19, 038.2, 038.3, 038.40-038.49, 038.8, 038.9	Septicemia
112.1	Recurrent vaginal candidiasis
112.3	Interdigital candidiasis
118	Opportunistic mycoses
157.4	Malignant neoplasm of Islets of Langerhans
158.0	Malignant neoplasm of retroperitoneum
211.7	Benign neoplasm of Islets of Langerhans
242.00-242.91	Thyrotoxicosis
249.00-249.01	Secondary diabetes mellitus without mention of complication
249.10-249.11	Secondary diabetes mellitus with ketoacidosis
249.20-249.21	Secondary diabetes mellitus with hypersmolarity
249.30-249.31	Secondary diabetes mellitus with other coma
249.40-249.41	Secondary diabetes mellitus with renal manifestations
249.50-249.51	Secondary diabetes mellitus with ophthalmic manifestations
249.60-249.61	Secondary diabetes mellitus with neurological manifestations
249.70-249.71	Secondary diabetes mellitus with peripheral circulatory disorders
249.80-249.81	Secondary diabetes mellitus with other specified manifestations
249.90-249.91	Secondary diabetes mellitus with unspecified complication
250.00-250.93	Diabetes mellitus
251.0-251.9	Disorders of pancreatic internal secretion
253.0-253.9	Disorders of the pituitary gland
255.0	Cushing syndrome
263.0-263.9	Malnutrition
271.0-271.9	Disorders of carbohydrate transport and metabolism
272.0-272.4	Disorders of lipoid metabolism
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
276.0	Hyperosmolality and/or hypernatremia
276.1	Hyposmolality and/or hyponatremia
276.2	Acidosis
276.3	Alkalosis
276.4	Mixed acid-base balance disorder
276.50-276.52	Volume depletion
276.61	Transfusion associated circulatory overload
276.69	Other fluid overload
276.7	Hyperpotassemia
276.8	Hypopotassemia
276.9	Electrolyte and fluid disorders not elsewhere classified
278.3	Hypercarotinemia
293.0	Delirium due to conditions classified elsewhere
294.9	Unspecified persistent mental disorders due to conditions classified elsewhere
298.9	Unspecified psychosis
300.9	Unspecified nonpsychotic mental disorder
310.1	Personality change due to conditions classified elsewhere
331.83	Mild cognitive impairment, so stated
337.9	Autonomic nervous system neuropathy
345.10-345.11	Generalized convulsive epilepsy
348.31	Metabolic encephalopathy
355.9	Neuropathy, not otherwise specified
356.9	Unspecified hereditary and idiopathic peripheral neuropathy
357.9	Unspecified inflammatory and toxic neuropathy
362.10	Background retinopathy
362.18	Retinal vasculitis
362.29	Nondiabetic proliferative retinopathy
362.50-362.57	Degeneration of macular posterior pole
362.60-362.66	Peripheral retinal degeneration
362.81-362.89	Other retinal disorders
362.9	Unspecified retinal disorders
365.04	Borderline glaucoma, ocular hypertension
365.32	Corticosteroid-induced glaucoma residual
366.00-366.09	Presenile cataract
366.10-366.19	Senile cataract
367.1	Acute myopia
368.8	Other specified visual disturbance
373.00	Blepharitis
377.24	Pseudopapilledema
377.9	Unspecified disorder of optic nerve and visual pathways
378.50-378.55	Paralytic strabismus

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.20 Blood Glucose Testing (2 of 3)

Data Source: http://www.cms.gov

CPT Codes: 82947, 82948, 82962

NCD Description:. This policy is intended to apply to blood samples used to determine glucose levels.

ICD-9-CM Codes that Support Medical Necessity

The Blood Glucose Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

379.45	Argyll-Robertson pupils
410.00-410.92	Acute myocardial infarctions
414.00-414.06	Coronary atherosclerosis, of unspecified type of vessel, native or graft and of native coronary artery of transplanted heart
414.07	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
414.10-414.12	Coronary atherosclerosis, aneurysm of heart (wall), aneurysm of coronaryvessels, and dissection of coronary artery
414.19	Coronary atherosclerosis, other aneurysm of heart
414.3	Coronary atherosclerosis due to lipid rich plaque
414.4	Coronary atherosclerosis due to calcified coronary lesion
425.9	Secondary cardiomyopathy, unspecified
440.23	Arteriosclerosis of extremities with ulceration
440.24	Arteriosclerosis of extremities with gangrene
440.9	Arteriosclerosis, not otherwise specified
458.0	Postural hypotension
462	Acute pharyngitis
466.0	Acute bronchitis
480.0-480.3, 480.8, 480.9	Viral pneumonia
481	Pneumococcal pneumonia
482.0-482.2, 482.30-482.32, 482.39, 482.40-482.42, 482.49, 482.81-482.84,482.89, 482.9	Other bacterial pneumonia
483.0-483.1, 483.8	Pneumonia due to other specified organism
484.1, 484.3, 484.5-484.8	Pneumonia in infectious diseases classified elsewhere
485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
490	Recurrent bronchitis, not specified as acute or chronic
491.0-491.9	Chronic bronchitis
527.7	Disturbance of salivary secretion (drymouth)
528.00	Stomatitis and mucositis, unspecified
528.09	Other stomatitis and mucositis (ulcerative)
535.50-535.51	Gastritis
536.8	Dyspepsia
571.8	Other chronic nonalcoholic liver disease
572.0	Abscess of liver
572.1	Portal pyemia
572.2	Hepatic encephalopathy
572.3	Portal hypertension
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
574.50-574.51	Choledocholithiasis
575.0-575.12	Cholecystitis
576.1	Cholangitis
577.0	Acute pancreatitis
577.1	Chronic pancreatitis
577.8	Pancreatic multiple calculi
590.00-590.9	Infections of the kidney
595.9	Recurrent cystitis
596.4	Bladder atony
596.53	Bladder paresis
599.0	Urinary tract infection, recurrent
607.84	Impotence of organic origin
608.89	Other disorders male genital organs
616.10	Vulvovaginitis
626.0	Amenorrhea
626.4	Irregular menses
628.9	Infertility - female
648.00	Diabetes mellitus complicating pregnancy, Childbirth or the puerperium, unspecified as to episode of care or not applicable
648.03	Diabetes mellitus complicating pregnancy, Childbirth or the puerperium, antipartum condition or complication
648.04	Diabetes mellitus complicating pregnancy, Childbirth or the puerperium, postpartum condition or complication
648.80	Abnormal glucose tolerance complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care or not applicable
648.83	Abnormal glucose tolerance complicating pregnancy, childbirth or the puerperium, antepartum condition or complication
648.84	Abnormal glucose tolerance complicating pregnancy, childbirth or the puerperium, postpartum condition or complication

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.20 Blood Glucose Testing (3 of 3)

Data Source: http://www.cms.gov

CPT Codes: 82947, 82948, 82962

NCD Description:. This policy is intended to apply to blood samples used to determine glucose levels.

ICD-9-CM Codes that Support Medical Necessity

The Blood Glucose Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

649.20	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
649.21	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
649.22	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
649.23	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
649.24	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
656.60-656.63	Fetal problems affecting management of mother large for-date of fetus
657.00-657.03	Polyhydramnios
680.0-680.9	Carbuncle and furuncle
686.00-686.9	Infections of skin and subcutaneous tissue
698.0	Pruritus ani
698.1	Pruritus of genital organs
704.1	Hirsutism
705.0	Anhidrosis
707.00-707.25, 707.8, 707.9	Chronic ulcer of skin
709.3	Degenerative skin disorders
729.1	Myalgia
730.07	Acute osteomyelitis of ankle and foot
730.17	Chronic osteomyelitis of ankle and foot
730.27	Unspecified osteomyelitis of ankle and foot
780.01	Coma
780.02	Transient alteration of awareness
780.09	Alteration of consciousness, other
780.2	Syncope and collapse
780.31	Febrile convulsions (simple), unspecified
780.32	Complex febrile convulsions
780.33	Post traumatic seizures
780.39	Seizures, not otherwise specified
780.4	Dizziness and giddiness
780.71	Malaise and fatigue
780.72	Functional quadriplegia
780.79	Other malaise and fatigue
780.8	Generalized hyperhidrosis
781.0	Abnormal involuntary movements
782.0	Loss of vibratory sensation
783.1	Abnormal weight gain
783.21	Abnormal loss of weight
783.5	Polydipsia
783.6	Polyphagia
785.0	Tachycardia
785.4	Gangrene
786.01	Hyperventilation
786.09	Dyspnea
786.50	Chest pain, unspecified
787.60	Full incontinence of feces
787.61	Incomplete defecation
787.62	Fecal smearing
787.63	Fecal urgency
787.91	Diarrhea
788.41-788.43	Frequency of urination and polyuria
789.1	Hepatomegaly
790.21-790.29	Abnormal glucose tolerance test
790.6	Other abnormal blood chemistry (hyperglycemia)
791.0	Proteinuria
791.5	Glycosuria
796.1	Abnormal reflex
799.4	Cachexia
V23.0-V23.3, V23.41-V23.49, V23.5, V23.7, V23.81-V23.87, V23.89, V23.9	Supervision of high-risk pregnancy
V58.63-V58.65	Long-term (current) drug use
V58.67	Long-term (current) use of insulin
V58.69	Long term current use of other medication
V67.2	Follow-up examination, following chemotherapy
V67.51	Follow-up examination with high-risk medication not elsewhere classified
V77.1	Covered for procedure code 82947 only Special screening for endocrine, nutrition, metabolic, & immunity disorders

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.26 Carcinoembryonic Antigen

Data Source: http://www.cms.gov

CPT Code: 82378

NCD Description: Carcinoembryonic antigen (CEA) is a protein polysaccharide found in some carcinomas. It is effective as a biochemical marker for monitoring the response of certain malignancies to therapy.

ICD-9-CM Codes that Support Medical Necessity

The CEA is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

150.0-150.9	Malignant neoplasm of the esophagus
151.0-151.9	Malignant neoplasm of stomach
152.0-154.8	Malignant neoplasm of small intestine, including duodenum, rectum, rectosigmoid junction and anus.
157.0-157.9	Primary malignancy of pancreas
159.0	Malignant neoplasm of intestinal tract, part unspecified
162.0-162.9	Malignant neoplasm of trachea, bronchus, lung
174.0-174.9	Malignant neoplasm of female breast
175.0-175.9	Malignant neoplasm of male breast
183.0	Malignant neoplasm of ovary
197.0	Secondary malignant neoplasm of neoplasm of lung
197.4	Secondary malignant neoplasm of small intestine
197.5	Secondary malignant neoplasm of large intestine and rectum
209.00-209.03	Malignant carcinoid tumors of the small intestine
209.10-209.17	Malignant carcinoid tumors of the appendix, large intestine and rectum
209.20-209.27, 209.29	Malignant carcinoid tumors of other and unspecified sites
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone
209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites
230.3	Carcinoma in situ of colon
230.4	Carcinoma in situ of rectum
230.7	Carcinoma in situ of other/unspecified parts of intestine
230.9	Carcinoma in situ other and unspecified digestive organs
235.2	Neoplasm of uncertain behavior of stomach, intestines, rectum
338.3	Neoplasm related pain (acute) (chronic)
790.99	Other nonspecific findings on examination of blood
795.81	Elevated carcinoembryonic antigen [CEA]
795.89	Other abnormal tumor markers
V10.00	Personal history of malignant neoplasm of gastro-intestinal tract, unspecified
V10.05	Personal history of malignant neoplasm, large intestine
V10.06	Personal history of malignant neoplasm, rectum, rectosigmoid junction, anus
V10.11	Personal history of malignant neoplasm, bronchus, and lung
V10.3	Personal history of malignant neoplasm, breast
V10.43	Personal history of malignant neoplasm, ovary
V67.2	Follow-up examination following chemotherapy

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.19 Collagen Crosslinks - Any Method

Data Source: http://www.cms.gov

CPT Code: 82523

NCD Description: Collagen crosslinks, part of the matrix of bone upon which bone mineral is deposited, are biochemical markers the excretion of which provides a quantitative measurement of bone resorption. Elevated levels of urinary collagen crosslinks indicate elevated bone resorption. Elevated bone resorption contributes to age-related and postmenopausal loss of bone leading to osteoporosis and increased risk of fracture. The collagen crosslinks assay can be performed by immunoassay or by high performance liquid chromatography (HPLC). Collagen crosslinks immunoassays measure the pyridinoline crosslinks and associated telopeptides in urine.

ICD-9-CM Codes that Support Medical Necessity

The Collage Crosslinks tests are determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s)
This list was compiled from the Medicare National Coverage Determination Policy. An ICD-D-9-CM book should be used as a complete reference.

242.00-242.91	Thyrotoxicosis
245.2	Chronic lymphocytic thyroiditis (only if thyrotoxic)
246.9	Unspecified disorder of thyroid
252.00-252.02, 252.08	Hyperparathyroidism
256.2	Postablative ovarian failure
256.31-256.39	Other ovarian failure
256.8	Other ovarian dysfunction
256.9	Unspecified ovarian dysfunction
268.9	Unspecified vitamin D deficiency
269.3	Mineral deficiency, not elsewhere classified
627.0	Premenopausal menorrhagia
627.1	Postmenopausal bleeding
627.2	Symptomatic menopausal or female climacteric state
627.4	Symptomatic states associated with artificial menopause
627.8	Other specified menopausal and postmenopausal disorders
627.9	Unspecified menopausal & postmenopausal disorder
731.0	Osteitis deformans w/o mention of bone tumor (Paget's bone disease)
733.00-733.09	Osteoporosis
733.10-733.19	Pathological fracture
733.90	Disorder of bone and cartilage, unspecified
805.8	Fracture of vertebral column without mention of spiral cord injury, unspecified, closed
V58.65	Long-term (current) use of steroids
V58.69	Long-term (current) use of other medications

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.24 Digoxin Therapeutic Drug Assay (1 of 2)

Data Source: http://www.cms.gov

CPT Code: 80162

NCD Description:. A Digoxin therapeutic drug assay is useful for diagnosis and prevention of digoxin toxicity, and/or prevention for under dosage of digoxin.

ICD-9-CM Codes that Support Medical Necessity

The Digoxin is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

242.00-242.91	Thyrotoxicosis with or without goiter
243	Congenital hypothyroidism
244.0-244.9	Acquired hypothyroidism
245.0-245.9	Thyroiditis
275.2	Disorders of magnesium metabolism
275.40-275.49	Disorders of calcium metabolism
275.5	Hungry bone syndrome
276.0	Hyperosmolality
276.1	Hyposmolality
276.2	Acidosis
276.3	Alkalosis
276.4	Mixed acid-base balance disorder
276.50-276.52	Volume depletion
276.61	Transfusion associated circulatory overload
276.69	Other fluid overload
276.7	Hyperpotassemia
276.8	Hypopotassemia
276.9	Electrolyte and fluid disorders not elsewhere classified
293.0	Delirium due to conditions classified elsewhere
293.1	Subacute delirium
307.47	Other dysfunctions of sleep stages or arousal from sleep
339.3	Drug induced headache, not elsewhere classified
368.16	Psychophysical visual disturbances
368.8	Other specified visual disturbances
368.9	Unspecified visual disturbances
397.9	Rheumatic diseases of endocardium
398.0	Rheumatic Myocarditis
398.91	Rheumatic Heart Failure
402.01	Hypertensive heart disease, malignant with heart failure
402.11	Hypertensive heart disease, benign with heart failure
402.91	Hypertensive heart disease, unspecified with heart failure
403.00-403.91	Hypertensive chronic kidney disease
404.00-404.93	Hypertensive heart and chronic kidney disease
410.00-410.92	Acute myocardial infarction
411.0-411.89	Other acute & subacute forms of ischemic heart disease
413.0-413.9	Angina pectoris
414.4	Coronary atherosclerosis due to calcified coronary lesion
422.0-422.99	Acute myocarditis
425.0, 425.11, 425.18, 425.2-425.9	Cardiomyopathy
426.0-426.9	Conduction disorders
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure
429.2	Cardiovascular disease, unspecified
429.4	Heart Disturbances Postcardiac Surgery
429.5	Rupture chordae tendineae
429.6	Rupture papillary muscle
429.71	Acquired cardiac septal defect
444.01	Saddle embolus of abdominal aorta
444.09	Other arterial embolism and thrombosis of abdominal aorta
514	Pulmonary congestion & hypostasis
573.5	Hepatopulmonary syndrome
579.9	Unspecified Intestinal malabsorption

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.24 Digoxin Therapeutic Drug Assay (2 of 2)

Data Source: http://www.cms.gov

CPT Code: 80162

NCD Description:. A Digoxin therapeutic drug assay is useful for diagnosis and prevention of digoxin toxicity, and/or prevention for under dosage of digoxin.

ICD-9-CM Codes that Support Medical Necessity

The Digoxin is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

584.5	Acute kidney failure with lesion of tubular necrosis
584.6	Acute kidney failure with lesion of renal cortical necrosis
584.7	Acute kidney failure with lesion of renal medullary (papillary) necrosis
584.8	Acute kidney failure with other specified pathological lesion in kidney
584.9	Acute kidney failure, unspecified
584.9	Acute kidney failure, unspecified
585.1-585.9	Chronic kidney disease
586	Renal Failure, unspecified
587	Renal sclerosis, unspecified
588.0	Renal osteodystrophy
588.1	Nephrogenic Diabetes Insipidus
588.81	Secondary hyperparathyroidism (of renal origin)
588.89	Other specified disorders resulting from impaired renal function
588.9	Unspecified disorder resulting from impaired renal function
780.01	Coma
780.02	Transient alteration of awareness
780.09	Other ill-defined general symptoms (drowsiness, semicoma, somnolence, stupor, unconsciousness)
780.1	Hallucinations
780.2	Syncope and collapse
780.4	Dizziness and giddiness
780.71	Malaise and fatigue
780.72	Functional quadriplegia
780.79	Other malaise and fatigue
783.0	Anorexia
784.0	Headache
787.01-787.03	Nausea & vomiting
787.04	Bilious emesis
787.91	Diarrhea
794.31	Abnormal electrocardiogram
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional lability
799.25	Demoralization and apathy
799.29	Other signs and symptoms involving emotional state
972.0	Poisoning by cardiac rhythm regulators
972.1	Poisoning by cardiotonic glycosides & drugs of similar action
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance
995.21	Arthus phenomenon
995.24	Failed moderate sedation during procedure
995.27	Other drug allergy
995.29	Unspecified adverse effect of other drug, medicinal & biological substance
*E942.1	Adverse effect of cardiotonic glycosides and drugs of similar action
V58.69	Encounter long term - medication use (not elsewhere classified)
*Code may not be reported as a stand-alone or first-listed code on the claim	

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.34 Fecal Occult Blood Test (1 of 4)

Data Source: http://www.cms.gov

CPT Code: 82272

NCD Description:. The Fecal Occult Blood Test (FOBT) detects the presence of trace amounts of blood in the stool. The procedure is performed by testing one or several small samples of one, two, or three different stool specimens.

ICD-9-CM Codes that Support Medical Necessity

The Occult Fecal Blood is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided

003.0	Salmonella gastroenteritis
003.1	Salmonella septicemia
004.0-004.9	Shigellosis
005.0-005.4, 005.81, 005.89, 005.9	Other food poisoning (bacterial)
006.0-006.9	Amebiasis
007.0-007.9	Other protozoal intestinal diseases
008.41-008.49	Intestinal infections due to other specified bacteria
009.0-009.3	Ill-defined intestinal infections
014.00-014.86	Tuberculosis of intestines, peritoneum, and mesenteric glands
040.2	Whipple's disease
095.2	Syphilitic peritonitis
095.3	Syphilis of liver
098.0	Gonococcal infection, acute, lower genitourinary tract
098.7	Gonococcal Infection anus and rectum
098.84	Gonococcal endocaritis
123.0-123.9	Other cestode infection
124	Trichinosis
127.0-127.9	Other intestinal helminthiases
139.8	Late effects of other and unspecified infectious and parasitic diseases
150.0-157.9	Malignant neoplasm of digestive organisms
159.0-159.9	Malignant neoplasm of other and ill-defined sites within the digestive organs and peritoneum
176.3	Kaposi's sarcoma, gastrointestinal sites
197.4-197.5	Secondary malignant neoplasm of intestines
197.8	Secondary malignant neoplasm of other digestive organs & spleen
199.0	Disseminated malignant neoplasm
204.00-204.01	Acute lymphoid leukemia, without mention of having achieved remission and in remission
204.02	Acute lymphoid leukemia, in relapse
204.10-204.11	Chronic lymphoid leukemia, without mention of having achieved remission and in remission
204.12	Chronic lymphoid leukemia, in relapse
204.20-204.21	Subacute lymphoid leukemia, without mention of having achieved remission and in remission
204.22	Subacute lymphoid leukemia, in relapse
204.80-204.81	Other lymphoid leukemia, without mention of having achieved remission and in remission
204.82	Other lymphoid leukemia, in relapse
204.90-204.91	Unspecified lymphoid leukemia, without mention of having achieved remission and in remission
204.92	Unspecified lymphoid leukemia, in relapse
205.00-205.01	Acute myeloid leukemia, without mention of having achieved remission and in remission
205.02	Acute myeloid leukemia, in relapse
205.10-205.11	Chronic myeloid leukemia, without mention of having achieved remission and in remission
205.12	Chronic myeloid leukemia, in relapse
205.20-205.21	Subacute myeloid leukemia, without mention of having achieved remission and in remission
205.22	Subacute myeloid leukemia, in relapse
205.30-205.31	Myeloid sarcoma, without mention of having achieved remission and in remission
205.32	Myeloid sarcoma, in relapse
205.80-205.81	Other myeloid leukemia, without mention of having achieved remission and in remission
205.82	Other myeloid leukemia, in relapse
205.90-205.91	Unspecified myeloid leukemia, without mention of having achieved remission and in remission
205.92	Unspecified myeloid leukemia, in relapse

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.34 Fecal Occult Blood Test (2 of 4)

Data Source: http://www.cms.gov

CPT Code: 82272

NCD Description:. The Fecal Occult Blood Test (FOBT) detects the presence of trace amounts of blood in the stool. The procedure is performed by testing one or several small samples of one, two, or three different stool specimens.

ICD-9-CM Codes that Support Medical Necessity

The Occult Fecal Blood is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided

206.00-206.01	Acute monocytic leukemia, without mention of having achieved remission and in remission
206.02	Acute monocytic leukemia, in relapse
206.10-206.11	Chronic monocytic leukemia, without mention of having achieved remission and in remission
206.12	Chronic monocytic leukemia, in relapse
206.20-206.21	Subacute monocytic leukemia, without mention of having achieved remission and in remission
206.22	Subacute monocytic leukemia, in relapse
206.80-206.81	Other monocytic leukemia, without mention of having achieved remission and in remission
206.82	Other monocytic leukemia, in relapse
206.90-206.91	Unspecified monocytic leukemia, without mention of having achieved remission and in remission
206.92	Unspecified monocytic leukemia, in relapse
207.00-207.01	Acute erythremia and erythroleukemia, without mention of having achieved remission and in remission
207.02	Acute erythremia and erythroleukemia, in relapse
207.10-207.11	Chronic erythremia, without mention of having achieved remission and in remission
207.12	Chronic erythremia, in relapse
207.20-207.21	Megakaryocytic leukemia, without mention of having achieved remission and in remission
207.22	Megakaryocytic leukemia, in relapse
207.80-207.81	Other specified leukemia, without mention of having achieved remission and in remission
207.82	Other specified leukemia, in relapse
208.00-208.01	Acute leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.02	Acute leukemia of unspecified cell type, in relapse
208.10-208.11	Chronic leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.12	Chronic leukemia of unspecified cell type, in relapse
208.20-208.21	Subacute leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.22	Subacute leukemia of unspecified cell type, in relapse
208.80-208.81	Other leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.82	Other leukemia of unspecified cell type, in relapse
208.90-208.91	Unspecified leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.92	Unspecified leukemia of unspecified cell type, in relapse
209.00-209.03	Malignant carcinoid tumors of the small intestine
209.10-209.17	Malignant carcinoid tumors of the appendix, large intestine & rectum
209.40-209.43	Benign carcinoid tumors of the small intestine
209.50-209.57	Benign carcinoid tumors of the appendix, large intestine and rectum
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone
209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.34 Fecal Occult Blood Test (3 of 4)

Data Source: http://www.cms.gov

CPT Code: 82272

NCD Description:. The Fecal Occult Blood Test (FOBT) detects the presence of trace amounts of blood in the stool. The procedure is performed by testing one or several small samples of one, two, or three different stool specimens.

ICD-9-CM Codes that Support Medical Necessity

The Occult Fecal Blood is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided

211.0-211.9	Benign neoplasm of other parts of digestive system
228.04	Hemangioma of intra-abdominal structures
230.2-230.9	Carcinoma in situ of digestive organs
235.2	Neoplasm of uncertain behavior of stomach, intestines, and rectum
235.5	Neoplasm of uncertain behavior of other & unspecified digestive organs
239.0	Neoplasm of unspecified nature, digestive system
280.0-280.9	Iron deficiency anemias
284.2	Myelophthisis
285.0-285.29	Siderblastic anemia and anemia of other chronic disease
285.3	Antineoplastic chemotherapy induced anemia
285.8-285.9	Other and unspecified anemias
286.0-286.9	Coagulation defects
*10/1/11 Per CR 7507 delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.	
287.0-287.39	Allergic purpura; qualitative platelet defects; other non-thrombocytopenic purpuras; primary thrombocytopenia
287.41	Posttransfusion purpura
287.49	Other secondary thrombocytopenia
287.5-287.9	Thrombocytopenia, unspecified; other specified and unspecified hemorrhagic conditions
338.3	Neoplasm related pain (acute) (chronic)
448.0	Hereditary hemorrhagic telangiectasia
455.0-455.8	Hemorrhoids
456.0-456.21	Esophageal varices with or without mention of bleeding
530.10-530.21, 530.3-530.7, 530.81-530.89, 530.9	Diseases of the esophagus
531.00-535.61	Gastric ulcer; duodenal ulcer; peptic ulcer, site unspecified; gastrojejunal ulcer; and gastritis and duodenitis
535.70	Eosinophilic gastritis, without mention of obstruction
535.71	Eosinophilic gastritis, with obstruction
536.2	Persistent vomiting
536.8-536.9	Dyspepsia and other specified and unspecified functional disorders of stomach
537.0-537.4	Other disorders of stomach and duodenum
537.82-537.83	Angiodysplasia of stomach and duodenum
537.84	Dieulafoy lesion (hemorrhagic) of stomach and duodenum
537.89	Other specified disorders of stomach and duodenum
555.0-558.3	Non-infectious enteritis and colitis
558.41	Eosinophilic gastroenteritis
558.42	Eosinophilic colitis
558.9	Non-infectious enteritis and colitis
560.0-560.2	Intestinal obstruction: intussusceptions, paralytic ileus, volvulus
560.30	Impaction of intestine, unspecified
560.31	Gallstone ileus
560.32	Fecal impaction
560.39	Other impaction of intestine
562.10-562.13	Diverticulosis/diverticulitis of colon
564.00-564.9	Functional digestive disorders, not elsewhere classified
565.0-565.1	Anal fissure and fistula
569.0	Anal and rectal polyp
569.1	Rectal prolapse
569.3	Hemorrhage of rectum and anus
569.41 - 569.44, 569.49	Other specified disorders of rectum and anus
569.82-569.83	Ulceration and perforation of intestine
569.84-569.85	Angiodysplasia of intestine with or without mention of hemorrhage
569.86	Dieulafoy lesion (hemorrhagic) of intestine
569.87	Vomiting of fecal matter
571.0 - 571.9	Chronic liver disease and cirrhosis
577.0-577.9	Diseases of the pancreas
578.0-578.9	Gastrointestinal hemorrhage

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.34 Fecal Occult Blood Test (4 of 4)

Data Source: http://www.cms.gov

CPT Code: 82272

NCD Description:. The Fecal Occult Blood Test (FOBT) detects the presence of trace amounts of blood in the stool. The procedure is performed by testing one or several small samples of one, two, or three different stool specimens.

ICD-9-CM Codes that Support Medical Necessity

The Occult Fecal Blood is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided

579.0	Celiac disease
579.8	Other specified intestinal malabsorption
596.1	Intestinovesical fistula
617.5	Endometriosis of intestine
780.71	Chronic fatigue syndrome
780.72	Functional quadriplegia
780.79	Other malaise and fatigue
783.0	Anorexia
783.21	Abnormal loss of weight
787.01-787.03	Nausea and vomiting
787.04	Bilious emesis
787.1	Heartburn
787.20	Dysphagia, unspecified
787.21	Dysphagia, oral phase
787.22	Dysphagia, oropharyngeal phase
787.23	Dysphagia, pharyngeal phase
787.24	Dysphagia, pharyngo-esophageal phase
787.29	Other dysphagia
787.7	Abnormal feces
787.91	Diarrhea
787.99	Other symptoms involving digestive system
789.00-789.09	Abdominal pain
789.30-789.39	Abdominal or pelvic swelling, mass, or lump
789.40-789.49	Abdominal rigidity
789.51	Malignant ascites
789.59	Other ascites
789.60-789.69	Abdominal tenderness
789.7	Colic
790.92	Abnormal coagulation profile
792.1	Nonspecific abnormal findings in stool contents
793.6	Nonspecific (abnormal) findings on radiological and other examination, abdominal area, including retroperitoneum
794.8	Nonspecific abnormal results of function studies, liver
863.0-863.90	Injury to gastrointestinal tract
863.91-863.95, 863.99	Injury to gastrointestinal tract
864.00-864.09	Injury to liver without mention of open wound into cavity
864.11-864.19	Injury to liver with open wound into cavity
866.00-866.03	Injury to kidney without mention of open wound into cavity
866.10-866.13	Injury to kidney with open wound into cavity
902.0 -902.9	Injury to blood vessels of abdomen and pelvis
926.11-926.19	Crushing injury of trunk, other specified sites
926.8	Crushing injury of trunk, multiple sites
926.9	Crushing injury of trunk, unspecified site
964.2	Poisoning by agents primarily affecting blood constituents, anticoagulants
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance
995.24	Failed moderate sedation during procedure
V10.00-V10.09	Personal history of malignant neoplasm, gastrointestinal tract
V12.00	Personal history of unspecified infectious and parasitic disease
V12.72	Personal history of colonic polyps
V58.61	Long term (current) use of anticoagulants
V58.63-V58.65	Long-term (current) drug use
V58.66	Long-term (current) use of aspirin
V58.69	Long term (current) use of other medications
V67.51	Following treatment w/ high risk medication, not elsewhere specified

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (1 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

003.1	Salmonella septicemia
006.0-006.9	Amebiasis
014.00-014.86	Tuberculosis of intestines, peritoneum, and mesenteric glands
017.90-017.96	Tuberculosis of other specified organs
018.90-018.96	Miliary tuberculosis, unspecified
020.0-020.9	Plague
022.3	Anthrax septicemia
027.0	Listeriosis
027.1	Erysipelothrix infection
030.1	Tuberculoid leprosy [Type T]
032.83	Diphtheritic peritonitis
036.1	Meningococcal encephalitis
036.2	Meningococcemia
038.0, 038.10-038.19, 038.2, 038.3, 038.40-038.49, 038.8, 038.9	Septicemia
038.12	Methicillin resistant Staphylococcus aureus septicemia
039.2	Actinomycotic infections, abdominal
040.0	Gas gangrene
042	Human immunodeficiency virus (HIV) disease
054.0	Eczema herpeticum
054.5	Herpetic septicemia
060.0-060.1	Yellow fever
070.0-070.9	Viral hepatitis
072.71	Mumps hepatitis
073.0	Ornithosis, with pneumonia
074.8	Other specified diseases due to Coxsackie virus
075 I	Infectious mononucleosis
078.5	Cytomegaloviral disease
079.99	Unspecified viral infection
082.0-082.9	Tick-borne rickettsioses, stet
084.9	Other pernicious complications of malaria
086.1	Chagas disease with organ involvement other than heart
088.81	Lyme disease
091.62	Secondary syphilitic hepatitis
095.3	Syphilis of liver
100.0	Leptospirosis icterohemorrhagica
112.5	Candidiasis, disseminated
115.00	Infection by Histoplasma capsulatum without mention of manifestation
120.9	Schistosomiasis, unspecified
121.1	Clonorchiasis
121.3	Fascioliasis
122.0	Echinococcus granulosus infection of liver
122.5	Echinococcus multilocularis infection of liver
122.8	Echinococcosis, unspecified, of liver
122.9	Echinococcus, other and unspecified
130.5	Hepatitis due to toxoplasmosis
135	Sarcoidosis
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin, and breast
*10/1/11 Per CR 7507 delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of ICD-9-CM codes that are covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.	

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (2 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

170.0-176.9	Malignant neoplasm of bone, connective tissue, skin, and breast
*10/1/11 Per CR 7507 add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.	
179-189.9	Malignant neoplasm of genitourinary organs
200.00-200.28	Lymphosarcoma and reticulosarcoma; Burkitt's tumor or lymphoma
200.30-200.38	Marginal zone lymphoma
200.40-200.48	Mantle cell lymphoma
200.50-200.58	Primary central nervous system lymphoma
200.60-200.68	Anaplastic large cell lymphoma
200.70-200.78	Large cell lymphoma
200.80-200.88	Malignant tumors of lymphatic tissue; other named variants
201.00-201.98	Hodgkin's disease
202.00-202.68	Other malignant neoplasms of lymphoid and histiocytic tissue
202.70-202.78	Peripheral T-cell lymphoma
202.80-202.98	Other lymphomas; other and unspecified malignant neoplasms of lymphoid and histiocytic tissue
203.00-203.01	Multiple myeloma, without mention of having achieved remission and in remission
203.02	Multiple myeloma, in relapse
203.10-203.11	Plasma cell leukemia, without mention of having achieved remission and in remission
203.12	Plasma cell leukemia, in relapse
203.80-203.81	Other immunoproliferative neoplasms, without mention of having achieved remission and in remission
203.82	Other immunoproliferative neoplasms, in relapse
204.00-204.01	Acute lymphoid leukemia, without mention of having achieved remission and in remission
204.02	Acute lymphoid leukemia, in relapse
204.10-204.11	Chronic lymphoid leukemia, without mention of having achieved remission and in remission
204.12	Chronic lymphoid leukemia, in relapse
204.20-204.21	Subacute lymphoid leukemia, without mention of having achieved remission and in remission
204.22	Subacute lymphoid leukemia, in relapse
204.80-204.81	Other lymphoid leukemia, without mention of having achieved remission and in remission
204.82	Other lymphoid leukemia, in relapse
204.90-204.91	Unspecified lymphoid leukemia, without mention of having achieved remission and in remission
204.92	Unspecified lymphoid leukemia, in relapse
205.00-205.01	Acute myeloid leukemia, without mention of having achieved remission and in remission
205.02	Acute myeloid leukemia, In relapse
205.10-205.11	Chronic myeloid leukemia, without mention of having achieved remission and in remission
205.12	Chronic myeloid leukemia, in relapse
205.20-205.21	Subacute myeloid leukemia, without mention of having achieved remission and in remission
205.22	Subacute myeloid leukemia, in relapse

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (3 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

205.30-205.31	Myeloid sarcoma, without mention of having achieved remission and in remission
205.32	Myeloid sarcoma, in relapse
205.80-205.81	Other myeloid leukemia, without mention of having achieved remission and in remission
205.82	Other myeloid leukemia, in relapse
205.90-205.91	Unspecified myeloid leukemia, without mention of having achieved remission and in remission
205.92	Unspecified myeloid leukemia, in relapse
206.00-206.01	Acute monocytic leukemia, without mention of having achieved remission and in remission
206.02	Acute monocytic leukemia, in relapse
206.10-206.11	Chronic monocytic leukemia, without mention of having achieved remission and in remission
206.12	Chronic monocytic leukemia, in relapse
206.20-206.21	Subacute monocytic leukemia, without mention of having achieved remission and in remission
206.22	Subacute monocytic leukemia, in relapse
206.80-206.81	Other monocytic leukemia, without mention of having achieved remission and in remission
206.82	Other monocytic leukemia, in relapse
206.90-206.91	Unspecified monocytic leukemia, without mention of having achieved remission and in remission
206.92	Unspecified monocytic leukemia, in relapse
207.00-207.01	Acute erythremia and erythroleukemia, without mention of having achieved remission and in remission
207.02	Acute erythremia and erythroleukemia, in relapse
207.10-207.11	Chronic erythremia, without mention of having achieved remission and in remission
207.12	Chronic erythremia, in relapse
207.20-207.21	Megakaryocytic leukemia, without mention of having achieved remission and in remission
207.22	Megakaryocytic leukemia, in relapse
207.80-207.81	Other specified leukemia, without mention of having achieved remission and in remission
207.82	Other specified leukemia, in relapse
208.00-208.01	Acute leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.02	Acute leukemia of unspecified cell type, in relapse
208.10-208.11	Chronic leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.12	Chronic leukemia of unspecified cell type, in relapse
208.20-208.21	Subacute leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.22	Subacute leukemia of unspecified cell type, in relapse
208.80-208.81	Other leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.82	Other leukemia of unspecified cell type, in relapse
208.90-208.91	Unspecified leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.92	Unspecified leukemia of unspecified cell type, in relapse
209.20-209.27, 209.29	Malignant carcinoid tumors of other and unspecified sites
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (4 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites
211.5	Benign neoplasm of liver and biliary passages
211.6	Benign neoplasm of pancreas, except islets of Langerhans
211.7	Benign neoplasm of islets of Langerhans
228.04	Hemangioma of intra-abdominal structures
230.7	Carcinoma in situ of other and unspecified parts of intestine
230.8	Carcinoma in situ of liver and biliary system
230.9	Carcinoma in situ other and unspecified digestive organs
235.0-235.9	Neoplasms of uncertain behavior of digestive and respiratory systems
236.0-236.99	Neoplasms of uncertain behavior of genitourinary organs
237.0-237.72	Neoplasms of uncertain behavior of endocrine glands and nervous system
237.73	Schwannomatosis
237.79	Other neurofibromatosis
237.9	Other and uncertain parts of the nervous system
238.0-238.6	Neoplasms of uncertain behavior of other and unspecified sites and tissues
238.71-238.76	Neoplasms of other lymphatic and hematopoietic tissues
238.77	Post-transplant lymphoproliferative disorder (PTLD)
238.79	Other lymphatic and hematopoietic tissues
238.8	Other specified sites
238.9	Site unspecified
239.0	Neoplasm of unspecified nature of digestive system
250.00-250.93	Diabetes mellitus
252.00-252.02, 252.08	Hyperparathyroidism
263.1	Malnutrition of mild degree
263.9	Unspecified protein-calorie malnutrition
268.0	Rickets, active
268.2	Osteomalacia, unspecified
269.0	Deficiency of vitamin K
270.2	Other disturbances of aromatic amino acid metabolism
270.9	Unspecified disorder of amino acid metabolism
271.0	Glycogenosis
272.0	Pure hypercholesterolemia
272.1	Pure hypertriglyceridemia
272.2	Mixed hyperlipidemia
272.4	Other and unspecified hyperlipidemia
272.7	Lipidoses
272.9	Unspecified disorder of lipoid metabolism
273.4	Alpha-1-antitrypsin deficiency
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
275.1	Disorders of copper metabolism
275.2	Disorders of magnesium metabolism
275.3	Disorders of phosphorus metabolism
275.40-275.49	Disorders of calcium metabolism
275.5	Hungry bone syndrome
277.1	Disorders of porphyrin metabolism
277.30	Amyloidosis, unspecified
277.31	Familial Mediterranean fever
277.39	Other amyloidosis
277.4	Disorders of biliuria excretion

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (5 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

277.6	Other deficiencies of circulating enzymes
282.60-282.69	Sickle cell disease
286.6	Defibrination syndrome
286.7	Acquired coagulation factor deficiency
289.4	Hypersplenism
289.52	Splenic sequestration
291.0-291.9	Alcoholic psychoses
303.00-303.03	Acute alcoholic intoxication
303.90-303.93	Other and unspecified alcohol dependence
304.00-304.93	Drug dependence
305.00-305.93	Non-dependent abuse of drugs
357.5	Alcoholic polyneuropathy
359.21	Myotonic muscular dystrophy
359.22	Myotonia congenita
359.23	Myotonic chondrodystrophy
359.24	Drug induced myotonia
359.29	Other specified myotonic disorder
452	Portal vein thrombosis
453.0	Budd-Chiari syndrome
453.1	Thrombophlebitis migrans
453.2	Embolism and thrombosis of inferior vena cava
453.3	Embolism and thrombosis of renal vein
453.40	Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.41	Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
453.42	Acute venous embolism and thrombosis of deep vessels of distal lower extremity
453.50	Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.51	Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity
453.52	Chronic venous embolism and thrombosis of deep vessels of distal lower extremity
453.6	Venous embolism and thrombosis of superficial vessels of lower extremity
453.71	Chronic venous embolism and thrombosis of superficial veins of upper extremity
453.72	Chronic venous embolism and thrombosis of deep veins of upper extremity
453.73	Chronic venous embolism and thrombosis of upper extremity, unspecified
453.74	Chronic venous embolism and thrombosis of axillary veins
453.75	Chronic venous embolism and thrombosis of subclavian veins
453.76	Chronic venous embolism and thrombosis of internal jugular veins
453.77	Chronic venous embolism and thrombosis of other thoracic veins
453.79	Chronic venous embolism and thrombosis of other specified veins
453.81	Acute venous embolism and thrombosis of superficial veins of upper extremity
453.82	Acute venous embolism and thrombosis of deep veins of upper extremity
453.83	Acute venous embolism and thrombosis of upper extremity, unspecified
453.84	Acute venous embolism and thrombosis of axillary veins
453.85	Acute venous embolism and thrombosis of subclavian veins
453.86	Acute venous embolism and thrombosis of internal jugular veins

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (6 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

453.87	Acute venous embolism and thrombosis of other thoracic veins
453.89	Acute venous embolism and thrombosis of other specified veins
453.9	Other venous embolism and thrombosis of unspecified site
456.0-456.21	Esophageal varices
555.0-555.9	Regional enteritis
556.0-556.9	Ulcerative colitis
557.0	Acute vascular insufficiency of intestine
558.1-558.3, 558.41-558.49, 558.9	Other and unspecified noninfectious gastroenteritis and colitis
560.0-560.2	Intestinal obstruction: intussusceptions, paralytic ileus, volvulu
560.30	Impaction of intestine, unspecified
560.31	Gallstone ileus
560.32	Fecal impaction
560.39	Other impaction of intestine
560.81-560.89, 560.9	Other and unspecified intestinal obstruction
562.01	Diverticulitis of small intestine (without mention of hemorrhage)
562.03	Diverticulitis of small intestine with hemorrhage
562.11	Diverticulitis of colon (without mention of hemorrhage)
562.13	Diverticulitis of colon with hemorrhage
567.0-567.29, 567.38-567.9	Peritonitis
569.83	Perforation of intestine
569.87	Vomiting of fecal matter
570	Acute and subacute necrosis of liver
571.0-571.9	Chronic liver disease and cirrhosis
572.0	Abscess of liver
572.1	Portal pyemia
572.2	Hepatic encephalopathy
572.3	Portal hypertension
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
573.0-573.9	Other disorders of liver
574.00-574.91	Cholelithiasis
575.0-575.9	Other disorders of gallbladder
576.0-576.9	Other disorders of biliary tract
581.0-581.9	Nephrotic syndrome
582.0-582.9	Chronic glomerulonephritis
583.0-583.9	Nephritis and nephropathy not specified as acute or chronic
584.5	Acute kidney failure with lesion of tubular necrosis
584.6	Acute kidney failure with lesion of renal cortical necrosis
584.7	Acute kidney failure with lesion of renal medullary (papillary) necrosis
584.8	Acute kidney failure with other specified pathological lesion in kidney
584.9	Acute kidney failure, unspecified
585.6	End stage renal disease
586	Renal failure, unspecified
587	Renal sclerosis, unspecified
588.0-588.9	Disorders resulting from impaired renal function
642.50-642.54	Severe pre-eclampsia
646.70, 646.71, 646.73	Liver disorders in pregnancy
782.4	Jaundice, unspecified, not of newborn
789.1	Hepatomegaly
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase
790.5	Other nonspecific abnormal serum enzyme levels
960.0-960.9	Poisoning by antibiotics
961.0-961.9	Poisoning by other anti-infectives
962.0-962.9	Poisoning by hormones and synthetic substitutes

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.32 Gamma Glutamyl Transferase (7 of 7)

Data Source: http://www.cms.gov

CPT Code: 82977

NCD Description: Gamma Glutamyltransferase (GGT) is an intracellular enzyme that appears in blood following leakage from cells. Renal tubules, liver, and pancreas contain high amounts, although the measurement of GGT in serum is almost always used for assessment of Hepatoliliary function. Unlike other enzymes which are found in heart, skeletal muscle and intestinal mucosa as well as liver, the appearance of an elevated level of GGT in serum is almost always the result of liver disease or injury. It is specifically useful to differentiate elevated alkaline phosphatase levels when the source of the alkaline phosphatase increase (bone, liver, or placenta) is unclear. The combination of high alkaline phosphatase and a normal GGT does not, however, rule out liver disease completely.

ICD-9-CM Codes that Support Medical Necessity

The Gamma Glutamyltransferase (GTT) test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

963.0-963.5, 963.8, 963.9	Poisoning by primarily systemic agents
964.0-964.9	Poisoning by agents primarily affecting blood constituent
965.00-965.02, 965.09, 965.1, 965.4-965.5, 965.61, 965.69, 965.7-965.9	Poisoning by analgesics, antipyretics, and antirheumatics
966.0-966.4	Poisoning by anticonvulsants and anti-parkinsonism drugs
967.0-967.6, 967.8, 967.9	Poisoning by sedatives and hypnotics
968.0-968.7, 968.9	Poisoning by other CNS depressants and anesthetics
969.00	Poisoning by antidepressant, unspecified
969.01	Poisoning by monoamine oxidase inhibitors
969.02	Poisoning by selective serotonin & norepinephrine reuptake Inhibitors
969.03	Poisoning by selective serotonin reuptake inhibitors
969.04	Poisoning by tetracyclic antidepressants
969.05	Poisoning by tricyclic antidepressants
969.09	Poisoning by other antidepressants
969.1-969.5, 969.6	Poisoning by tranquilizers and psychodysleptics (hallucinogens)
969.70	Poisoning by psychostimulant, unspecified
969.71	Poisoning by caffeine
969.72	Poisoning by amphetamines
969.73	Poisoning by methylphenidate
969.79	Poisoning by other psychostimulants
969.8, 969.9	Poisoning by other specified and unspecified psychotropic agents
970.0-970.1	Poisoning by analeptics and opiate antagonists
970.81	Poisoning by cocaine
970.89	Poisoning by other central nervous system stimulants
970.9	Poisoning by unspecified central nervous system stimulants
971.0-971.3, 971.9	Poisoning by drugs primarily affecting the autonomic nervous system
972.0-972.9	Poisoning by agents primarily affecting the cardiovascular system
973.0-973.6, 973.8, 973.9	Poisoning by agents primarily affecting the GI system
974.0-974.7	Poisoning by water, mineral, and uric acid metabolism drugs
975.0-975.8	Poisoning by agents primarily acting on the smooth a skeletal muscles and respiratory system
976.0-976.9	Poisoning by agents primarily affecting skin and mucous membrane, ophthalmological, otorhinolaryngological, and dental drugs
977.0-977.4, 977.8, 977.9	Poisoning by other and unspecified drugs, and medicinal substances
978.0-978.6, 978.8, 978.9	Poisoning by bacterial vaccines
978.0-978.6, 978.8, 978.9	Poisoning by bacterial vaccines
979.0-979.7	Poisoning by other vaccines and biological sustances
979.9	Poisoning by drugs, medicinal, and biological substances
980.0-989.89	Toxic effects of substances chiefly nonmedicinal as to source
V42.7	Organ replaced by transplant, liver
V58.61-V58.64, V58.69	Long-term (current) drug use
V67.1	Follow-up examination, radiotherapy
V67.2	Follow-up examination, chemotherapy
V67.51	Follow-up examination after completed treatment with high-risk medications, not elsewhere classified

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.21 Glycated Hemoglobin - Glycated Protein

Data Source: http://www.cms.gov

CPT Codes: 82985, 83036

NCD Description: The management of diabetes mellitus requires regular determinations of blood glucose levels. Glycated hemoglobin/protein levels are used to assess long-term glucose control in diabetes. Alternative names for these tests include glycated or glycosylated hemoglobin or Hgb, hemoglobin glycated or glycosylated protein, and fructosamine.

ICD-9-CM Codes that Support Medical Necessity

The Glycated Hemoglobin/Glycated Protein test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

211.7	Benign neoplasm of islets of Langerhans
249.00-249.01	Secondary diabetes mellitus without mention of complication
249.10-249.11	Secondary diabetes mellitus with ketacidosis
249.20-249.21	Secondary diabetes mellitus with hyperosmolarity
249.30-249.31	Secondary diabetes mellitus with other coma
249.40-249.41	Secondary diabetes mellitus with renal manifestations
249.50-249.51	Secondary diabetes mellitus with ophthalmic manifestations
249.60-249.61	Secondary diabetes mellitus with neurological manifestations
249.70-249.71	Secondary diabetes mellitus with peripheral circulatory disorders
249.80-249.81	Secondary diabetes mellitus with other specified manifestations
249.90-249.91	Secondary diabetes mellitus with unspecified complication
250.00-250.93	Diabetes mellitus & various related codes
251.0	Hypoglycemic coma
251.1	Other specified hypoglycemia
251.2	Hypoglycemia unspecified
251.3	Post-surgical hypoinsulinemia
251.4	Abnormality of secretion of glucagon
251.8	Other specified disorders of pancreatic internal secretion
251.9	Unspecified disorder of pancreatic internal secretion
258.0-258.9	Polyglandular dysfunction and related disorders
271.4	Renal glycosuria
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
577.1	Chronic pancreatitis
579.3	Other and unspecified postsurgical nonabsorption
648.00	Diabetes mellitus complicating pregnancy, Childbirth or the puerperium, unspecified as to episode of care or not applicable
648.03	Diabetes mellitus complicating pregnancy, Childbirth or the puerperium, antepartum condition or complication
648.04	Diabetes mellitus complicating pregnancy, Childbirth or the puerperium, postpartum condition or complication
648.80	Abnormal glucose tolerance complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care or not applicable
648.83	Abnormal glucose tolerance complicating pregnancy, childbirth or the puerperium, antepartum condition or complication
648.84	Abnormal glucose tolerance complicating pregnancy, childbirth or the puerperium, postpartum condition or complication
790.21-790.29	Abnormal glucose tolerance test
790.6	Other abnormal blood chemistry (hyperglycemia)
962.3	Poisoning by insulin and antidiabetic agents
V12.21	Personal history of gestational diabetes
V12.29	Personal history of other endocrine, metabolic, and immunity disorders
V58.67	Long-term (current) use of insulin
V58.69	Long-term use of other medication

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.33 Hepatitis Panel /Acute Hepatitis Panel

Data Source: http://www.cms.gov

CPT Code: 80074

NCD Description: This panel consists of the following tests:
Hepatitis A antibody (HAAB),IgM antibody (CPT86709)
Hepatitis B core antibody (HBcAb), IgM Antibody (86705)
Hepatitis B surface antigen (HBsAg) (CPT 87340)
Hepatitis C antibody.(CPT 86803)

ICD-9-CM Codes that Support Medical Necessity

The Hepatitis Panel test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s)

070.0-070.9	Viral hepatitis
456.0-456.21	Esophageal varices with or without mention of bleeding
570	Acute and subacute necrosis of liver
571.5	Cirrhosis of liver without mention of alcohol
572.0	Abscess of liver
572.1	Portal pyemia
572.2	Hepatic encephalopathy
572.3	Portal hypertension
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
573.3	Hepatitis, unspecified
573.5	Hepatopulmonary syndrome
780.31	Febrile convulsions (simple), unspecified
780.32	Complex febrile convulsions
780.33	Post traumatic seizures
780.71	Chronic fatigue syndrome
780.72	Functional quadriplegia
780.79	Other malaise and fatigue
782.4	Jaundice, unspecified, not of newborn
783.0-783.6	Symptoms concerning nutrition, metabolism, and development
787.01-787.03	Nausea and vomiting
787.04	Bilious emesis
789.00-789.09	Abdominal pain
789.1	Hepatomegaly
789.61	Localized abdominal tenderness (RUQ)
789.7	Colic
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase (LDH)
794.8	Nonspecific abnormal results of function studies, liver
996.82	Complications of transplanted organ, liver
V72.85	Liver transplant recipient evaluation

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.27 Human Chorionic Gonadotropin

Data Source: http://www.cms.gov

CPT Code: 84702

NCD Description:. Human Chorionic Gonadopropin (hCG) is useful for monitoring and diagnosis of germ cell neoplasms of the ovary, testis,mediastinum,retroperitoneum,and central nervous system.In addition ,Hcg is useful for monitoring pregnant patients with vaginal bleeding,hypertension and/or suspected fetal loss.

ICD-9-CM Codes that Support Medical Necessity

The Human Chorionic Gonadotropin test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

158.0	Malignant neoplasm of retroperitoneum
158.8	Malignant neoplasm of specified parts of peritoneum
164.2	Malignant neoplasm of anterior mediastinum
164.3	Malignant neoplasm of posterior mediastinum
164.8	Malignant neoplasm, other (includes malignant neoplasm contiguous overlapping sites of thymus, heart, and mediastinum whose point of origin cannot be determined
164.9	Malignant neoplasm of mediastinum, part specified
181	Malignant neoplasm of placenta
183.0	Malignant neoplasm of ovary
183.8	Other specified sites of uterine adnexa
186.0	Malignant neoplasm of undescended testis
186.9	Malignant neoplasm of other and unspecified testis
194.4	Malignant neoplasm of pineal gland
197.1	Secondary malignant neoplasm of mediastinum
197.6	Secondary malignant neoplasm of retroperitoneum and peritoneum
198.6	Secondary malignant neoplasm of ovary
198.82	Secondary malignant neoplasm of other genital organs
236.1	Neoplasm of uncertain behavior, placenta
338.3	Neoplasm related pain (acute) (chronic)
623.8	Vaginal bleeding
625.9	Pelvic pain
630	Hydatidiform mole
631.0	Inappropriate change in quantitative human chorionic gonadotropin(hCG) in early pregnancy
631.8	Other abnormal products of conception
632	Missed abortion
633.90-633.91	Unspecified ectopic pregnancy
634.00-634.02	Spontaneous abortion, complicated by genital tract and pelvic infection
640.00-640.03	Threatened abortion
642.30-642.34	Transient hypertension of pregnancy
642.40-642.74	Pre-eclampsia or eclampsia
642.90-642.94	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium
795.89	Other abnormal tumor markers
V10.09	Personal history of malignant neoplasm, other gastrointestinal sites
V10.29	Personal history of malignant neoplasm of other respiratory and intrathoracic organs
V10.43	Personal history of malignant neoplasm, ovary
V10.47	Personal history of malignant neoplasm, testis
V22.0-V22.1	Normal pregnancy

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

Data Source: http://www.cms.gov

190.14 Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (1 of 4)

CPT Codes: 86689,86701,86702,86703,87390,87391,87534,87535,87537,87538

NCD Description: Diagnosis of Human Immunodeficiency Virus (HIV) infection is primarily made through the use of serological assays. These assays take one of two forms: antibody detection assays and specific HIV antigen (p24) procedures. The antibody assays are usually enzyme Immunoassays (EIA) which are used to confirm exposure of an individual's immune system to specific viral antigens. These assays may be formatted to detect HIV-1, HIV-2, or HIV1 and 2 simultaneously and to detect both IgM and IgG. When the initial EIA test is repeatedly positive or indeterminant, an alternative test is used to confirm the specificity of the antibodies to individual viral components. The most commonly used method is the Western Blot.

ICD-9-CM Codes that Support Medical Necessity

The Human Immunodeficiency Virus Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

003.1	Salmonella septicemia
007.2	Coccidiosis (Isoporiasis)
007.4	Cryptosporidiosis
007.8	Other specified protozoal intestinal diseases
010.00-010.96	Primary tuberculous infection
011.00-011.96	Pulmonary tuberculosis
012.00-012.86	Other respiratory tuberculosis
013.00-013.96	Tuberculosis of meninges--+ and central nervous system
014.00-014.86	Tuberculosis of intestines, peritoneum and mesenteric glands
015.00-015.96	Tuberculosis of bones and joints
016.00-016.96	Tuberculosis of genitourinary system
017.00-017.96	Tuberculosis of other organs
018.00-018.96	Miliary tuberculosis
027.0	Listeriosis
031.0-031.9	Diseases due to other mycobacteria
038.2	Pneumococcal septicemia
038.43	Septicemia (Pseudomonas)
039.0-039.9	Actinomycotic infections (includes Nocardia)
041.7	Pseudomonas infection
042	HIV disease (Acute retroviral syndrome, AIDS-related complex)
046.3	Progressive multifocal leukoencephalopathy
049.0-049.9	Other non-arthropod-borne viral diseases of central nervous system
052.0-052.1, 052.2, 052.7-052.8	Chickenpox(with complication)
053.0, 053.10-053.13,053.14, 053.19-053.22, 053.29, 053.71,053.79, 053.8, 053.9	Herpes zoster
054.0, 054.10-054.13, 054.19, 054.2, 054.3, 054.40-054.44, 054.49, 054.5, 054.6, 054.7-054.73, 054.74, 054.79, 054.8, 054.9	Herpes simplex
055.0-055.8	Measles (with complication)
070.20-070.23	Viral hepatitis B with hepatic coma
070.30-070.33	Viral hepatitis B without mention of hepatic coma
070.41	Acute hepatitis C with hepatic coma
070.42	Hepatitis delta without mention of active hepatitis B disease with hepatic coma
070.44	Chronic hepatitis C with hepatic coma
070.49	Other specified viral hepatitis with hepatic coma
070.51	Acute hepatitis C without mention of hepatic coma
070.52	Hepatitis delta without mention of active hepatitis B disease without hepatic coma
070.54	Chronic hepatitis C without hepatic coma
070.59	Other specified viral hepatitis without hepatic coma
070.6	Unspecified viral hepatitis with hepatic coma
070.70	Unspecified viral hepatitis C without hepatic coma
070.71	Unspecified viral hepatitis C with hepatic coma
070.9	Unspecified viral hepatitis without hepatic coma
078.0	Molluscum contagiosum
078.10–078.19	Viral warts
078.3	Cat-scratch disease
078.5	Cytomegaloviral disease
078.88	Other specified diseases due to Chlamydiae

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

Data Source: http://www.cms.gov

190.14 Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (2 of 4)

CPT Codes: 86689,86701,86702,86703,87390,87391,87534,87535,87537,87538

NCD Description: Diagnosis of Human Immunodeficiency Virus (HIV) infection is primarily made through the use of serological assays. These assays take one of two forms: antibody detection assays and specific HIV antigen (p24) procedures. The antibody assays are usually enzyme Immunoassays (EIA) which are used to confirm exposure of an individual's immune system to specific viral antigens. These assays may be formatted to detect HIV-1, HIV-2, or HIV1 and 2 simultaneously and to detect both IgM and IgG. When the initial EIA test is repeatedly positive or indeterminant, an alternative test is used to confirm the specificity of the antibodies to individual viral components. The most commonly used method is the Western Blot.

ICD-9-CM Codes that Support Medical Necessity

The Human Immunodeficiency Virus Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

079.50	Retrovirus unspecified
079.51	HTLV-I
079.52	HTLV-II
079.53	Human immunodeficiency virus, type 2
079.59	Other specified Retrovirus
079.83	Parvovirus B19
079.88	Other specified chlamydial infection
079.98	Unspecified chlamydial infection
085.0-085.9	Leishmaniasis
088.0	Bartonellosis
090.0-090.9	Congenital syphilis
091.0-091.9	Early syphilis symptomatic
092.0-092.9	Early syphilis, latent
093.0-093.9	Cardiovascular syphilis
094.0-094.9	Neurosyphilis
095.0-095.9	Other forms of late syphilis, with symptoms
096	Late syphilis, latent
097.0-097.9	Other and unspecified syphilis
098.0-098.89	Gonococcal infections
099.0	Chancroid
099.1	Lymphogranuloma venereum
099.2	Granuloma inguinale
099.3	Reiter's disease
099.40-099.49	Other nongonococcal urethritis
099.50-099.59	Other venereal diseases due oChlamydia trachomatis
099.8	Other specified venereal diseases
099.9	Venereal disease, unspecified
110.1	Dermatophytosis of nail
111.0	Pityriasis versicolor
112.0-112.9	Candidiasis
114.0-114.9	Coccidioidomycosis
115.00-115.99	Histoplasmosis
116.0-116.2	Blastomycotic infection
117.3	Aspergillosis
117.5	Cryptococcosis
118	Opportunistic mycoses
127.2	Strongyloidiasis
130.0-130.9	Toxoplasmosis
131.01	Trichomonal vulvovaginitis
132.2	Phthirus pubis
133.0	Scabies
136.21	Specific infection due to acanthamoeba
136.29	Other specific infections by free-living amebae
136.3	Pneumocystosis
136.8	Other specified infectious and parasitic disease (i.e.: microsporidiosis)
176.0-176.9	Kaposi's sarcoma
180.0-180.9	Malignant neoplasm of cervix uteri
200.20-200.28	Burkitt's tumor or lymphoma
200.80-200.88	Lymphosarcoma, other named variants
201.00-201.98	Hodgkin's disease
263.0	Malnutrition of moderate degree

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

Data Source: http://www.cms.gov

190.14 Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (3 of 4)

CPT Codes: 86689,86701,86702,86703,87390,87391,87534,87535,87537,87538

NCD Description: Diagnosis of Human Immunodeficiency Virus (HIV) infection is primarily made through the use of serological assays. These assays take one of two forms: antibody detection assays and specific HIV antigen (p24) procedures. The antibody assays are usually enzyme Immunoassays (EIA) which are used to confirm exposure of an individual's immune system to specific viral antigens. These assays may be formatted to detect HIV-1, HIV-2, or HIV1 and 2 simultaneously and to detect both IgM and IgG. When the initial EIA test is repeatedly positive or indeterminant, an alternative test is used to confirm the specificity of the antibodies to individual viral components. The most commonly used method is the Western Blot.

ICD-9-CM Codes that Support Medical Necessity

The Human Immunodeficiency Virus Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

263.1	Malnutrition of mild degree	294.8	Other persistent mental disorders due to conditions classified elsewhere
263.9	Unspecified protein-calorie malnutrition	310.1	Personality change due to conditions classified elsewhere
280.0-280.9	Iron deficiency anemias	322.2	Chronic meningitis
285.9	Anemia, unspecified	331.19	Other frontotemporal dementia
287.30-287.39	Primary thrombocytopenia	331.83	Mild cognitive impairment, so stated
288.00	Neutropenia, unspecified	336.9	Unspecified disease of spinal cord
288.01	Congenital neutropenia	348.30	Encephalopathy unspecified
288.02	Cyclic neutropenia	348.39	Other encephalopathy
288.03	Drug induced neutropenia	354.0-354.9	Mononeuritis of upper limbs and mononeuritis multiplex
288.04	Neutropenia due to infection	356.8	Other specified idiopathic peripheral neuropathy
288.09	Other neutropenia	363.20	Chorioretinitis, unspecified
288.4	Hemophagocytic syndromes	425.4	Other primary cardiomyopathies
288.50	Leukocytopenia, unspecified	473.0-473.9	Chronic sinusitis
288.51	Lymphocytopenia	481-482.41	Pneumococcal pneumonia and other bacterial pneumonia
288.59	Other decreased white blood cell count	482.42	Methicillin resistant pneumonia due to Staphylococcus aureus
288.60	Leukocytosis, unspecified	482.49-482.9	Other pneumonia due to Staphylococcus, specified and unspecified
288.61	Lymphocytosis (symptomatic)	484.1	Pneumonia in cytomegalic inclusion disease
288.62	Leukemoid reaction	486	Pneumonia, organism unspecified
288.63	Monocytosis (symptomatic)	512.81	Primary spontaneous pneumothorax
288.64	Plasmacytosis	512.82	Secondary spontaneous pneumothorax
288.65	Basophilia	512.83	Chronic pneumothorax
288.66	Bandemia		
288.69	Other elevated white blood cell count		
288.8	Other specified disease of white blood cells		
289.53	Neutropenic splenomegaly		

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

Data Source: http://www.cms.gov

190.14 Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (4 of 4)

CPT Codes: 86689,86701,86702,86703,87390,87391,87534,87535,87537,87538

NCD Description: Diagnosis of Human Immunodeficiency Virus (HIV) infection is primarily made through the use of serological assays. These assays take one of two forms: antibody detection assays and specific HIV antigen (p24) procedures. The antibody assays are usually enzyme Immunoassays (EIA) which are used to confirm exposure of an individual's immune system to specific viral antigens. These assays may be formatted to detect HIV-1, HIV-2, or HIV1 and 2 simultaneously and to detect both IgM and IgG. When the initial EIA test is repeatedly positive or indeterminant, an alternative test is used to confirm the specificity of the antibodies to individual viral components. The most commonly used method is the Western Blot.

ICD-9-CM Codes that Support Medical Necessity

The Human Immunodeficiency Virus Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

516.8	Other specified alveolar and parietoalveolar pneumonopathies
528.2	Oral aphthae
528.6	Leukoplakia of oral mucosa
530.20-530.21	Ulcer of esophagus
530.85	Barrett's esophagus
583.9	Nephropathy with unspecified pathological lesion in kidney
588.81	Secondary hyperparathyroidism (of renal origin)
588.89	Other specified disorders resulting from impaired renal function
647.60-647.64	Other viral diseases complicating pregnancy (use for HIV I and II)
682.0-682.9	Other cellulitis and abscess
690.10-690.18	Seborrheic dermatitis
696.1	Other psoriasis
698.3	Lichenification and lichen simplex chronicus
704.8	Other specified diseases of hair and hair follicles
706.0-706.9	Diseases of sebaceous glands
780.60	Fever, unspecified
780.61	Fever presenting with conditions classified elsewhere
780.62	Postprocedural feer
780.63	Postvaccination fever
780.64	Chills (without fever)
780.65	Hypothermia not associated with low environmental temperature
780.66	Febrile nonhemolytic transfusion reaction
780.79	Other malaise and fatigue
783.21	Abnormal loss of weight
783.40	Lack of expected normal physiological development
785.6	Enlargement of lymph nodes
786.00	Respiratory abnormality, unspecified
786.05	Shortness of breath
786.2	Cough
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants (AIPHI)
786.39	Other hemoptysis
786.4	Abnormal sputum
787.91	Diarrhea
795.71	Nonspecific serologic evidence of human immunodeficiency virus
799.4	Wasting disease
V01.71	Contact or exposure to varicella
V01.79	Contact or exposure to other viral diseases
V71.5	Rape

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.13 Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring)

Data Source: http://www.cms.gov

CPT Code: 87536, 87539
HIV-1 or HIV-2 quantification or viral load

NCD Description: HIV quantification is achieved through the use of a number of different assays, which measure the amount of circulatory viral RNA. Assays vary both in methods used to detect viral RNA as well as in ability to detect viral levels at lower limits. However, all employ some type of nucleic acid amplification technique to enhance sensitivity, and results are expressed as the HIV copy number.

ICD-9-CM Codes that Support Medical Necessity

The HIV Quantification test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s). This list was compiled from the Medicare National Coverage Determination Policy. An ICD-D-9-CM book should be used as a complete reference.

042	Human immunodeficiency virus [HIV] disease
079.53	Human immunodeficiency virus, type 2 [HIV-2]
647.60-647.64	Other viral diseases complicating pregnancy (including HIV-I and II)
795.71	Nonspecific serologic evidence of human immunodeficiency virus [HIV]
V08	Asymptomatic human immunodeficiency virus [HIV] infection status

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.23 Lipids Testing (1 of 3)

Data Source: http://www.cms.gov

CPT Codes: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478

NCD Description: Lipoproteins are a class of heterogeneous particles of varying sizes and densities containing lipid and protein. These lipoproteins include cholesterol esters and free cholesterol, triglycerides, phospholipids and A, C, and E apoproteins. Total cholesterol comprises all the cholesterol found in various lipoproteins. Factors that affect blood cholesterol levels include age, sex, body weight, diet, alcohol and tobacco use, exercise, genetic factors, family history, medications, menopausal status, the use of hormone replacement therapy, and chronic disorders such as hypothyroidism, obstructive liver disease, pancreatic disease (including diabetes), and kidney disease.

ICD-9-CM Codes that Support Medical Necessity

Lipid tests are determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

242.00-245.9	Disorders of the thyroid gland with hormonal dysfunction
249.00-249.01	Secondary diabetes mellitus without mention of complication
249.10-249.11	Secondary diabetes mellitus with ketoacidosis
249.20-249.21	Secondary diabetes mellitus with hyperosmolarity
249.30-249.31	Secondary diabetes mellitus with other coma
249.40-249.41	Secondary diabetes mellitus with renal manifestations
249.50-249.51	Secondary diabetes mellitus with ophthalmic manifestations
249.60-249.61	Secondary diabetes mellitus with neurological manifestations
249.70-249.71	Secondary diabetes mellitus with peripheral circulatory disorders
249.80-249.81	Secondary diabetes mellitus with other specified manifestations
249.90-249.91	Secondary diabetes mellitus with unspecified complication
250.00-250.93	Diabetes mellitus
255.0	Cushing's syndrome
260	Kwashiorkor
261	Nutritional marasmus
262	Other severe, protein-calorie malnutrition
263.0	Malnutrition of moderate degree
263.1	Malnutrition of mild degree
263.8	Other protein-calorie malnutrition
263.9	Unspecified protein-calorie malnutrition
270.0	Disturbances of amino-acid transport
271.1	Galactosemia
272.0	Pure hypercholesterolemia
272.1	Hypertriglyceridemia
272.2	Mixed hyperlipidemia (tuberous xanthoma)
272.2	Mixed hyperlipidemia (tuberous xanthoma)
272.3	Hyperchylomicronemia
272.4	Other and unspecified hyperlipidemia (unspecified xanthoma)
272.5	Lipoprotein deficiencies
272.6	Lipodystrophy
272.7	Lipidoses
272.8	Other disorders of lipoid metabolism
272.9	Unspecified disorders of lipoid metabolism
277.30	Amyloidosis, unspecified
277.31	Familial Mediterranean fever
277.39	Other amyloidosis
278.00	Obesity
278.01	Morbid obesity
278.02	Overweight
278.03	Obesity hypoventilation syndrome
303.90-303.92	Alcoholism
362.10-362.16	Other background retinopathy and retinal vascular change
362.30-362.34	Retinal vascular occlusion
362.82	Retinal exudates and deposits
371.41	Senile corneal changes
374.51	Xanthelasma

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.23 Lipids Testing (2 of 3)

Data Source: http://www.cms.gov

CPT Codes: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478

NCD Description: Lipoproteins are a class of heterogeneous particles of varying sizes and densities containing lipid and protein. These lipoproteins include cholesterol esters and free cholesterol, triglycerides, phospholipids and A, C, and E apoproteins. Total cholesterol comprises all the cholesterol found in various lipoproteins. Factors that affect blood cholesterol levels include age, sex, body weight, diet, alcohol and tobacco use, exercise, genetic factors, family history, medications, menopausal status, the use of hormone replacement therapy, and chronic disorders such as hypothyroidism, obstructive liver disease, pancreatic disease (including diabetes), and kidney disease.

ICD-9-CM Codes that Support Medical Necessity

Lipid tests are determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

379.22	Crystalline deposits in vitreous
388.00	Degenerative & vascular disorder of ear, unspecified
388.02	Transient ischemic deafness
401.0, 401.1, 401.9	Essential hypertension
402.00-402.91	Hypertensive heart disease
403.00-403.91	Hypertensive chronic kidney disease
404.00-404.93	Hypertensive heart and chronic kidney disease
405.01-405.99	Secondary hypertension
410.00-410.92	Acute myocardial infarction
411.0-411.1	Other acute & subacute forms of ischemic heart disease
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute and subacute ischemic heart disease
412	Old myocardial infarction
413.0-413.1	Angina pectoris
413.9	Other and unspecified angina pectoris
414.00-414.03	Coronary atherosclerosis
414.04	Coronary atherosclerosis, of artery bypass graft
414.05	Coronary atherosclerosis, of unspecified graft
414.06	Coronary atherosclerosis, of coronary artery of transplanted heart
414.07	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart
414.10	Aneurysm of heart (wall)
414.11	Coronary vessel aneurysm
414.12	Dissection of coronary artery
414.19	Other aneurysm of heart
414.3	Coronary atherosclerosis due to lipid rich plaque
414.4	Coronary atherosclerosis due to calcified coronary lesion
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
428.0-428.9	Heart failure
429.2	Heart disease, unspecified
429.9	Heart disease NOS
431	Intracerebral hemorrhage
433.00-433.91	Occlusion & stenosis of precerebral arteries
434.00-434.91	Occlusion of cerebral arteries
435.0-435.9	Transient cerebral ischemia
437.0	Cerebral atherosclerosis
437.1	Other generalized ischemic cerebrovascular disease
437.5	Moyamoya disease
438.0, 438.10-438.14, 438.19, 438.20-438.22, 438.30-438.32, 438.40-438.42, 438.50-438.53, 438.6, 438.7, 438.81-438.85, 438.89, 438.9	Late effects of cerebrovascular disease
440.0-440.32	Atherosclerosis of aorta; of other arteries; of bypass grafts
440.4	Chronic total occlusion of the artery of the extremities
440.8-440.9	Atherosclerosis of other specified arteries; generalized and unspecified atherosclerosis

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.23 Lipids Testing (3 of 3)

Data Source: http://www.cms.gov

CPT Codes: 80061, 82465, 83700, 83701, 83704, 83718, 83721, 84478

NCD Description: Lipoproteins are a class of heterogeneous particles of varying sizes and densities containing lipid and protein. These lipoproteins include cholesterol esters and free cholesterol, triglycerides, phospholipids and A, C, and E apoproteins. Total cholesterol comprises all the cholesterol found in various lipoproteins. Factors that affect blood cholesterol levels include age, sex, body weight, diet, alcohol and tobacco use, exercise, genetic factors, family history, medications, menopausal status, the use of hormone replacement therapy, and chronic disorders such as hypothyroidism, obstructive liver disease, pancreatic disease (including diabetes), and kidney disease.

ICD-9-CM Codes that Support Medical Necessity

Lipid tests are determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

441.00-441.9	Aortic aneurysms and dissection
442.0	Upper extremity aneurysm
442.1	Renal artery aneurysm
442.2	Iliac artery aneurysm
444.01, 444.09, 444.1-444.9	Arterial embolism and thrombosis
557.1	Chronic vascular insufficiency of intestine
571.8	Other chronic non-alcoholic liver disease
571.9	Unspecified chronic liver disease without mention of alcohol
573.5	Hepatopulmonary syndrome
573.8	Other specified disorders of liver
573.9	Unspecified disorders of liver
577.0-577.9	Pancreatic disease
579.3	Other & unspecified postsurgical nonabsorption
579.8	Other specified intestinal malabsorption
581.0-581.9	Nephrotic syndrome
584.5	Acute kidney failure with lesion of tubular necrosis
585.4 – 585.9	Chronic kidney disease
588.0	Renal osteodystrophy
588.1	Nephrogenic diabetes insipidus
588.81	Secondary hyperparathyroidism (of renal origin)
588.89	Other specified disorders resulting from impaired renal function
588.9	Unspecified disorder resulting from impaired renal function
607.84	Impotence of organic origin, penis disorder
646.70-646.71	Liver disorders in pregnancy
646.73	Liver and biliary tract disorders in pregnancy, antepartum condition or complication
648.10-648.14	Thyroid dysfunction in pregnancy and the puerperium
696.0	Psoriatic arthropathy
696.1	Other psoriasis
751.61	Biliary atresia
764.10-764.19	"Light for dates" with signs of fetal malnutrition
786.50	Chest pain unspecified
786.51	Precordial pain
786.59	Chest pain, other
789.1	Hepatomegaly
790.4	Abnormal transaminase
790.5	Abnormal alkaline phosphatase
790.6	Other abnormal blood chemistry
793.4	Nonspecific (abnormal) findings on radiological and other examination of gastrointestinal tract
987.9	Toxic effect of unspecified gas or vapor
996.81	Complication of transplanted organ, kidney
V42.0	Transplanted organ, kidney
V42.7	Organ replacement by transplant, liver
V58.63-V58.64	Long-term (current) drug use
V58.69	Long term (current) use of other medications
V81.0-V81.2	Covered only for procedure codes **80061, 82465, 83718 & 84478**. Special screening for cardiovascular, respiratory, and genitourinary diseases

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.16 Partial Thromboplastin Time (PTT) (1 of 6)

Data Source: http://www.cms.gov

CPT Code: 85730

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: The Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PTT test is an in vitro laboratory test used to assess the intrinsic coagulation pathway and monitor heparin therapy.

ICD-9-CM Codes that Support Medical Necessity

The Partial Thromboplastin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

002.0-002.9	Typhoid and paratyphoid
003.0-003.9	Other Salmonella infections
038.9	Unspecified Septicemia
042	Human immunodeficiency virus (HIV) disease
060.0-060.9	Yellow fever
065.0-065.9	Arthropod borne hemorrhagic fever
070.0-070.9	Viral hepatitis
075	Infectious mononucleosis
078.6	Hemorrhagic nephrosonephritis
078.7	Arenaviral hemorrhagic fever
120.0	Schistosomiasis haematobium
121.1	Clonorchiasis
121.3	Fascioliasis
124	Trichinosis
135	Sarcoidosis
155.0-155.2	Malignant neoplasm of liver and intrahepatic bile ducts
197.7	Malignant neoplasm of liver, specified as secondary
238.4	Polycythemia vera
238.71	Essential thrombocythemia
238.72	Low grade myelodysplastic syndrome lesions
238.73	High grade myelodysplastic syndrome lesions
238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.76	Myelofibrosis with myeloid metaplasia
238.77	Post-transplant lymphoproliferative disorder (PTLD)
238.79	Other lymphatic and hematopoietic tissues
239.9	Neoplasm of unspecified nature, site unspecified
246.3	Hemorrhage and infarction of thyroid
249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled
250.40-250.43	Diabetic with renal manifestations
269.0	Deficiency of Vitamin K
273.0-273.3, 273.8-273.9	Disorders of plasma protein metabolism
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
275.1	Disorders of copper metabolism
275.2	Disorders of magnesium metabolism
275.3	Disorders of phosphorus metabolism
275.40-275.49	Disorders of calcium metabolism
275.5	Hungry bone syndrome
275.8-275.9	Other specified disorders of mineral metabolism, and unspecified disorder of mineral metabolism
277.1	Disorders of porphyrin metabolism
277.30	Amyloidosis, unspecified
277.31	Familial Mediterranean fever
277.39	Other amyloidosis
285.1	Acute posthemorrhagic anemia
286.0	Congenital factor VIII disorder - Hemophilia A
286.1	Congenital factor IX disorder - Hemophilia B
286.2-286.3	Other congenital factor deficiencies
286.4	von Willebrand's disease
286.52	Acquired hemophilia
286.53	Antiphospholipid antibody with hemorrhagic disorder
286.59	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
286.6	Defibrination syndrome
286.7	Acquired coagulation factor deficiency
286.9	Other and unspecified coagulation defects

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.16 Partial Thromboplastin Time (PTT) (2 of 6)

Data Source: http://www.cms.gov

CPT Code: 85730

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: The Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PTT test is an in vitro laboratory test used to assess the intrinsic coagulation pathway and monitor heparin therapy.

ICD-9-CM Codes that Support Medical Necessity

The Partial Thromboplastin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

287.0-287.39	Allergic purpura; qualitative platelet defects; other non-thrombocytopenic purpuras; primary thrombocytopenia
287.41	Posttransfusion purpura
287.49	Other secondary thrombocytopenia
287.5-287.9	Thrombocytopenia, unspecified; other specified and unspecified hemorrhagic conditions
289.0	Polycythemia, secondary
289.81	Primary hypercoagulable state
325	Phlebitis and thrombophlebitis of intracranial venous sinuses
360.43	Hemophthalmos, except current injury
362.30-362.37	Retinal vascular occlusion
362.43	Hemorrhagic detachment of retinal pigment epithelium
362.81	Retinal hemorrhage
363.61-363.63	Choroidal hemorrhage
363.72	Choroidal detachment
368.9	Unspecified Visual Disturbances
372.72	Conjunctive hemorrhage
374.81	Hemorrhage of eyelid
376.32	Orbital hemorrhage
377.42	Hemorrhage in optic nerve sheaths
379.23	Vitreous hemorrhage
380.31	Hematoma of auricle or pinna
403.01, 403.11, 403.91	Hypertensive chronic kidney disease, with chronic kidney disease stage V or end stage renal disease
404.02, 404.12, 404.92	Hypertensive heart and chronic kidney disease, without heart failure and with chronic kidney disease stage V or end stage renal disease
410.00-410.92	Acute myocardial infarction
423.0	Hemopericardium
427.31	Atrial fibrillation
427.9	Cardiac dysrhythmias, unspecified
428.0	Congestive heart failure, unspecified
429.79	Mural thrombus
430-432.9	Cerebral hemorrhage
433.00-433.91	Occlusion and stenosis of precerebral arteries
434.00-434.91	Occlusion of cerebral arteries
435.9	Focal neurologic deficit
444.01, 444.09, 444.1-444.9	Arterial embolism and thrombosis
446.6	Thrombotic microangiopathy
447.2	Rupture of artery
448.0	Hereditary Hemorrhagic telangiectasia
451.0-451.9	Phlebitis and thrombophlebitis
453.0	Budd-Chiari syndrome
453.1	Thrombophlebitis migrans
453.2	Embolism and thrombosis of inferior vena cava
453.3	Embolism and thrombosis of renal vein
453.40	Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.41	Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
453.42	Acute venous embolism and thrombosis of deep vessels of distal lower extremity
453.50	Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.51	Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity
453.52	Chronic venous embolism and thrombosis of deep vessels of distal lower extremity
453.6	Venous embolism and thrombosis of superficial vessels of lower extremity
453.71	Chronic venous embolism and thrombosis of superficial veins of upper extremity

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.16 Partial Thromboplastin Time (PTT) (3 of 6)

Data Source: http://www.cms.gov

CPT Code: 85730

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: The Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PTT test is an in vitro laboratory test used to assess the intrinsic coagulation pathway and monitor heparin therapy.

ICD-9-CM Codes that Support Medical Necessity

The Partial Thromboplastin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

453.72	Chronic venous embolism and thrombosis of deep veins of upper extremity
453.73	Chronic venous embolism and thrombosis of upper extremity, unspecified
453.74	Chronic venous embolism and thrombosis of axillary veins
453.75	Chronic venous embolism and thrombosis of subclavian veins
453.76	Chronic venous embolism and thrombosis of internal jugular veins
453.77	Chronic venous embolism and thrombosis of other thoracic veins
453.79	Chronic venous embolism and thrombosis of other specified veins
453.81	Acute venous embolism and thrombosis of superficial veins of upper extremity
453.82	Acute venous embolism and thrombosis of deep veins of upper extremity
453.83	Acute venous embolism and thrombosis of upper extremity, unspecified
453.84	Acute venous embolism and thrombosis of axillary veins
453.85	Acute venous embolism and thrombosis of subclavian veins
453.86	Acute venous embolism and thrombosis of internal jugular veins
453.87	Acute venous embolism and thrombosis of other thoracic veins
453.89	Acute venous embolism and thrombosis of other specified veins
453.9	Other venous embolism and thrombosis of unspecified site
456.0	Esophageal varices with bleeding
456.1	Esophageal varices without bleeding
456.8	Varices of other sites
459.89	Ecchymosis
530.7	Gastroesophageal laceration – hemorrhage syndrome
530.82	Esophageal hemorrhage
531.00-535.61	Gastric-Duodenal ulcer disease
535.70	Eosinophilic gastritis, without mention of obstruction
535.71	Eosinophilic gastritis, with obstruction
537.83	Angiodysplasia of stomach and duodenum with hemorrhage
537.84	Dieulafoy lesion (hemorrhagic) of stomach and duodenum
556.0-557.9	Hemorrhagic bowel disease
562.02-562.03	Diverticulosis of small intestine with hemorrhage
562.12	Diverticulosis of colon with hemorrhage
562.13	Diverticulitis of colon with hemorrhage
568.81	Hemoperitoneum (nontraumatic)
569.3	Hemorrhage of rectum and anus
570	Acute and subacute necrosis of liver
571.0-571.9	Chronic liver disease and cirrhosis
572.0	Abscess of liver
572.1	Portal pyemia
572.2	Hepatic encephalopathy
572.3	Portal hypertension
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
573.0-573.9	Other disorders of liver
576.0-576.9	Biliary tract disorders
577.0	Acute pancreatitis
578.0-578.9	Gastrointestinal Hemorrhage
579.0-579.9	Malabsorption
581.0-581.9	Nephrotic Syndrome
583.9	Nephritis, with unspecified pathological lesion in kidney
584.5	Acute kidney failure with lesion of tubular necrosis
584.6	Acute kidney failure with lesion of renal cortical necrosis
584.7	Acute kidney failure with lesion of renal medullary (papillary) necrosis
584.8	Acute kidney failure with other specified pathological lesion in kidney
584.9	Acute kidney failure, unspecified
585.4-585.9	Chronic kidney disease
586	Renal failure
593.81-593.89	Other disorders of kidney and ureter, with hemorrhage

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.16 Partial Thromboplastin Time (PTT) (4 of 6)

Data Source: http://www.cms.gov

CPT Code: 85730

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: The Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PTT test is an in vitro laboratory test used to assess the intrinsic coagulation pathway and monitor heparin therapy.

ICD-9-CM Codes that Support Medical Necessity

The Partial Thromboplastin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

596.7	Hemorrhage into bladder wall
596.81	Infection of cystostomy
596.82	Mechanical complication of cystostomy
596.83	Other complication of cystostomy
596.89	Other specified disorders of bladder
599.70	Hematuria, unspecified
599.71	Gross hematuria
599.72	Microscopic hematuria
607.82	Penile hemorrhage
608.83	Vascular disorders of male genital organs
611.89	Other specified disorders of breast including hematoma
620.7	Hemorrhage of broad ligament
621.4	Hematometra
622.8	Other specified disorders of cervix, with hemorrhage
623.6	Vaginal hematoma
623.8	Other specified diseases of the vagina, with hemorrhage
624.5	Hematoma of vulva
626.6	Metrorrhagia
626.7	Postcoital bleeding
627.0	Premenopausal bleeding
627.1	Postmenopausal bleeding
629.0	Hematocele female not elsewhere classified
632	Missed abortion
634.00-634.92	Spontaneous abortion
635.10-635.12	Legally induced abortion, complicated by delayed or excessive hemorrhage
636.10-636.12	Illegally induced abortion, complicated by delayed or excessive hemorrhage
637.10-637.12	Abortion unspecified, complicated by delayed or excessive hemorrhage
638.1	Failed attempt abortion, complicated by delayed or excessive hemorrhage
639.1	Delayed or excessive hemorrhage following abortion and ectopic and molar pregnancies
639.6	Complications following abortion and ectopic and molar pregnancies, embolism
640.00-640.93	Hemorrhage in early pregnancy
641.00-641.93	Antepartum hemorrhage
642.00-642.94	Hypertension complicating pregnancy, childbirth, and the puerperium
646.70-646.73	Liver disorders in pregnancy
649.30	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
649.31	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition
649.32	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
649.33	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
649.34	Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
649.50	Spotting complicating pregnancy, unspecified as to episode of care or not applicable
649.51	Spotting complicating pregnancy, delivered, with or without mention of antepartum condition
649.53	Spotting complicating pregnancy, antepartum condition or complication
656.00-656.03	Fetal maternal hemorrhage
658.40-658.43	Infection of amniotic cavity
666.00-666.34	Postpartum hemorrhage
671.20-671.54	Phlebitis in pregnancy

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.16 Partial Thromboplastin Time (PTT) (5 of 6)

Data Source: http://www.cms.gov

CPT Code: 85730

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: The Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PTT test is an in vitro laboratory test used to assess the intrinsic coagulation pathway and monitor heparin therapy.

ICD-9-CM Codes that Support Medical Necessity

The Partial Thromboplastin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

673.00-673.84	Obstetrical pulmonary embolus
674.30-674.34	Other complications of surgical wounds, with hemorrhage
710.0	Systemic Lupus erythematosus
713.2	Arthropathy associated with hematologic disorders (note: may not be used without indicating associated condition first)
713.6	Arthropathy associated with Henoch Schonlein (note: may not be used without indicating associated condition first)
719.10-719.19	Hemarthrosis
729.5	Pain in limb
729.81	Swelling of limb
733.10-733.19	Pathologic fracture associated with fat embolism
762.1	Other forms of placental separation with hemorrhage (affecting newborn code – do not assign to mother's record)
764.90-764.99	Fetal intrauterine growth retardation
767.0, 767.11	Subdural and cerebral hemorrhage
767.8	Other specified birth trauma, with hemorrhage
770.3	Fetal and newborn pulmonary hemorrhage
772.0	Fetal blood loss affecting newborn
772.10-772.14	Fetal and neonatal intraventricular hemorrhage
772.2	Fetal and neonatal subarachnoid hemorrhage
772.3	Fetal and neonatal umbilical hemorrhage after birth
772.4	Fetal and neonatal gastrointestinal hemorrhage
772.5	Fetal and neonatal adrenal hemorrhage
772.6	Fetal and neonatal cutaneous hemorrhage
772.8	Fetal and neonatal other specified hemorrhage of fetus or newborn
772.9	Fetal and neonatal unspecified hemorrhage of newborn
774.0-774.7	Other perinatal jaundice
776.0	Hemorrhagic disease of the newborn
776.1	Transient neonatal thrombocytopenia
776.2	Disseminated intravascular coagulation in newborn
776.3	Other transient neonatal disorders of coagulation
776.4	Polycythemia neonatorum
776.5	Congenital anemia
776.6	Anemia of prematurity
776.7	Transient neonatal neutropenia
776.8	Other specified transient hematological disorders
776.9	Unspecified hematological disorder specific to newborn
780.2	Syncope
782.4	Jaundice, unspecified, not of newborn
782.7	Spontaneous ecchymoses Petechiae
784.7	Epistaxis
784.8	Hemorrhage from throat
785.4	Gangrene
785.50	Shock
786.05	Shortness of breath
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants (AIPHI)
786.39	Other hemoptysis
786.50	Chest pain, unspecified
786.59	Chest pain
789.00-789.09	Abdominal pain
789.7	Colic
790.92	Abnormal coagulation profile
800.00-800.99	Fracture of vault of skull
801.00-801.99	Fracture of base of skull
802.20-802.9	Fracture of face bones
803.00-803.99	Other fracture, skull
804.00-804.99	Multiple fractures, skull
805.00- 806.9	Fracture, vertebral column
807.00-807.09	Fracture of rib(s), closed

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.16 Partial Thromboplastin Time (PTT) (6 of 6)

Data Source: http://www.cms.gov

CPT Code: 85730

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: The Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PTT test is an in vitro laboratory test used to assess the intrinsic coagulation pathway and monitor heparin therapy.

ICD-9-CM Codes that Support Medical Necessity

The Partial Thromboplastin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

807.10-807.19	Fracture of rib(s), open
808.8-808.9	Fracture of pelvis
809.0-809.1	Fracture of trunk
810.00-810.13	Fracture of clavicle
811.00-811.19	Fracture of scapula
812.00-812.59	Fracture of humerus
813.10-813.18	Fracture of radius and ulna, upper end, open
813.30-813.33	Fracture of radius and ulna, shaft, open
813.50-813.54	Fracture of radius and ulna, lower end, open
813.90-813.93	Fracture of radius and ulna, unspecified part, open
819.0-819.1	Multiple fractures
820.00–821.39	Femur
823.00-823.92	Tibia and fibula
827.0–829.1	Other multiple lower limb
852.00–853.19	Subarachnoid subdural, and extradural hemorrhage, following injury, Other and specified intracranial hemorrhage following injury
860.0-860.5	Traumatic pneumothorax and hemothorax
861.00-861.32	Injury to heart and lung
862.0-862.9	Injury to other and unspecified intrathoracic organs
863.0-863.99	Injury to gastrointestinal tract
864.00-864.19	Injury to liver
865.00-865.19	Injury to spleen
866.00-866.13	Injury to kidney
867.0-867.9	Injury to pelvic organs
868.00-868.19	Injury to other intra-abdominal organs
869.0-869.1	Internal injury to unspecified or ill defined organs
900.00-900.9	Injury to blood vessels of head and neck
901.0-901.9	Injury to blood vessels of the thorax
902.0-902.9	Injury to blood vessels of the abdomen and pelvis
903.00-903.9	Injury to blood vessels of upper extremity
904.0-904.9	Injury to blood vessels of lower extremity and unspecified sites
920-924.9	Contusion with intact skin surface
925.1-929.9	Crushing injury
958.2	Secondary and recurrent hemorrhage
959.9	Injury, unspecified site
964.2	Poisoning by anticoagulants
964.5	Poisoning by anticoagulant antagonists
964.7	Poisoning by natural blood and blood products
980.0	Toxic effects of alcohol
989.5	Snake venom
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance
995.21	Arthus phenomenon
995.24	Failed moderate sedation during procedure
995.27	Other drug allergy
995.29	Unspecified adverse effect of other drug, medicinal and biological substance
996.70-996.79	Other complications of internal prosthetic device
997.02	Iatrogenic cerebrovascular infarction or hemorrhage
998.11	Hemorrhage or hematoma complicating a procedure
998.12	Hematoma complicating a procedure
999.2	Other vascular complications of medical care
V12.3	Personal history of diseases of blood and blood forming organs
V58.2	Admission for Transfusion of blood products
V58.61	Long term (current use) of anticoagulants
V58.83	Encounter for therapeutic drug monitoring

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.31 Prostate Specific Antigen

Data Source: http://www.cms.gov

CPT Code: 84153

NCD Description:. Prostate Specific Antigen (PSA), a tumor marker for adenocarcinoma of the prostate, can predict residual tumor in the post-operative phase of prostate cancer. Three to 6 months after radical prostatectomy, PSA is reported to provide a sensitive indicator of persistent disease. Six months following introduction of antiandrogen therapy, PSA is reported as capable of distinguishing patients with favorable response from those in whom limited response is anticipated.

ICD-9-CM Codes that Support Medical Necessity

The Prostate Specific Antigen test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

185	Malignant neoplasm of prostate	600.10	Nodular prostate without urinary obstruction
188.5	Malignant neoplasm of bladder neck	600.11	Nodular prostate with urinary obstruction
196.5	Secondary malignant neoplasm, lymph nodes of inguinal region & lower limb	600.21	Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)
196.6	Secondary malignant neoplasm, intrapelvic lymph nodes	601.9	Unspecified prostatitis
196.8	Secondary malignant neoplasm, lymph nodes of multiple sites	602.9	Unspecified disorder of prostate
198.5	Secondary malignant neoplasm, bone and bone marrow	788.20	Retention of urine, unspecified
198.82	Secondary malignant neoplasm, genital organs	788.21	Incomplete bladder emptying
233.4	Carcinoma in situ, prostate	788.30	Urinary incontinence, unspecified
236.5	Neoplasm of uncertain behavior of prostate	788.41	Urinary frequency
239.5	Neoplasm of unspecified nature, other genitourinary organs	788.43	Nocturia
596.0	Bladder neck obstruction	788.62	Slowing of urinary stream
599.60, 599.69	Urinary obstruction	788.63	Urgency of urination
599.70	Hematuria, unspecified	788.64	Urinary hesitancy
599.71	Gross hematuria	788.65	Straining on urination
599.72	Microscopic hematuria	790.93	Elevated prostate specific antigen (PSA)
600.00	Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract (LUTS)	793.6	Non-specific (abnormal) findings on radiological and other examination of abdominal area, including retroperitoneum
600.01	Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)	793.7	Non-specific (abnormal) findings on radiological and other examination of musculoskeletal system
		794.9	Bone scan evidence of malignancy
		V10.46	Personal history of malignant neoplasm; prostate

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (1 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

002.0-002.9	Typhoid and paratyphoid
003.0-003.9	Other Salmonella infections
038.9	Unspecified Septicemia
042	Human Immunodeficiency virus (HIV) disease
060.0-060.9	Yellow fever
065.0-065.9	Arthropod-borne hemorrhagic fever
070.0-070.9	Viral hepatitis
075	Infectious mononucleosis
078.6	Hemorrhagic nephrosonephritis
078.7	Arenaviral hemorrhagic fever
084.8	Blackwater fever
120.0	Schistosomiasis
121.1	Clonorchiasis
121.3	Fascioliasis
124	Trichinosis
134.2	Hirudiniasis
135	Sarcoidosis
152.0-152.9	Malignant neoplasm of small intestine, including duodenum
155.0-155.2	Malignant neoplasm of liver and intrahepatic bile ducts
156.0-156.9	Malignant neoplasm of gallbladder and extrahepatic bile ducts
157.0-157.9	Malignant neoplasm of pancreas
188.0-189.9	Malignant neoplasm of bladder, kidney, and other and unspecified urinary organs
197.7	Secondary malignant neoplasm, liver
198.0	Secondary malignant neoplasm, kidney
198.1	Secondary malignant neoplasm, other urinary organs
200.00-200.28	Lymphosarcoma and reticulosarcoma; Burkitt's tumor or lymphoma
200.30-200.38	Marginal zone lymphoma
200.40-200.48	Mantle cell lymphoma
200.50-200.58	Primary central nervous system lymphoma
200.60-200.68	Anaplastic large cell lymphoma
200.70-200.78	Large cell lymphoma
200.80-200.88	Malignant tumors of lymphatic tissue; other named variants
202.00-202.68	Other malignant neoplasms of lymphoid and histiocytic tissue
202.70-202.78	Peripheral T-cell lymphoma
202.80-202.98	Other lymphomas; other and unspecified malignant neoplasms of lymphoid and histiocytic tissue
209.20-209.27, 209.29	Malignant carcinoid tumors of other and unspecified sites
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone
209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites
223.0-223.9	Benign neoplasm of kidney and other urinary organs
238.4	Polycythemia vera
238.5	Histocytic and mast cells – neoplasm of uncertain behavior
238.6	Plasma cells – neoplasm of uncertain behavior
238.71	Essential thrombocythemia
238.72	Low grade myelodysplastic syndrome lesions
238.73	High grade myelodysplastic syndrome lesions
238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.76	Myelofibrosis with myeloid metaplasia
238.77	Post-transplant lymphoproliferative disorder (PTLD)
238.79	Other lymphatic and hematopoietic tissues
239.4	Neoplasm of unspecified nature, bladder
239.5	Neoplasm of unspecified nature, other genitourinary organs
239.9	Neoplasm of unspecified nature, site unspecified
246.3	Hemorrhage and infarction of thyroid

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (2 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for the test(s) provided.

249.40	Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled
249.41	Secondary diabetes mellitus with renal manifestations, uncontrolled
250.40-250.43	Diabetic with renal manifestations
263.0-263.9	Other and unspecified protein/calorie malnutrition
269.0	Deficiency of Vitamin K
269.2	Unspecified vitamin deficiency
273.0-273.3, 273.8-273.9	Disorders of plasma protein metabolism
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
277.1	Disorders of porphyrin metabolism
277.30	Amyloidosis, unspecified
277.31	Familial Mediterranean fever
277.39	Other amyloidosis
280.0	Iron deficiency anemia, secondary to blood loss - chronic
280.9	Iron deficiency anemia, unspecified
281.0	Pernicious anemia
281.1	Other vitamin B12 deficiency anemia, NEC
281.9	Unspecified deficiency anemia, NOS
285.0	Sideroblastic anemia
285.1	Acute posthemorrhagic anemia
286.0-286.9	Coagulation defects
*10/1/2015 Per CR 7507 delete ICD-9-CM codes 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.	
287.0-287.39	Allergic purpura; qualitative platelet defects; other non-thrombocytopenic purpuras; primary thrombocytopenia
287.41	Posttransfusion purpura
287.49	Other secondary thrombocytopenia
287.5-287.9	Thrombocytopenia, unspecified; other specified and unspecified hemorrhagic conditions
289.81	Primary hypercoagulable state
290.40-290.43	Vascular dementia
325	Phlebitis and thrombophlebitis of intracranial venous sinuses
342.90-342.92	Hemiplegia NOS
360.43	Hemophthalmos, except current injury
362.18	Retinal vasculitis
362.30-362.37	Retinal vascular occlusion
362.43	Hemorrhagic detachment of retinal pigment epithelium
362.81	Retinal hemorrhage
363.61-363.72	Choroidal hemorrhage and rupture, detachment
368.9	Unspecified visual disturbances
372.72	Conjunctival hemorrhage
374.81	Hemorrhage of eyelid
376.32	Orbital hemorrhage
377.42	Hemorrhage in optic nerve sheaths
377.53	Disorders of optic chiasm associated with vascular disorders
377.62	Disorders of visual pathways associated with vascular disorders
377.72	Disorders of visual cortex associated with vascular disorders
379.23	Vitreous hemorrhage
380.31	Hematoma of auricle or pinna
386.2	Vertigo of central origin
386.50	Labyrinthine dysfunction, unspecified
394.0-394.9	Diseases of the mitral valve
395.0	Rheumatic aortic stenosis
395.2	Rheumatic aortic stenosis with insufficiency
396.0-396.9	Diseases of mitral and aortic valves
397.0-397.9	Diseases of other endocardial structures
398.0-398.99	Other rheumatic heart disease
403.01, 403.11, 403.91	Hypertensive chronic kidney disease, with chronic kidney disease stage V or end stage renal disease

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (3 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

404.02, 404.12, 404.92	Hypertensive heart and chronic kidney disease, without heart failure and with chronic kidney disease stage V or end stage renal disease
410.00-410.92	Acute myocardial infarction
411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction
411.89	Other acute and subacute forms of ischemic heart disease
413.0-413.9	Angina pectoris
414.00-414.07	Coronary atherosclerosis
414.3	Coronary atherosclerosis due to lipid rich plaque
414.4	Coronary atherosclerosis due to calcified coronary lesion
414.8	Other specified forms of chronic ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
415.0 – 415.19	Acute pulmonary heart disease
416.9	Chronic pulmonary heart disease, unspecified
423.0	Hemopericardium
424.0	Mitral valve disorders
424.1	Aortic valve disorder
424.90	Endocarditis, valve unspecified, unspecified cause
425.0, 425.11, 425.18, 425.2-425.9	Cardiomyopathy
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure
429.0-429.4	Ill-defined descriptions and complications of heart disease
429.79	Other sequelae of myocardial infarction, not elsewhere classified
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.0-432.9	Other and unspecified intracranial hemorrhage
433.00-433.91	Occlusion and stenosis of precerebral arteries
434.00-434.91	Occlusion of cerebral arteries
435.0-435.9	Transient cerebral ischemia
436	Acute, but ill-defined cerebrovascular disease
437.0	Cerebral atherosclerosis
437.1	Other generalized ischemic cerebrovascular disease
437.6	Nonpyogenic thrombosis of intracranial venous sinus
440.0-440.32	Atherosclerosis of aorta; of other arteries; of bypass grafts
*10/1/111 Per CR 7507 delete ICD-9-CM codes 286.5, 425.1, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.	
440.4	Chronic total occlusion of artery of the extremities
440.8-440.9	Atherosclerosis of other specified arteries; generalized and unspecified atherosclerosis
441.0-441.9	Aortic aneurysm and dissection
443.0-443.9	Other peripheral vascular disease
444.01, 444.09, 444.1-444.9	Arterial embolism and thrombosis
447.1	Stricture of artery
447.2	Rupture of artery
447.6	Arteritis, unspecified
448.0	Hereditary hemorrhagic telangiectasia
448.9	Other and unspecified capillary diseases
451.0-451.9	Phlebitis and thrombophlebitis
452	Portal vein thrombosis
453.0	Budd-Chiari syndrome
453.1	Thrombophlebitis migrans
453.2	Embolism and thrombosis of inferior vena cava
453.3	Embolism and thrombosis of renal vein
453.40	Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.41	Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
453.42	Acute venous embolism and thrombosis of deep vessels of distal lower extremity
453.50	Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (4 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

453.51	Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity	453.89	Acute venous embolism and thrombosis of other specified veins
453.52	Chronic venous embolism and thrombosis of deep vessels of distal lower extremity	453.9	Other venous embolism and thrombosis of unspecified site
453.6	Venous embolism and thrombosis of superficial vessels of lower extremity	455.2	Internal hemorrhoids with other complication
453.71	Chronic venous embolism and thrombosis of superficial veins of upper extremity	455.5	External hemorrhoids with other complication
453.72	Chronic venous embolism and thrombosis of deep veins of upper extremity	455.8	Unspecified hemorrhoids with other complication
453.73	Chronic venous embolism and thrombosis of upper extremity, unspecified	456.0-456.1	Esophageal varices
453.74	Chronic venous embolism and thrombosis of axillary veins	456.8	Varices of other sites
453.75	Chronic venous embolism and thrombosis of subclavian veins	459.0	Hemorrhage, unspecified
453.76	Chronic venous embolism and thrombosis of internal jugular veins	459.10-459.19	Postphlebetic syndrome
453.77	Chronic venous embolism and thrombosis of other thoracic veins	459.2	Compression of vein
453.79	Chronic venous embolism and thrombosis of other specified veins	459.81	Venous (peripheral) insufficiency, unspecified
453.81	Acute venous embolism and thrombosis of superficial veins of upper extremity	459.89	Other, other specified disorders of circulatory system
453.82	Acute venous embolism and thrombosis of deep veins of upper extremity	511.81	Malignant pleural effusion
453.83	Acute venous embolism and thrombosis of upper extremity, unspecified	511.89	Other specified forms of effusion, except tuberculosis
453.84	Acute venous embolism and thrombosis of axillary veins	514	Pulmonary congestion and hypostasis
453.85	Acute venous embolism and thrombosis of subclavian veins	530.7	Gastroesophageal laceration - hemorrhage syndrome
453.86	Acute venous embolism and thrombosis of internal jugular veins	530.82	Esophageal hemorrhage
453.87	Acute venous embolism and thrombosis of other thoracic veins	530.86	Infection of esophagostomy
		530.87	Mechanical complication of esophagostomy
		531.00-535.61	Gastric ulcer, duodenal ulcer, peptic ulcer, gastrojejunal ulcer, gastritis and duodenitis
		535.70	Eosinophilic gastritis, without mention of obstruction
		535.71	Eosinophilic gastritis, with obstruction
		555.0-555.9	Regional enteritis
		556.0-556.9	Ulcerative colitis
		557.0-557.9	Vascular insufficiency of intestine
		562.02-562.03	Diverticulosis of small intestine with hemorrhage
		562.10	Diverticulosis of colon w/o hemorrhage
		562.11	Diverticulitis of colon w/o hemorrhage
		562.12	Diverticulosis of colon with hemorrhage

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (5 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

562.13	Diverticulitis of colon with hemorrhage
568.81	Hemoperitoneum (nontraumatic)
569.3	Hemorrhage of rectum and anus
571.0-571.9	Chronic liver disease and cirrhosis
572.2	Hepatic encephalopathy
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
573.1-573.9	Hepatitis in viral diseases, other and unspecified disorder of liver
576.0-576.9	Other disorders of Biliary tract
577.0 Acute	pancreatitis
578.0-578.9	Gastrointestinal hemorrhage
579.0-579.9	Intestinal Malabsorption
581.0-581.9	Nephrotic Syndrome
583.9	Nephritis, with unspecified pathological lesion in kidney
584.5	Acute kidney failure with lesion of tubular necrosis
584.6	Acute kidney failure with lesion of renal cortical necrosis
584.7	Acute kidney failure with lesion of renal medullary (papillary) necrosis
584.8	Acute kidney failure with other specified pathological lesion in kidney
584.9	Acute kidney failure, unspecified
585.4-585.9	Chronic kidney disease
586	Renal failure, unspecified
593.81-593.89	Other specified disorders of kidney and ureter
596.7	Hemorrhage into bladder wall
596.81	Infection of cystostomy
596.82	Mechanical complication of cystostomy
596.83	Other complication of cystostomy
596.89	Other specified disorders of bladder
599.70	Hematura, unspecified
599.71	Gross hematuria
599.72	Microscopic hematuria
607.82	Vascular disorders of penis
608.83	Vascular disorders of male genital organs
611.89	Other specified disorders of breast including hematoma
620.7	Hematoma of broad ligament
621.4	Hematometra
622.8	Other specified noninflammatory disorders of cervix
623.6	Vaginal hematoma
623.8	Other specified noninflammatory disorders of the vagina
624.5	Hematoma of vulva
626.2-626.9	Abnormal bleeding from female genital tract
627.0	Premenopausal menorrhagia
627.1	Postmenopausal bleeding
629.0	Hematocele female, not classified elsewhere
632	Missed abortion
634.10-634.12	Spontaneous abortion, complicated by excessive hemorrhage
635.10-635.12	Legally induced abortion, complicated by delayed or excessive hemorrhage
636.10-636.12	Illegally induced abortion, complicated by delayed or excessive hemorrhage
637.10-637.12	Abortion unspecified, complicated by delayed or excessive hemorrhage
638.1	Failed attempted abortion, complicated by delayed or excessive hemorrhage
639.1	Delayed or excessive hemorrhage following abortion and ectopic and molar pregnancies
639.6	Complications following abortion and ectopic and molar pregnancies with embolism
640.00-640.93	Hemorrhage in early pregnancy
641.00-641.93	Antepartum hemorrhage, abruptio placentae, and placenta previa

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (6 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

642.00-642.94	Hypertension complicating pregnancy, childbirth, and the puerperium
646.70-646.73	Liver disorders in pregnancy
649.30	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable
649.31 the	Coagulation defects complicating pregnancy, childbirth, or puerperium, delivered, with or without mention of antepartum condition
649.32	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication
649.33	Coagulation defects complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication
649.34	Coagulation defects complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication
649.50 of	Spotting complicating pregnancy, unspecified as to episode care or not applicable
649.51	Spotting complicating pregnancy, delivered, with or without mention of antepartum condition
649.53	Spotting complicating pregnancy, antepartum condition or complication
656.00-656.03	Fetal maternal hemorrhage
658.40-658.43	Infection of amniotic cavity
666.00-666.34	Postpartum hemorrhage
671.20-671.94	Venous complications in pregnancy and the puerperium except legs, vulva and perineum
673.00-673.84	Obstetrical pulmonary embolism
674.30-674.34	Other complications of obstetrical surgical wounds
713.2	Arthropathy associated with hematological disorders
713.6	Arthropathy associated with hypersensitivity reaction
719.15	Hemarthrosis pelvic region and thigh
719.16	Lower leg
719.19	Multiple sites
729.5	Pain in limb
729.81	Swelling of limb
733.10	Pathologic fracture, unspecified site
746.00-746.9	Other Congenital anomalies of heart
762.1	Other forms of placental separation and hemorrhage
767.0, 767.11	Birth trauma, subdural and cerebral hemorrhage and injury to scalp
767.8	Other specified birth trauma
770.3	Pulmonary hemorrhage
772.0	Fetal blood loss affecting newborn
772.10-772.14	Fetal and neonatal intraventricular hemorrhage
772.2	Fetal and neonatal subarachnoid hemorrhage
772.3	Fetal and neonatal umbilical hemorrhage after birth
772.4	Fetal and neonatal gastrointestinal hemorrhage
772.5	Fetal and neonatal adrenal hemorrhage
772.6	Fetal and neonatal cutaneous hemorrhage
772.8	Fetal and neonatal other specified hemorrhage of fetus or newborn
772.9	Fetal and neonatal unspecified hemorrhage of newborn
774.6	Unspecified fetal and neonatal jaundice
776.0	Hemorrhagic disease of the newborn
776.1	Transient neonatal thrombocytopenia
776.2	Disseminated intravascular coagulation in newborn
776.3	Other transient neonatal disorders of coagulation
776.4	Polycythemia neonatorum
776.5	Congenital anemia
776.6	Anemia of prematurity
776.7	Transient neonatal neutropenia
776.8	Other specified transient hematological disorders
776.9	Unspecified hematological disorder specific to newborn

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (7 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

780.2	Syncope and collapse
782.3	Edema
782.4	Jaundice, unspecified, not of newborn
782.7	Spontaneous ecchymosis
784.7	Epistaxis
784.8	Hemorrhage from throat
785.4	Gangrene
785.50	Shock without mention of trauma
786.05	Shortness of breath
786.30	Hemoptysis, unspecified
786.31	Acute idiopathic pulmonary hemorrhage in infants (AIPHI)
786.39	Other hemoptysis
786.50	Chest pain, unspecified
786.51	Precordial pain
786.59	Chest pain, other
789.00-789.09	Abdominal pain
789.1	Hepatomegaly
789.51	Malignant ascites
789.59	Other ascites
789.7	Colic
790.92	Abnormal coagulation profile
790.94	Euthyroid sick syndrome
791.2	Hemoglobinuria
794.8	Abnormal Liver Function Study
800.00-800.99	Fracture of vault of skull
801.00-801.99	Fracture of base of skull
802.20-802.9	Fracture of face bones
803.00-803.99	Other and unqualified skull fractures
804.00-804.99	Multiple fractures involving skull or face with other bones
805.00-806.9	Fracture, vertebral column
807.00-807.09	Fractures of rib(s), closed
807.10-807.19	Fracture of rib(s), open
808.8-808.9	Unspecified fracture of pelvis
809.0-809.1	Ill-defined fractures of bones of trunk
810.00-810.13	Fracture of clavicle
811.00-811.19	Fracture of scapula
812.00-812.59	Fracture of humerus
813.10-813.18	Fracture of radius and ulna, upper end, open
813.30-813.33	Shaft, open
813.50-813.54	Lower end, open
813.90-813.93	Fracture unspecified part, open
819.0-819.1	Multiple fractures involving both upper limbs, closed and open
820.00-821.39	Fracture of neck of femur
823.00-823.92	Fracture of tibia and fibula
827.0-829.1	Other multiple lower limb
852.00-853.19	Subarachnoid subdural, and extradural hemorrhage, following injury, Other and specified intracranial hemorrhage following injury
860.0-860.5	Traumatic pneumothorax and hemothorax
861.00-861.32	Injury to heart and lung
862.0-862.9	Injury to other and unspecified intrathoracic organs
863.0-863.90	Injury to gastrointestinal tract
863.91-863.95, 863.99	Adding to Injury to gastrointestinal tract
864.00-864.19	Injury to liver

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (8 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

865.00-865.19	Injury to spleen
866.00-866.13	Injury to kidney
867.0-867.9	Injury to pelvic organs
868.00-868.19	Injury to other intra-abdominal organs
869.0-869.1	Internal injury to unspecified or ill defined organs
900.00-900.9	Injury to blood vessels of head and neck
901.0-901.9	Injury to blood vessels of the thorax
902.0-902.9	Injury to blood vessels of the abdomen and pelvis
903.00-903.9	Injury to blood vessels of upper extremity
904.0-904.9	Injury to blood vessels of lower extremity and unspecified sites
920-924.9	Contusion with intact skin surface
925.1-929.9	Crushing injury
958.2	Secondary and recurrent hemorrhage
959.9	Injury, unspecified site
964.0-964.9	Poisoning by agents primarily affecting blood constituents
980.0-980.9	Toxic effect of alcohol
981	Toxic effect of petroleum products
982.0-982.8	Toxic effects of solvents other than petroleum-based
987.0-987.9	Toxic effect of other gases, fumes or vapors
989.0-989.9	Toxic effect of other substances chiefly non-medicinal as to source
995.20	Unspecified adverse effect of unspecified drug, medicinal and biological substance
995.21	Arthus phenomenon
995.24	Failed moderate sedation during procedure
995.27	Other drug allergy
995.29	Unspecified adverse effect of other drug, medicinal & biological substance
996.82	Complication of transplanted liver
997.02	Iatrogenic cerebrovascular infarction or hemorrhage
997.41	Retained cholelithiasis following cholecystectomy
997.49	Other digestive system complications
998.11-998.12	Hemorrhage or hematoma complicating a procedure
999.2	Other vascular complications
999.80	Transfusion reaction, unspecified
999.83	Hemolytic transfusion reaction, incompatibility unspecified
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified
999.89	Other transfusion reaction
V08	Asymptomatic HIV infection
V12.1	History of nutritional deficiency
V12.3	Personal history of diseases of blood and blood-forming organs
V12.50-V12.55, V12.59	Personal history of transient ischemic attack, cerebral infarction, or pulmonary embolism without residual deficits
V15.1	Personal history of surgery to heart and great vessels
V15.21	Personal history of undergoing in utero procedure during pregnancy
V15.22	Personal history of undergoing in utero procedure while a fetus
V15.29	Surgery to other organs
V42.0	Kidney replaced by transplant

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.17 Prothrombin Time (PT) (9 of 9)

Data Source: http://www.cms.gov

CPT Code: 85610

NCD Description: Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway.

ICD-9-CM Codes that Support Medical Necessity

The Prothrombin Time is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

V42.1	Heart replaced by transplant
V42.2	Heart valve replaced by transplant
V42.6	Lung replaced by transplant
V42.7	Liver replaced by transplant
V42.81-V42.89	Other specified organ or tissue replaced by transplant
V43.21-V43.22	Heart replaced by other means
V43.3	Heart valve replaced by other means
V43.4	Blood vessel replaced by other means
V58.2	Transfusion of blood products
V58.61	Long-term (current) use of anticoagulants
V58.83	Encounter for therapeutic drug monitoring

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (1 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

002.0-002.9	Typhoid and paratyphoid fevers
003.0-003.9	Other salmonella infections
006.0-006.9	Amebiasis
007.0-007.9	Other protozoal intestinal diseases
008.00	Intestinal infections due to Escherichia coli [E. coli], unspecified
008.01	Intestinal infections due to enteropathogenic E. coli
008.02	Intestinal infections due to enterotoxigenic E. coli
008.03	Intestinal infections due to enteroinvasive E. coli
008.04	Intestinal infections due to enterohemorrhagic E. coli
008.09	Intestinal infections due to other intestinal E. coli organisms
008.1	Intestinal infections due to Arizona group of paracolon bacilli
008.2	Intestinal infections due to Aerobacter aerogenes
008.3	Intestinal infections due to Proteus (mirabilis) (morganii)
008.41	Intestinal infections due to Staphylococcus
008.42	Intestinal infections due to Pseudomonas
008.43	Intestinal infections due to Campylobacter
008.44	Intestinal infections due to Yersinia enterocolitis
008.45	Intestinal infections due to Clostridium difficile
008.46	Intestinal infections due to other anaerobes
008.47	Intestinal infections due to other gram-negative bacteria
008.49	Intestinal infections due to other bacteria
008.5	Bacterial enteritis, unspecified
008.61	Enteritis due to Rotavirus
008.62	Enteritis due to Adenovirus
008.63	Enteritis due to Norwalk virus
008.64	Enteritis due to other small round viruses (SRVs)
008.65	Enteritis due to Calicivirus
008.66	Enteritis due to Astrovirus
008.67	Enteritis due to Enterovirus, not elsewhere classified
008.69	Other viral enteritis
008.8	Intestinal infections due to other organisms, not elsewhere classified
009.0-009.3	Ill-defined intestinal infections
011.50-011.56	Tuberculous bronchiectasis
014.00-014.86	Tuberculosis of intestines, peritoneum, and mesenteric glands
015.00-015.96	Tuberculosis of bones and joints
016.00-016.06	Tuberculosis of kidney
016.10-016.16	Tuberculosis of bladder
016.20-016.26	Tuberculosis of ureter
016.30-016.36	Tuberculosis of other urinary organs
042	Human Immunodeficiency virus (HIV) disease
070.0-070.9	Viral hepatitis
140.0-149.9	Malignant neoplasm of lip oral cavity and pharynx
150.0-159.9	Malignant neoplasm of digestive organs and peritoneum
160.0-165.9	Malignant neoplasm of respiratory and intrathoracic organs
170.0-176.9	Malignant neoplasm of bone, connective tissue, skin and breast

*10/1/11 Per CR 7507 delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (2 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

*10/1/11 Per CR 7507 add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 282.40, 282.43, 282.44, 282.45, 282.46, 282.47, 286.52, 286.53, 286.59, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.

*173.00 Unspecified malignant neoplasm of skin of lip
*173.01 Basal cell carcinoma of skin of lip
*173.02 Squamous cell carcinoma of skin of lip
*173.09 Other specified malignant neoplasm of skin of lip
*173.10 Unspecified malignant neoplasm of eyelid, including canthus
*173.11 Basal cell carcinoma of eyelid, including canthus
*173.12 Squamous cell carcinoma of eyelid, including canthus
*173.19 Other specified malignant neoplasm of eyelid, including canthus
*173.20 Unspecified malignant neoplasm of skin of ear and external auditory canal
*173.21 Basal cell carcinoma of skin of ear and external auditory canal
*173.22 Squamous cell carcinoma of skin of ear =and external auditory canal
*173.29 Other specified malignant neoplasm of skin of ear and external auditory canal
*173.60 Unspecified malignant neoplasm of skin of upper limb, including shoulder
*173.61 Basal cell carcinoma of skin of upper limb, including shoulder
*173.62 Squamous cell carcinoma of skin of upper limb, including shoulder
*173.69 Other specified malignant neoplasm of skin of upper limb, including shoulder
*173.70 Unspecified malignant neoplasm of skin of lower limb, including hip
*173.71 Basal cell carcinoma of skin of lower limb, including hip
*173.72 Squamous cell carcinoma of skin of lower limb, including hip
*173.79 Other specified malignant neoplasm of skin of lower limb, including hip
*173.80 Unspecified malignant neoplasm of other specified sites of skin
*173.81 Basal cell carcinoma of other specified sites of skin
*173.82 Squamous cell carcinoma of other specified sites of skin
*173.89 Other specified malignant neoplasm of other specified sites of skin
*173.90 Unspecified malignant neoplasm of skin, site unspecified
*173.91 Basal cell carcinoma of skin, site unspecified
*173.92 Squamous cell carcinoma of skin, site unspecified
*173.99 Other specified malignant neoplasm of skin, sites unspecified

179-189.9	Malignant neoplasm of genitourinary organs
190.0-199.1	Malignant neoplasm of other and unspecified sites
199.2	Malignant neoplasm associated with transplanted organ
200.00-200.28	Lymphosarcoma and reticulosarcoma; Burkitt's tumor or lymphoma
200.30-200.38	Marginal zone lymphoma
200.40-200.48	Mantle cell lymphoma
200.50-200.58	Primary central nervous system lymphoma
200.60-200.68	Anaplastic large cell lymphoma
200.70-200.78	Large cell lymphoma
200.80-200.88	Malignant tumors of lymphatic tissue; other named variants
201.00-201.98	Hodgkin's disease
202.00-202.68	Other malignant neoplasms of lymphoid and histiocytic tissue
202.70-202.78	Peripheral T-cell lymphoma

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (3 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

202.80-202.98	Other lymphomas; other and unspecified malignant neoplasms of lymphoid and histiocytic tissue
203.00-203.01	Multiple myeloma, without mention of having achieved remission and in remission
203.02	Multiple myeloma, in relapse
203.10-203.11	Plasma cell leukemia, without mention of having achieved remission and in remission
203.12	Plasma cell leukemia, in relapse
203.80-203.81	Other immunoproliferative neoplasms, without mention of having achieved remission and in remission
203.82	Other immunoproliferative neoplasms, in relapse
204.00-204.01	Acute lymphoid leukemia, without mention of having achieved remission and in remission
204.02	Acute lymphoid leukemia, in relapse
204.10-204.11	Chronic lymphoid leukemia, without mention of having achieved remission and in remission
204.12	Chronic lymphoid leukemia, in relapse
204.20-204.21	Subacute lymphoid leukemia, without mention of having achieved remission and in remission
204.22	Subacute lymphoid leukemia, in relapse
204.80-204.81	Other lymphoid leukemia, without mention of having achieved remission and in remission
204.82	Other lymphoid leukemia, in relapse
204.90-204.91	Unspecified lymphoid leukemia, without mention of having achieved remission and in remission
204.92	Unspecified lymphoid leukemia, in relapse
205.00-205.01	Acute myeloid leukemia, without mention of having achieved remission and in remission
205.02	Acute myeloid leukemia, In relapse
205.10-205.11	Chronic myeloid leukemia, without mention of having achieved remission and in remission
205.12	Chronic myeloid leukemia, in relapse
205.20-205.21	Subacute myeloid leukemia, without mention of having achieved remission and in remission
205.22	Subacute myeloid leukemia, in relapse
205.30-205.31	Myeloid sarcoma, without mention of having achieved remission and in remission
205.32	Myeloid sarcoma, in relapse
205.80-205.81	Other myeloid leukemia, without mention of having achieved remission and in remission
205.82	Other myeloid leukemia, in relapse
205.90-205.91	Unspecified myeloid leukemia, without mention of having achieved remission and in remission
205.92	Unspecified myeloid leukemia, in relapse
206.00-206.01	Acute monocytic leukemia, without mention of having achieved remission and in remission
206.02	Acute monocytic leukemia, in relapse
206.10-206.11	Chronic monocytic leukemia, without mention of having achieved remission and in remission
206.12	Chronic monocytic leukemia, in relapse
206.20-206.21	Subacute monocytic leukemia, without mention of having achieved remission and in remission
206.22	Subacute monocytic leukemia, in relapse
206.80-206.81	Other monocytic leukemia, without mention of having achieved remission and in remission
206.82	Other monocytic leukemia, in relapse
206.90-206.91	Unspecified monocytic leukemia, without mention of having achieved remission and in remission
206.92	Unspecified monocytic leukemia, in relapse
207.00-207.01 A	cute erythremia and erythroleukemia, without mention of having achieved remission and in remission
207.02	Acute erythremia and erythroleukemia, in relapse

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (4 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for the test(s) provided.

207.10-207.11	Chronic erythremia, without mention of having achieved remission and in remission
207.12	Chronic erythremia, in relapse
207.20-207.21	Megakaryocytic leukemia, without mention of having achieved remission and in remission
207.22	Megakaryocytic leukemia, in relapse
207.80-207.81	Other specified leukemia, without mention of having achieved remission and in remission
207.82	Other specified leukemia, in relapse
208.00-208.01	Acute leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.02	Acute leukemia of unspecified cell type, in relapse
208.10-208.11	Chronic leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.12	Chronic leukemia of unspecified cell type, in relapse
208.20-208.21	Subacute leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.22	Subacute leukemia of unspecified cell type, In relapse
208.80-208.81	Other leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.82	Other leukemia of unspecified cell type, in relapse
208.90-208.91	Unspecified leukemia of unspecified cell type, without mention of having achieved remission and in remission
208.92	Unspecified leukemia of unspecified cell type, in relapse
209.00-209.03	Malignant carcinoid tumors of the small intestine
209.10-209.17	Malignant carcinoid tumors of the appendix, large intestine and rectum
209.20-209.27, 209.29	Malignant carcinoid tumors of other and unspecified sites
209.30	Malignant poorly differentiated neuroendocrine tumor, any site
209.31	Merkel cell carcinoma of the face
209.32	Merkel cell carcinoma of the scalp and neck
209.33	Merkel cell carcinoma of the upper limb
209.34	Merkel cell carcinoma of the lower limb
209.35	Merkel cell carcinoma of the trunk
209.36	Merkel cell carcinoma of other sites
209.40-209.43	Benign carcinoid tumors of the small intestine
209.50-209.57	Benign carcinoid tumors of the appendix, large intestine and rectum
209.60-209.67, 209.69	Benign carcinoid tumor of other and unspecified sites
209.70	Secondary neuroendocrine tumor, unspecified site
209.71	Secondary neuroendocrine tumor of distant lymph nodes
209.72	Secondary neuroendocrine tumor of liver
209.73	Secondary neuroendocrine tumor of bone
209.74	Secondary neuroendocrine tumor of peritoneum
209.75	Secondary Merkel cell carcinoma
209.79	Secondary neuroendocrine tumor of other sites
210.0-229.9	Benign neoplasms
230.0-233.2	Carcinoma in situ (various)
233.30	Carcinoma in situ, unspecified female genital organ
233.31	Carcinoma in situ, vagina
233.32	Carcinoma in situ, vulva
233.39	Carcinoma in situ, other female genital organ
233.4-234.9	Carcinoma in situ (various)
235.0-235.9	Neoplasms of uncertain behavior of digestive and respiratory systems
236.0-236.99	Neoplasms of uncertain behavior of genitourinary organs
237.0-237.72	Neoplasms of uncertain behavior of endocrine glands and nervous system
237.73	Schwannomatosis
237.79	Other neurofibromatosis
237.9	Other and uncertain parts of the nervous system

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (5 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

238.0-238.6	Neoplasms of uncertain behavior of other and unspecified sites and tissues
238.71-238.76	Neoplasms of other lymphatic and hematopoietic tissues
238.77	Post-transplant lymphoproliferative disorder (PTLD)
238.79, 238.8, 238.9	Neoplasms of uncertain behavior
239.0-239.7	Neoplasms of unspecified nature
239.81	Neoplasms of unspecified nature, retina and choroid
239.89	Neoplasms of unspecified nature, other specified sites
239.9	Neoplasms of unspecified nature, site unspecified
249.00-249.01	Secondary diabetes mellitus without mention of complication
249.10-249.11	Secondary diabetes mellitus with ketoacidosis
249.20-249.21	Secondary diabetes mellitus with hyperosmolarity
249.30-249.31	Secondary diabetes mellitus with other coma
249.40-249.41	Secondary diabetes mellitus with renal manifestations
249.50-249.51	Secondary diabetes mellitus with ophthalmic manifestations
249.60-249.61	Secondary diabetes mellitus with neurological manifestations
249.70-249.71	Secondary diabetes mellitus with peripheral circulatory disorders
249.80-249.81	Secondary diabetes mellitus with other specified manifestations
249.90-249.91	Secondary diabetes mellitus with unspecified complication
250.00-250.93	Diabetes mellitus
253.2	Panhypopituitarism
253.7	Iatrogenic pituitary disorders
253.8	Other disorders of the pituitary and other syndromes of diencephalohypophysial origin
256.31-256.39	Other ovarian failure
257.2	Other testicular hypofunction
260	Kwashiorkor
261	Nutritional marasmus
262	Other severe protein-calorie malnutrition
263.0-263.9	Other and unspecified protein-calorie malnutrition
275.01	Hereditary hemochromatosis
275.02	Hemochromatosis due to repeated red blood cell transfusions
275.03	Other hemochromatosis
275.09	Other disorders of iron metabolism
277.1	Disorders of porphyrin metabolism
280.0-280.9	Iron deficiency anemias
281.0-281.9	Other deficiency anemias
282.40-282.49	Thalassemias
282.60-282.63	Sickle-cell diseases
282.64	Sickle-cell/Hgb C disease with crisis
282.68	Other sickle-cell disease without crisis
282.69	Other sickle-cell disease with crisis
285.0	Sideroblastic anemia (includes hemochromatosis with refractory anemia)
285.1	Acute post-hemorrhagic anemia
285.3	Antineoplastic chemotherapy induced anemia
285.21	Anemia in chronic kidney disease
285.22	Anemia in neoplastic disease
285.29	Anemia of other chronic disease
285.9	Anemia, unspecified
286.0-286.9	Coagulation defects (congenital factor disorders)
*Per CR 7507 delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.	
287.0-287.39	Allergic purpura; qualitative platelet defects; other non-thrombocytopenic purpuras; primary thrombocytopenia
287.41	Posttransfusion purpura
287.49	Other secondary thrombocytopenia
287.5-287.9	Thrombocytopenia, unspecified; other specified and unspecified hemorrhagic conditions

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (6 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

289.52	Splenic sequestration
306.4	Physiological malfunction arising from mental factors, gastrointestinal
307.1	Anorexia nervosa
307.50-307.59	Other and unspecified disorders of eating
403.01	Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal
403.11	Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease
403.91	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease
404.02	Hypertensive heart & chronic kidney disease, malignant, without heart failure & with chronic kidney disease stage V or end stage renal disease
404.03	Hypertensive heart & chronic kidney disease, malignant, with heart failure & with chronic kidney disease stage Or end stage renal disease
404.12	Hypertensive heart & chronic kidney disease, benign, without heart failure & with chronic kidney disease stage Or end stage renal disease
404.13	Hypertensive heart and chronic kidney disease, benign, with heart failure & chronic kidney disease stage V or end stage renal disease
404.92	Hypertensive heart and chronic kidney disease, unspecified, without heart failure & with chronic kidney disease stage V or end stage renal disease
404.93	Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease
425.4	Other primary cardiomyopathies
425.5	Alcoholic cardiomyopathy
425.7	Nutritional and metabolic cardiomyopathy
425.8	Cardiomyopathy in other diseases classified elsewhere
425.9	Secondary cardiomyopathy, unspecified
426.0-426.81, 426.89, 426.9	Conduction disorders
427.0-427.9	Cardiac dysrhythmias
428.0-428.9	Heart failure
530.7	Gastroesophageal laceration-hemorrhage syndrome
530.82	Esophageal hemorrhage
531.00-531.91	Gastric ulcer
532.00-532.91	Duodenal ulcer
533.00-533.91	Peptic ulcer, site unspecified
534.00-534.91	Gastrojejunal ulcer
535.00-535.61	Gastritis and duodenitis
535.70	Eosinophilic gastritis, without mention of obstruction
535.71	Eosinophilic gastritis, with obstruction
536.0-536.9	Disorders of function of stomach
537.83	Angiodysplasia of stomach and duodenum with hemorrhage
537.84	Dieulafoy lesion (hemorrhagic) of stomach and duodenum
555.0-555.9	Regional enteritis
556.0-556.9	Ulcerative colitis
557.0	Acute vascular insufficiency of intestine
557.1	Chronic vascular insufficiency of intestine
562.02	Diverticulosis of small intestine with hemorrhage
562.03	Diverticulitis of small intestine with hemorrhage
562.12	Diverticulosis of colon with hemorrhage
562.13	Diverticulitis of colon with hemorrhage
569.3	Hemorrhage of rectum and anus
569.85	Angiodysplasia of intestine with hemorrhage
569.86	Dieulafoy lesion (hemorrhagic) of intestine
569.87	Vomiting of fecal matter
570	Acute and subacute necrosis of liver
571.0-571.9	Chronic liver disease and cirrhosis
572.0	Abscess of liver
572.1	Portal pyemia

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.18 Serum Iron Studies (7 of 7)

Data Source: http://www.cms.gov

CPT Codes: 82728, 83540, 83550, 84466

NCD Description:. Serum iron studies are useful in the evaluation of disorders of iron metabolism, particularly iron deficiency and iron excess. Iron studies are best performed when the patient is fasting in the morning and has abstained from medications that may influence iron balance.

ICD-9-CM Codes that Support Medical Necessity

Serum Iron Study is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

572.2	Hepatic encephalopathy
572.3	Portal hypertension
572.4	Hepatorenal syndrome
572.8	Other sequelae of chronic liver disease
573.0-573.9	Other disorders of liver
578.0-578.9	Gastrointestinal hemorrhage
579.0-579.3	Intestinal malabsorption
579.8-579.9	Other specified and unspecified intestinal malabsorption
581.0-581.9	Nephrotic syndrome
585.4-585.9	Chronic kidney disease
586	Renal failure, unspecified
608.3	Atrophy of testis
626.0-626.9	Disorders of menstruation and other abnormal bleeding from female genital tract
627.0	Premenopausal menorrhagia
627.1	Postmenopausal bleeding
648.20-648.24	Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium: Anemia
698.0-698.9	Pruritus and related conditions
704.00-704.09	Alopecia
709.00-709.09	Dyschromia
713.0	Arthropathy associated with other endocrine and metabolic disorders
716.40-716.99	Other and unspecified arthropathies
719.40-719.49	Pain in joint
773.2	Hemolytic disease due to other and unspecified isoimmunization
773.3	Hydrops fetalis due to isoimmunization
773.4	Kernicterus due to isoimmunization
773.5	Late anemia due to isoimmunization
783.9	Other symptoms concerning nutrition, metabolism and development
790.01-790.09	Abnormality of red blood cells
790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase [LDH]
790.5	Other nonspecific abnormal serum enzyme levels
790.6	Other abnormal blood chemistry
799.4	Cachexia
964.0	Poisoning by agents primarily affecting blood constituents, iron compounds
984.0-984.9	Toxic effect of lead and its compounds (including fumes)
996.85	omplications of transplanted organ, bone marrow
999.80	Transfusion reaction, unspecified
999.83	Hemolytic transfusion reaction, incompatibility unspecified
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified
999.89	Other transfusion reaction
V08	Asymptomatic HIV infection
V12.1	Personal history of nutritional deficiency
V12.3	Personal history of diseases of blood and blood forming organs
V15.1	Personal history of surgery to heart and great vessels
V15.21	Personal history of undergoing in utero procedure during pregnancy
V15.22	Personal history of undergoing in utero procedure while a fetus
V15.29	Surgery to other organs
V43.21-V43.22	Heart replaced by other means
V43.3	Heart valve replaced by other means
V43.4	Blood vessel replaced by other means
V43.60	Unspecified joint replaced by other means
V56.0	Extracorporeal dialysis
V56.8	Other dialysis

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.22 Thyroid Testing (1 of 4)

Data Source: http://www.cms.gov

CPT Codes: 84436, 84439, 84443, 84479

NCD Description: Thyroid function studies are used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction.

ICD-9-CM Codes that Support Medical Necessity

The Thyroid Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

017.50-017.56	Tuberculosis of the thyroid gland
183.0	Malignant neoplasm of ovary
193	Malignant neoplasm of thyroid gland
194.8	Malignant neoplasm of other endocrine glands and related structures
198.89	Secondary malignant neoplasm of the thyroid
220	Benign neoplasm of ovary
226	Benign neoplasm of thyroid gland
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct
234.8	Carcinoma in situ of other and unspecified sites
237.4	Neoplasm of uncertain behavior of other and unspecified endocrine glands
239.7	Neoplasm of unspecified nature, thyroid gland
240.0-240.9	Goiter specified and unspecified
241.0-241.9	Nontoxic nodular goiter
242.00-242.91	Thyrotoxicosis with or without goiter
243	Congenital hypothyroidism
244.0-244.9	Acquired hypothyroidism
245.0-245.9	Thyroiditis
246.0-246.9	Other disorders of thyroid
249.00-249.01	Secondary diabetes mellitus without mention of complication
249.10-249.11	Secondary diabetes mellitus with ketoacidosis
249.20-249.21	Secondary diabetes mellitus with hyperosmolarity
249.30-249.31	Secondary diabetes mellitus with other coma
249.40-249.41	Secondary diabetes mellitus with renal manifestations
249.50-249.51	Secondary diabetes mellitus with ophthalmic manifestations
249.60-249.61	Secondary diabetes mellitus with neurological manifestations
249.70-249.71	Secondary diabetes mellitus with peripheral circulatory disorders
249.80-249.81	Secondary diabetes mellitus with other specified manifestations
249.90-249.91	Secondary diabetes mellitus with unspecified complication
250.00-250.93	Diabetes mellitus
252.1	Hypoparathyroidism
253.1	Other and unspecified anterior pituitary hyper function
253.2	Panhypopituitarism
253.3	Pituitary dwarfism
253.4	Other anterior pituitary disorders
253.7	Iatrogenic pituitary disorders
255.2	Adrenogenital disorders
255.41	Glucocorticoid deficiency
255.42	Mineralocorticoid deficiency
256.31-256.39	Ovarian failure
257.2	Testicular hypofunction
258.0 – 258.9	Polyglandular dysfunction and related disorders
262	Malnutrition, severe
263.0-263.9	Malnutrition, other and unspecified
266.0	Ariboflavinosis
272.0	Pure hypercholesterolemia
272.2	Mixed hyperlipidemia
272.4	Other and unspecified hyperlipidemia
275.40-275.49	Calcium disorders
275.5	Hungry bone syndrome
276.0	Hyposmolality and/or hypernatremia
276.1	Hyposmolality and/or hyponatremia
278.3	Hypercarotenemia

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.22 Thyroid Testing (2 of 4)

Data Source: http://www.cms.gov

CPT Codes: 84436, 84439, 84443, 84479

NCD Description: Thyroid function studies are used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction.

ICD-9-CM Codes that Support Medical Necessity

The Thyroid Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

279.41	Autoimmune lymphoproliferative syndrome
279.49	Autoimmune disease, not elsewhere classified
281.0	Pernicious anemia
281.9	Unspecified deficiency anemia
283.0	Autoimmune hemolytic anemia
285.9	Anemia, unspecified
290.0	Senile dementia, uncomplicated
290.10-290.13	Presenile dementia
290.20-290.21	Senile dementia with delusional or depressive features
290.3	Senile dementia with delirium
293.0-293.1	Delirium
293.81-293.89	Other specified transient mental disorders due to conditions classified elsewhere
294.8	Other persistent mental disorders due to conditions classified elsewhere
296.00-296.99	Episodic mood disorders
297.0	Paranoid state, simple
297.1	Delusional disorder
297.9	Unspecified paranoid state
298.3	Acute paranoid reaction
300.00-300.09	Anxiety states
307.9	Other and unspecified special symptoms or syndromes NEC
310.1	Personality change due to conditions classified elsewhere
311	Depressive disorder, NEC
327.00	Organic insomnia, unspecified
327.01	Insomnia due to medical condition classified elsewhere
327.09	Other organic insomnia
327.29	Other organic sleep apnea
327.52	Sleep related leg cramps
327.8	Other Organic sleep disorders
331.0, 331.11, 331.19, 331.2	Alzheimer's, pick's disease, Senile degeneration of brain
331.83	Mild cognitive impairment, so stated
333.1	Essential and other specified forms of tremor
333.99	Other extrapyramidal diseases and abnormal movement disorders
354.0	Carpal Tunnel syndrome
356.9	Idiopathic peripheral neuropathy, unspecified polyneuropathy
358.1	Myasthenic syndromes in diseases classified elsewhere
359.5	Myopathy in endocrine diseases classified elsewhere
359.9	Myopathy, unspecified
368.2	Diplopia
372.71	Conjunctival hyperemia
372.73	Conjunctival edema
374.41	Lid retraction or lag
374.82	Eyelid edema
376.21	Thyrotoxic exophthalmos
376.22	Exophthalmic ophthalmoplegia
376.30-376.31	Exophthalmic conditions, unspecified and constant
376.33-376.34	Orbital edema or congestion, intermittent exophthalmos
378.50-378.55	Paralytic strabismus
401.0-401.9	Essential hypertension
403.00-403.91	Hypertensive chronic kidney disease
404.00-404.93	Hypertensive heart and chronic kidney disease
423.9	Unspecified disease of pericardium
425.7	Nutritional and metabolic cardiomyopathy
427.0	Paroxysmal supraventricular tachycardia
427.2	Paroxysmal tachycardia, unspecified

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.22 Thyroid Testing (3 of 4)

CPT Codes: 84436, 84439, 84443, 84479

Data Source: http://www.cms.gov

NCD Description: Thyroid function studies are used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction.

ICD-9-CM Codes that Support Medical Necessity

The Thyroid Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

427.31	Atrial fibrillation	728.9	Unspecified disorder of muscle, ligament, and fascia
427.89	Other specified cardiac dysrhythmia	729.1	Myalgia and myositis, unspecified
427.9	Cardiac dysrhythmia, unspecified	729.82	Musculoskeletal cramp
428.0	Congestive heart failure, unspecified	730.30-730.39	Periostitis without osteomyelitis
428.1	Left heart failure	733.02	Idiopathic osteoporosis
429.3	Cardiomegaly	733.09	Osteoporosis, drug induced
511.9	Unspecified pleural effusion	750.15	Macroglossia, congenital
518.81	Acute respiratory failure	759.2	Anomaly of other endocrine glands
529.8	Other specified conditions of the tongue	780.01	Coma
560.1	Paralytic ileus	780.02	Transient alteration of awareness
564.00-564.09	Constipation	780.09	Alteration of consciousness, other
564.7	Megacolon, other than Hirschsprung's	780.50	Insomnia
568.82	Peritoneal effusion (chronic)	780.51	Insomnia with sleep apnea, unspecified
625.3	Dysmenorrhea	780.52	Insomnia, unspecified
626.0-626.2	Disorders of menstruation	780.60	Fever, unspecified
626.4	Irregular menstrual cycle	780.61	Fever presenting with conditions classified elsewhere
648.10-648.14	Other current conditions in mother, classifiable elsewhere, but complicating pregnancy, childbirth, or puerperium, thyroid dysfunction	780.62	Postprocedural fever
		780.63	Postvaccination fever
		780.64	Chills (without fever)
676.20-676.24	Engorgement of breast associated w/ childbirth & disorders of lactation	780.65	Hypothermia not associated with low environmental temperature
698.9	Unspecified pruritic disorder	780.66	Febrile nonhemolytic transfusion reaction
701.1	Keratoderma, acquired (dry skin)	780.71	Chronic fatigue syndrome
703.8	Other specified diseases of nail (Brittle nails)	780.72	Functional quadriplegia
704.00-704.09	Alopecia	780.79	Other malaise and fatigue
709.01	Vitiligo	780.8	Generalized hyperhidrosis
710.0-710.9	Diffuse disease of connective tissue	780.93	Memory loss
728.2	Muscle wasting	780.94	Early satiety
728.87	Muscle weakness (generalized)	780.96	Generalized pain

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.

Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.

Source: Federal Registry Negotiated Rule-making, November 23, 2001

"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed."

Last Updated: 7/1/2015

Medicare National Coverage Determination Policy

190.22 Thyroid Testing (4 of 4)

CPT Codes: 84436, 84439, 84443, 84479

Data Source: http://www.cms.gov

NCD Description: Thyroid function studies are used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction.

ICD-9-CM Codes that Support Medical Necessity

The Thyroid Testing is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s) provided.

780.97	Altered mental status
780.99	Other general symptoms
781.0	Abnormal involuntary movements
781.3	Lack of coordination, ataxia
782.0	Disturbance of skin sensation
782.3	Localized edema
782.8	Changes in skin texture
782.9	Other symptoms involving skin and integumentary tissues
783.0	Anorexia
783.1	Abnormal weight gain
783.21	Abnormal loss of weight
783.6	Polyphagia
784.1	Throat pain
784.42	Dysphonia
784.43	Hypernasality
784.44	Hyponasality
784.49	Other voice and resonance disorders
784.51	Dysarthria
784.59	Other speech disturbance
785.0	Tachycardia, unspecified
785.1	Palpitations
785.9	Other symptoms involving cardiovascular system
786.09	Other symptoms involving respiratory system
786.1	Stridor
787.20	Dysphagia, unspecified
787.21	Dysphagia, oral phase
787.22	Dysphagia, oropharyngeal phase
787.23	Dysphagia, pharyngeal phase
787.24	Dysphagia, pharyngo-esophageal phase
787.29	Other dysphagia
787.91-787.99	Other symptoms involving digestive system
789.51	Malignant Ascites
789.59	Other Ascites
793.99	Other nonspecific (abnormal) findings on radiological and other examination of body structure
794.5	Thyroid, abnormal scan or uptake
796.1	Other nonspecific abnormal findings, abnormal reflex
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional lability
799.25	Demoralization and apathy
799.29	Other signs and symptoms involving emotional state
990	Effects of radiation, unspecified
V10.87	Personal history of malignant neoplasm of the thyroid
V10.88	Personal history of malignant neoplasm of other endocrine gland
V10.91	Personal history of malignant neuroendocrine tumor
V12.21	Personal history of gestational diabetes
V12.29	Personal history of other endocrine, metabolic, and immunity disorders
V58.69	Long term (current) use of other medications
V67.00-V67.9	Follow-up examination

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.29 Tumor Antigen by Immunoassay CA 15-3 CA 27.29

Data Source: http://www.cms.gov

CPT Code: 86300

NCD Description: Immunoassay determinations of the serum levels of certain proteins or carbohydrates serve as tumor markers. When elevated, serum concentration of these markers may reflect tumor size and grade. This policy specifically addresses the following tumor antigens: CA15-3 and CA 27.29.

ICD-9-CM Codes that Support Medical Necessity

The Tumor Antigen by Immunoassay CA-15-3 CA 27.29 test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s)

174.0-174.9	Breast, primary (female) - malignant neoplasm of female breast
175.0-175.9	Breast, primary (male) - malignant neoplasm of male breast
198.2	Secondary malignant neoplasm (skin of breast)
198.81	Secondary malignant neoplasm (breast)
338.3	Neoplasm related pain (acute) (chronic)
795.89	Other abnormal tumor markers
V10.3	Personal history of malignant neoplasm, breast

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.30 Tumor Antigen by Immunoassay CA 19-9

Data Source: http://www.cms.gov

CPT Codes: 86301

NCD Description: Immunoassay determinations of the serum levels of certain proteins or carbohydrates serve as tumor markers. When elevated, serum concentration of these markers may reflect tumor size and grade. This policy specifically addresses the following tumor antigen: CA19-9.

ICD-9-CM Codes that Support Medical Necessity

The CA-19-9 test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test (s)

155.1	Malignant neoplasm, intrahepatic bile ducts
156.0	Malignant neoplasm of the gallbladder
156.1	Malignant neoplasm, extrahepatic bile ducts
156.2	Malignant neoplasm of the Ampulla of Vater
156.8	Malignant neoplasm, other specified sites of gallbladder and extrahepatic bile ducts
156.9	Malignant neoplasm, unspecified part of biliary tract
157.0-157.9	Malignant neoplasm, pancreas
197.8	Secondary malignant neoplasm, other digestive organs and spleen
235.3	Neoplasm of uncertain behavior, liver and biliary passages
235.5	Neoplasm of uncertain behavior, other & unspecified digestive organs
338.3	Neoplasm related pain (acute) (chronic)
795.89	Other abnormal tumor markers
V10.09	Other personal history of cancer

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.28 Tumor Antigen by Immunoassay CA-125

Data Source: http://www.cms.gov

CPT Code: 86304

NCD Description: Immunoassay determinations of the serum levels of certain proteins or carbohydrates serve as tumor markers. When elevated, serum concentration of these markers may reflect tumor size and grade.

ICD-9-CM Codes that Support Medical Necessity

The CA-125 test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s)

158.8	Malignant neoplasm, specified parts of peritoneum
158.9	Malignant neoplasm, peritoneum, unspecified
180.0	Malignant neoplasm, endocervix
182.0	Malignant neoplasm of corpus uteri, except isthmus
183.0	Malignant neoplasm,ovary
183.2	Malignant neoplasm, fallopian tube
183.8	Malignant neoplasm, other specified sites of uterine adnexa
184.8	Malignant neoplasm, other specified sites of female genital organs
198.6	Secondary malignant neoplasm, ovary
198.82	Secondary malignancy of genital organs

236.0-236.3	Neoplasm of uncertain behavior of female genital organs
338.3	Neoplasm related pain (acute) (chronic)
789.39	Abdominal or pelvic swelling, mass or lump of other specified site
795.82	Elevated cancer antigen 125 [CA 125]
795.89	Other abnormal tumor markers
V10.41	Personal history of malignant neoplasm, cervix uteri
V10.42	Personal history of malignant neoplasm, other parts of the uterus
V10.43-V10.44	Personal history of malignant neoplasm of female genital organs

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.12 Urine Culture, Bacterial (1 of 3)

Data Source: http://www.cms.gov

CPT Codes: 87086, 87088

NCD Description:. A bacterial urine culture is a laboratory procedure performed on a urine specimen to establish the probably etiology of a presumed urinary tract infection. It is common practice to do a urinalysis prior to a urine culture. A urine culture may also be used as part of the evaluation and management of another related condition. The procedure includes aerobic agar-based isolation of bacteria or other cultivable organisms present, and quantification of types present based on morphologic criteria. Isolates deemed significant may be subjected to additional identification and susceptibility procedures as requested by the ordering physician. The physician's request may be through clearly documented and communicated laboratory protocols.

ICD-9-CM Codes that Support Medical Necessity

The Bacterial Urine Culture test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for the test(s) provided. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

003.1	Salmonella septicemia
038.0, 038.10-038.11, 038.12, 038.19, 038.2, 038.3, 038.40-038.44, 038.49,	
038.8, 038.9	Septicemia
276.2	Acidosis
276.4	Metabolic acidosis/alkalosis
286.6	Defibrination syndrome/disseminated intravascular coagulation
288.00	Neutropenia, unspecified
288.01	Congenital neutropenia
288.02	Cyclic neutropenia
288.03	Drug induced neutropenia
288.04	Neutropenia due to infection
288.09	Other specified disease of white blood cells including leukemoid reaction/leukocytosis
288.8	Other specified disease of white blood cells
306.53	Psychogenic dysuria
306.59	Other psychogenic genitourinary malfunction
518.82	Other pulmonary insufficiency, not elsewhere classified
570	Acute and subacute necrosis of liver
580.0-580.9	Acute glomerulonephritis
583.0-583.9	Nephritis and Nephropathy, not specified as acute or chronic
585.6	End stage renal disease
590.00-590.9	Infections of kidney/pyelonephritis acute and chronic
592.0-592.9	Calculus of kidney and ureter
593.0-593.9	Other disorders of kidney & ureter (cyst, stricture, obstruction, reflux)
594.0-594.9	Calculus of lower urinary tract
595.0-595.9	Cystitis
597.0	Urethritis, not sexually transmitted and urethral syndrome
597.80-597.89	Other urethritis
598.00-598.01	Urethral stricture due to infection
599.0	Urinary tract infection, site not specified
599.70	Hematuria, unspecified
599.71	Gross hematuria
599.72	Microscopic hematuria
600.00-600.91	Hyperplasia of prostate
601.0-601.9	Inflammatory diseases of prostate
602.0-602.9	Other disorders of prostate (calculus, congestion, atrophy, etc.)
604.0-604.99	Orchitis and epididymitis
608.0 - 608.1, 608.20-608.24, 608.3-608.9	Other disorders of male genital organs (seminal vesiculitis, spermatocele, etc.)
614.0-614.9	Inflammatory disease of ovary, fallopian tube, pelvic cellular tissue, and peritoneum

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.12 Urine Culture, Bacterial (2 of 3)

Data Source: http://www.cms.gov

CPT Codes: 87086, 87088

NCD Description:. A bacterial urine culture is a laboratory procedure performed on a urine specimen to establish the probably etiology of a presumed urinary tract infection. It is common practice to do a urinalysis prior to a urine culture. A urine culture may also be used as part of the evaluation and management of another related condition. The procedure includes aerobic agar-based isolation of bacteria or other cultivable organisms present, and quantification of types present based on morphologic criteria. Isolates deemed significant may be subjected to additional identification and susceptibility procedures as requested by the ordering physician. The physician's request may be through clearly documented and communicated laboratory protocols.

ICD-9-CM Codes that Support Medical Necessity

The Bacterial Urine Culture test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

615.0-615.9	Inflammatory disease of uterus, except cervix
616.0	Cervicitis and endocervicitis
616.10-616.11	Vaginitis and vulvovaginitis
616.2–616.4, 616.50, 616.51, 616.81, 616.89, 616.9	Other inflammatory conditions of cervix, vagina and vulva
619.0-619.9	Fistula involving female genital tract
625.6	Stress incontinence, female
639.0	Genital tract and pelvic infection complicating abortion, ectopic or molar pregnancies
639.5	Shock complicating abortion, ectopic or molar pregnancies
646.60-646.64	Infections of genitourinary tract in pregnancy
670.00	Major puerperal infection, unspecified, unspecified as to episode of care or not applicable
670.02	Major puerperal infection, unspecified, delivered, with mention of postpartum complication
670.04	Major puerperal infection, unspecified, postpartum condition or complication
670.10	Puerperal endometritis, unspecified as to episode of care or not applicable
670.12	Puerperal endometritis, delivered, with mention of postpartum complication
670.14	Puerperal endometritis, postpartum condition or complication
670.20	Puerperal sepsis, unspecified as to episode of care or not applicable
670.22	Puerperal sepsis, delivered, with mention of postpartum complication
670.24	Puerperal sepsis, postpartum condition or complication
670.30	Puerperal septic thrombophlebitis, unspecified as to episode of care or not applicable
670.32	Puerperal septic thrombophlebitis, delivered, with mention of postpartum complication
670.34	Puerperal septic thrombophlebitis, postpartum condition or complication
670.80	Other major puerperal infection, unspecified as to episode of care or not applicable
670.82	Other major puerperal infection, delivered, with mention of postpartum complication
670.84	Other major puerperal infection, postpartum condition or complication
672.00-672.04	Pyrexia of unknown origin during the puerperium
724.5	Backache, unspecified
771.81	Septicemia (sepsis) of newborn

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015

Medicare National Coverage Determination Policy

190.12 Urine Culture, Bacterial (3 of 3)

Data Source: http://www.cms.gov

CPT Codes: 87086, 87088

NCD Description:. A bacterial urine culture is a laboratory procedure performed on a urine specimen to establish the probably etiology of a presumed urinary tract infection. It is common practice to do a urinalysis prior to a urine culture. A urine culture may also be used as part of the evaluation and management of another related condition. The procedure includes aerobic agar-based isolation of bacteria or other cultivable organisms present, and quantification of types present based on morphologic criteria. Isolates deemed significant may be subjected to additional identification and susceptibility procedures as requested by the ordering physician. The physician's request may be through clearly documented and communicated laboratory protocols.

ICD-9-CM Codes that Support Medical Necessity

The Bacterial Urine Culture test is determined to be medically necessary by Medicare only when it is ordered for patients with one of the conditions listed below. ICD-9-CM codes that support medical necessity are listed, but it is not enough to link the procedure code to a correct payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid and the procedure must be reasonable and medically necessary for that diagnosis. Documentation within the patient's medical record must support the medical necessity for the test(s) provided.

771.82	Urinary tract infection of newborn
771.83	Bacteremia of newborn
780.02	General symptoms, transient alteration of awareness
780.60	Fever, unspecified
780.61	Fever presenting with conditions classified elsewhere
780.62	Postprocedural fever
780.63	Postvaccination fever
780.64	Chills (without fever)
780.65	Hypothermia not associated with low environmental temperature
780.66	Febrile nonhemolytic transfusion reaction
780.79	Other malaise and fatigue
780.93	Memory loss
780.94	Early satiety
780.96	Generalized pain
780.97	Altered mental status
780.99	Other general symptoms
785.0	Tachycardia, unspecified
785.50-785.59	Shock without mention of trauma
788.0-788.63, 788.64, 788.65, 788.69, 788.7-788.8	Symptoms involving urinary system (renal colic, dysuria, retention of urine, incontinence of urine, frequency, polyuria, nocturia, oliguria, anuria, other abnormality of urination, urethral discharge, extravasation of urine.)
788.91	Functional urinary incontinence
788.99	Other symptoms involving urinary system
789.00-789.09	Abdominal pain
789.60-789.69	Abdominal tenderness
789.7	Colic
790.7	Bacteremia
791.0-791.9	Nonspecific findings on examination of urine (proteinuria, chyluria, hemoglobinuria, myoglobinuria, biliuria, glycosuria, acetonuria, other cells & casts in urine, other nonspecific findings on urine examination)
799.3	Debility, unspecified (only for declining functional status)
939.0	Foreign body in genitourinary tract, bladder and urethra
939.3	Foreign body in genitourinary tract, penis
V44.50-V44.6	Artificial cystostomy or other artificial opening of urinary tract status
V55.5-V55.6	Attention to cystostomy or other artificial opening of urinary tract
V58.69	Long-term (current) use of other medications

This list was compiled from Medicare's Limited Coverage Policies for informational and reference purposes only. For the most current information please reference www.cms.gov.
Note: If the patient's medical record does not support one of the above ICD-9-CM codes, please prepare an Advance Beneficiary Notice form, and ask the patient to read and sign it.
Source: Federal Registry Negotiated Rule-making, November 23, 2001
"The cpt codes provided are based on ama guidelines and are for informational purposes only. Cpt coding is the sole responsibility of the billing party.
Please direct any questions regarding coding to the payer being billed."

Last Updated:
7/1/2015