South Carolina
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
Post Office Box 8206
Columbia, South Carolina 29202-8206
**www.scdhhs.gov**

July 31, 2007

# MEDICAID BULLETIN

| | | | |
|---|---|---|---|
| ***HOS-IP-GEN*** | ***07-18*** | ***PHY-PATH*** | ***07-16*** |
| ***HOS-IP-IMD*** | ***07-17*** | ***PHY-PC-FP/GP*** | ***07-21*** |
| ***HOS-IP-RTF*** | ***07-17*** | ***PHY-PC-GER*** | ***07-17*** |
| ***HOS-OP*** | ***07-21*** | ***PHY-PC-INT*** | ***07-21*** |
| ***PHY-ALG*** | ***07-15*** | ***PHY-PC-NEO*** | ***07-18*** |
| ***PHY-ANES*** | ***07-15*** | ***PHY-PC-OG*** | ***07-19*** |
| ***PHY-CARD*** | ***07-16*** | ***PHY-PC-PED*** | ***07-22*** |
| ***PHY-DERM*** | ***07-15*** | ***PHY-PC-PED/SUB*** | ***07-20*** |
| ***PHY-ENT*** | ***07-15*** | ***PHY-PS*** | ***07-15*** |
| ***PHY-ER*** | ***07-16*** | ***PHY-RAD*** | ***07-16*** |
| ***PHY-MSP-CBP*** | ***07-19*** | ***PHY-S*** | ***07-15*** |
| ***PHY-MSP-HBP*** | ***07-19*** | ***PHY-SPEC*** | ***07-15*** |
| ***PHY-OPHT*** | ***07-16*** | ***PHY-SURG*** | ***07-16*** |

**TO:** **Physicians, Hospitals and Managed Care Providers**

**SUBJECT:** **Prior Authorization (PA) and Support Documentation Reviews by the New Quality Improvement Organization, Qualis Health**

The South Carolina Medicaid provider manuals for Hospital Services and Physicians, Laboratories and Other Medical Professionals have been updated to include the current list of the CPT and ICD-9 codes that require either prior authorization or support documentation review by Qualis Health. In addition, updated Request for Prior Approval Review and the Surgical Justification Review for Hysterectomy forms have also been added to the Forms Section of the manuals, which are attached to this bulletin for reference.

SCDHHS contracts with Qualis Health to perform a pre-surgical review of all hysterectomy procedures, pre-authorization and support documentation reviews for other select surgical procedures. Qualis Health will accept pre-authorization review requests via facsimile or mail. All post-procedure support documentation must be mailed or faxed to Qualis Health (see address and fax numbers below).

Upon receipt of the review request, Qualis Health's nurse reviewer will screen the medical information provided using appropriate InterQual criteria and other review screens for non-physician review. If criteria are met, the procedure will be approved and an authorization number assigned. Qualis Health will call the physician's office staff with the authorization number. Providers should include this number in Field 23 of the CMS-1500 or Field 63 of the UB-04 claim form.

If criteria are not met or a case is otherwise questioned, the case will be referred to a Qualis Health physician reviewer. When the physician reviewer cannot approve the procedure based on the initial information provided, he or she will make a reasonable effort to contact the requesting physician for additional clinical documentation to support the need for the procedure and/or hospitalization.

If Qualis Health's physician reviewer remains unable to approve the procedure based on the additional information, he or she will document the reasons for the decision. Qualis Health will call to notify the attending physician's office of the denial and will also issue a written notice to the attending physician, which describes the rationale for the denial as well as the reconsideration rights. The attending physician may request a reconsideration of the initial denial decision by submitting a written request to Qualis Health that includes the rationale for recommending the procedure. Reconsiderations may be requested whether the case was a pre-procedure or post-procedure review. For reconsideration, Qualis Health will have another peer review performed by a second physician reviewer who is matched by specialty to the attending physician. If Qualis Health upholds the denial in the reconsideration process, the determination is final and binding upon all parties (42CFR 473.38).

The responsibility for obtaining pre-authorization and pre-surgical review rests with the attending physician. (**Physician providers are responsible for providing the PA number to any facility or medical provider who will submit a Medicaid claim**.) The physician must submit all necessary documents, including the Request for Prior Approval Review Form, to:

Qualis Health
Attn: SC Medicaid Prior Approval Review
440 Knox Abbott Drive, Suite 220
Cayce, South Carolina 29033
or
Fax (877) 717 - 8594

Providers are responsible for verifying beneficiary eligibility prior to the PA request being submitted and again prior to performing a service. Eligibility and managed care enrollment status may change during the time a request is submitted and approved and the actual date the procedure is performed. PA requests for beneficiaries enrolled in a managed care organization (MCO) must be handled by the MCO.

Any questions concerning Qualis Health processes should be directed to the Qualis Health staff at (877) 717-8592 or (877) 717-8594 (fax). Please be advised that a beneficiary should not contact Qualis Health directly. Telephone or written approval from Qualis Health is not a guarantee of Medicaid payment.

Questions regarding this Medicaid Bulletin should be directed to the Division of Physician Services at (803) 898-2660 or Division of Hospital Services at (803) 898–2665.

/s/

Susan B. Bowling
Acting Director

SBB/gvb

Attachment

**NOTE: To receive Medicaid bulletins by email, please send an email to bulletin@scdhhs.gov indicating your email address and contact information.**
**To sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.scdhhs.gov/dhhsnew/serviceproviders/eft.asp**

**SOUTH CAROLINA MEDICAID PROGRAM**
**REQUEST FOR PRIOR APPROVAL REVIEW**

**MAIL COMPLETED REQUEST FORM WITH MEDICAL RECORDS TO:**

**MEDICAID PRIOR APPROVAL REVIEW**
**QUALIS HEALTH**
**440 KNOX ABBOTT DRIVE, SUITE 220**
**CAYCE, SC 29033**
**PHONE: (877) 717-8592**

PATIENT NAME _____
LAST FIRST MI

BIRTHDATE _____ *MEDICAID# _____
MONTH/DAY/YEAR

PROCEDURE _____ CODE _____

FACILITY _____ _____
NAME MEDICAID PROVIDER #

PLANNED SURGERY DATE _____

*TO AVOID THE RISK OF NON–PAYMENT, PROVIDERS SHOULD CHECK ELIGIBILITY OF RECIPIENT PRIOR TO REQUEST FOR PRIOR APPROVAL REVIEW. IF THE RECIPIENT IS MANAGED CARE, PRIOR APPROVAL MUST BE OBTAINED THROUGH THE MANAGED CARE PROVIDER.

PHYSICIAN'S NAME _____
LAST FIRST MI

ADDRESS _____

_____ NPI or MEDICAID PROVIDER ID: _____

CONTACT PERSON _____ TELEPHONE (_____) _____

DATE _____ FAX NUMBER (_____) _____

- **OFFICE NOTES DOCUMENTING THE REQUESTED INFORMATION MUST BE ATTACHED**
- **ALL PERTINENT DOCUMENTATION FOR THE PROCEDURE SHOULD BE MAILED TOGETHER**
- **PROVIDERS WILL BE NOTIFIED OF DETERMINATION VIA MAIL**

**APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE**

**SOUTH CAROLINA MEDICAID PROGRAM**
**SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY**

**THIS COMPLETED FORM AND A SIGNED "ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.**

**MAIL TO:**
**PRIOR APPROVAL REVIEW**
**QUALIS HEALTH**
**KNOX ABBOTT DRIVE, SUITE 220**
**CAYCE, SC 29033**
**PHONE: (877) 717-8592**
**FAX: (877) 717-8594**

**PATIENT**

**NAME** _____ **MEDICAID #** _____
**LAST FIRST MI**

**BIRTHDATE** _____ **GRAVITY** _____ **PARITY** _____
**MONTH/DAY/YEAR**

**PROCEDURE**

**HOSPITAL** _____ _____
**NAME ID# (IF AVAILABLE)**

**PLANNED ADMISSION DATE** _____ **PLANNED SURGERY DATE** _____

**TYPE OF HYSTERECTOMY PLANNED**_____

**GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:**

_____
_____
_____
_____
_____
_____
_____
_____

**HCT** ____ **HGB** ____ **CHECK ONE: PREMENOPAUSAL** _____ **POSTMENOPAUSAL** _____

**CONSERVATIVE TREATMENT/MEDICATION WITH DATES:**

_____
_____
_____

**PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):**

_____
_____
_____

***OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.***

**ATTENDING PHYSICIAN'S NAME** _____ _____
**LAST FIRST MI STATE ID #**

**ADDRESS** _____

**CONTACT PERSON** _____ **TELEPHONE** (_____) _____

**SIGNATURE** _____ **DATE** _____
**ATTENDING PHYSICIAN**

**APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.**

# CPT Codes Requiring Support Documentation

| Code | Description |
|---|---|
| 11960 | INSERTION OF TISSUE EXPANDERS |
| 11970 | REPLACE TISSUE EXPANDER WITH PERM PROSTH |
| 11971 | REMOVE TISSUE EXPANDER(S) WO INSERT PROSTH |
| 15823 | BLEPHAROPLASTY,UP LID SKIN WT DOWN LID |
| 19328 | REMOVAL INTACT MAMMARY IMPLANT |
| 19330 | REMOVAL MAMMARY IMPLANT MATERIAL UNILATE |
| 19350 | NIPPLE/AREOLA RECONSTRUCTION |
| 19355 | CORRECTION OF INVERTED NIPPLE |
| 19380 | REVISION OF RECONSTR BREAST |
| 29901 | ARTHSCPY METCARPPHALANG SURG W/DEBRIDE |
| 29902 | ARTHSCPY METCARPPHALANG SURG W/REDUCT |
| 31766 | CARNAL RECONSTRUCTION |
| 32997 | TOTAL LUNG LAVAGE (UNILATERAL) |
| 36550 | DECLOT THROMB AGT IMP VASCU DEV OR CATHR |
| 42509 | PAROTID DUCT DIVER BILAT EXCISE 2 GLANDS |
| 44955 | APPENDECTOMY W/OTH SURG FOR INDICAT PURP |
| 54235 | INJECT CORPORA CAVRN W PHARM AGENT(S) |
| 54240 | PENILE PLETHYSMOGRAPHY |
| 54250 | NOCTURN PENILE TUMESCENCE AND/OR RIG TES |
| 55450 | Ligation (Percutaneous) Vas Deferens Uni/Bilateral |
| 54690 | LAPAROXCOPY SURGICAL ORCHIECTOMY |
| 55200 | VASOTOMY CANNULI W/WO INCIS VAS UNI/BILA |
| 55250 | VASECTOMY UNI/BIL (SEP PRO) INC POSTOP SE |
| 57291 | CONSTRUCTION ARTIFICIAL VAGINA WITH GRAF |
| 57292 | CONSTRUCTION ARTIFICIAL VAGINA W/O GRAF |
| 57295 | REV OF PROSTH VAG GRAFT, VAGINAL APPROACH |
| 58600 | TRANSECT FALLOPIAN TUBE UNIL & BILAT |
| 58605 | TRANSECT FALLOPIAN TUBE POSTPART |
| 58611 | LIGATION TRANSEC FALLOP TUBE W/C-SECTION |
| 58615 | OCCLUSION FALLOP TUBE(S) BY DEVICE VAG/SU |
| 58660 | LAP SURG LYSIS ADHESIONS SALPING OVARIO |
| 58661 | LAP SURG REMV AXL STR P/T OOPHOR SALPING |
| 58670 | LAP SURG FULGURATION OVIDCT W/WOUT TRANS |
| 58671 | LAP SURG OCCL OVIDUCTS DEV EG BND CP FR |
| 58673 | LAP SURG SALPINGOSTOMY (SALPINGONEOSTOMY) |
| 58700 | SALPINGECTOMY CPLTE PART UNIL BILAT |
| 58720 | SALPINGO-OOPHORECTOMY CPLTE PART UNIL BI |
| 59135 | SURGI ECTOPIC INTERSITIAL PG W/HYSTERECT |
| 59840 | INDUCED ABORTION PER D&C |
| 59841 | INDUCE ABORT, DILATION & EVAC |
| 59850 | INDUCE ABORT, BY INJECT INCLD HOSP ADM, DV |
| 59851 | INDUCE ABORT, D&C &/OR EVACUATION |
| 59852 | INDUCED AB BY AMNIO INJ W HYSTEROTOMY |
| 59855 | INDUCE ABORT BY VAG SUPPOSIT INC HOS ADM |
| 59856 | INDUCE ABORT VAG SUPPOS HOSP ADM W/D&C |
| 59857 | INDUCE ABORT VAG SUPPOS HOSP ADM W/HYST |
| 61885 | OMCOS&SUBCUT PLACEM CRANIAL NEUROSTIMULA |
| 61886 | CRANIAL NEUROSTUM PUL GEN REC INCIS SUBCT |
| 63650 | PERC IMPLANTATION NEUROSTIM ELECTRODES |
| 63655 | LAMINECTOMY IMPLANTATION NEUROSTIM ELECT |
| 63660 | REV OR REM SPINAL NEUROSTIM TRODS |
| 63685 | INCIS SUBCUTAN SPINAL NEUROSTIM GENERATO |
| 63688 | REV/REM SPINAL NEUROSTIM GEMERA/RECIEVER |
| 67912 | CX LAGOPHTHALMOS, UP EYELID LID LOAD IMPL |
| 69300 | OTOPLASTY, PROTRUDING EAR; W/WO REDUCTION |
| 69710 | IMPLANT-REPLA BONE CONDUCT DEVICE TEMPOR |

# CPT Codes Requiring Prior Authorization

| Codes | Description | Codes | Description |
|---|---|---|---|
| 15831 | EXCISION EXCESSIVE SKIN/SUBQ TISSUE, ABDOMEN | 58280 | VAG HYSTER W/COLPECT W/REPAIR OF ENTEROCE |
| 15830 | EXCISION EXCESSIVE SKIN/SUBCUT TISS, ABDOMEN | 58285 | VAG HYSTER RADICAL SCHAUTA TYPE OPERAT |
| 15847 | EXCIS, EXCES SKIN&SUBCUT TIS, ABDOMN, ADD-ON | 58290 | VAGINAL HYSTERECTOMY, FOR UTERUS >250 GM |
| 19140 | MASTECTOMY FOR GYNECOMASTIA | 58291 | VAG HYSTERECTMY,UTER>250 GM, REMV TUB&OVAR |
| 19300 | GYNECOMASTIA MASTECTOMY (REM BREAST TIS) | 58292 | VAG HYSTEREC,REMV TUB&OVAR; REPR ENTEROCE |
| 19316 | MASTOPEXY, REPAIR AND RECONSTRUCT | 58293 | VAG HYSTERECTMY, W/COLPO-URETHROCYSTOPEXY |
| 19318 | REDUCTION MAMMAPLASTY | 58294 | VAGINAL HYSTERECTOMY, REPAIR ENTEROCELE |
| 19340 | IMMED INSRT BREAST PROSTHES FOLLOW MAST | 58952 | RESECT OVARI PERIT MALIGN/RADICA DISSECT |
| 19342 | DELAYED INSERT BREAST IMPLANT AFTER MAST | 58953 | BILAT SALP-OOPH, TAH & DISECT FOR DEBLKNG |
| 19357 | BREAST RECON TIS EXP INC SUBSEQ EXP | 58954 | BILAT SALP-OOPH, TAH & DISECT; LYMPHDECTMY |
| 19361 | BREAST RECON LATI DOR FLAP W/PROS IMPLA | 58956 | BIL SAL-OOPH W OMENT., ABD HYST F MALIGN |
| 19364 | BREAST RECON W/FREE FLAP | 58294 | VAGINAL HYSTERECTOMY, REPAIR ENTEROCELE |
| 19366 | BREAST RECON W OTHER TECHNIQUE | 58541 | LAPAROSCOPY, SUPRACERV HYSTERECTOMY, 250G< |
| 19367 | BREAST RECONS W/TRAV RECTUS ABDOM MYOCUT | 58542 | LAP, SUPRACERV HYSTER, 250G<,REMO TUBE/OVA |
| 19368 | BREAST RECONS W/TRAM SING PEDI W/MICROVA | 58543 | LAPAPROSCOPY,SUPERACERV HYSTERECTMY,>250G |
| 19369 | BREAST RECONS W/TRAM DOUBLE PEDICLE INC | 58544 | LAP,SUPRACERV HYSTER, >250 G, REMO TUBE/OVA |
| 37788 | PENILE REVAS ART W VEIN GRAFT | 58548 | LAPROSCOPY, RADICAL HYSTERECTOMY |
| 43644 | LAP, SURG, GAST RESTRIC;W/BYPASS & ROUX-EN-Y | 58550 | LAPROSCOPY SURGICAL, W/VAGINAL HYSTERECTM |
| 43645 | LAP, SURG, GAST RESTRIC; BYPASS & SM INT REC | 58552 | LAPAROSCOPY, VAG HYSTERECTOMY/TUBES/OVARI |
| 43770 | LAP, SURG, GASTRIC RESTRC PROC, PLC ADJ BAND | 58553 | LAPAROSCOPY VAG HYSTERECTOMY, COMPLEX |
| 43771 | LAP, SURG, GASTRIC RESTRC PROC, REV ADJ BAND | 58554 | LAP VAG HYSTERECTOMY, REMV TUB&OVA COMPLX |
| 43773 | LAP,SURG, GASTRIC RESTRC PROC; REMV-REPL BND | 58565 | HYSTEROSCOP,SURG;W/BILAT FALLOP TUBE CAN |
| 43842 | GASTRIC RESTRIC PROC, V-BAND GASTROPLASTY | 58956 | BIL SAL-OOPH W OMENT.,ABD HYST F MALIGN |
| 43845 | GASTROPLASTY, ANYMETHOD, MORBID OBESITY | 58957 | RESECTION RECURRENT BYN MALIGNANCY |
| 43846 | GASTRIC RESTRIC PROC W BYPASS-OBESITY | 59525 | SUBTOTAL HYSTERECT AFT C-SECT (S P) |
| 43847 | GASTRIC RESTRIC PROC, SM INTES RECONSTRUC | 69714 | IMPLANT, OSSEOINTEGRATE;W/O MASTOIDECTOMY |
| 43848 | REVIS OF GASTRIC RESTRICTIVE PROC MORBID | 69715 | IMPLANT, OSSEOINTEGRATE;W/MASTOIDECTOMY |
| 43886 | GASTRIC RESTRIC PROC, OPEN; REV SUBCU PORT | 69718 | REPLACE, OSSEOINTEGR IMPL; W/MASTOIDECTO |
| 43887 | GASTRIC RESTRC PROC, OPEN; REMV SUBCU PORT | 69930 | COCHLEAR DEVICE IMPLANT W/WO MASTOIDECTO |
| 43888 | GASTRIC RESTRC PROC, OPEN; REMV-REPL SUBC PR | | |
| 51925 | CLOS VESICOUTERINE FISTULA W HYSTERECTOM | | |
| 54400 | INSERT PENILE PROSTH NON-INFLAT (SEMI-RIG) | | |
| 54401 | INSERT PENILE PROSTH INFLAT SLF-CONT | | |
| 54405 | INSERT MULTI-COMPONEN, INFLAT PENILE PROS | | |
| 58150 | TOTAL HYSTERECT ABDOMIN W/WO REMOVE TUBE | | |
| 58152 | TOTAL ABDOM HYSTER , W/WO REMOVE TUB & OVAR | | |
| 58180 | SUPRACERVICAL HYSTERECTOMY | | |
| 58200 | TOTAL HYST INC VAGINECTOMY LYMP | | |
| 58210 | RADICAL HYST W/BILAT TOTAL PELVIC LYMPHAD | | |
| 58240 | PELVIC EXTENERATION FOR BYN MALIGNANCY | | |
| 58260 | VAGINAL HYSTERECTOMY; UTERUS <=250 GRAMS | | |
| 58262 | VAGINAL HYSTER., REMOVE TUBES &/OR OVARYS | | |
| 58263 | VAG HYST, REMV TUB/OVAR&ENTEROCELE REPAIR | | |
| 58267 | VAG HYST W/URINARY REPAIR | | |
| 58270 | VAG HYST W/ENTEROCELE REPAIR | | |
| 58275 | VAG HYSTER, W/TOTAL-PARTIAL VAGINECTOMY | | |

# ICD-9 Codes That Require Prior Authorization

| Code | Description |
|---|---|
| | **SURGICAL PROCEDURE** |
| **20.96** | IMPLANT/REPLACE COCHLEAR DEVICE NOS |
| **20.97** | IMPLAN/REPLACE COCHLEAR DEVICE SING CHANN |
| **20.98** | IMPLAN/REPLACE COCHLEAR DEVIDE MULTI CHAN |
| **44.31** | HIGH GASTRIC BYPASS |
| **44.95** | LAPAROSCOPIC GASTRIC RESTRICTIVE PROCEDU |
| **44.96** | LAPROS REVISION/GASTRIC RESTRICTIVE PROC |
| **44.98** | ADJ SIZE OF ADJ GASTRIC RESTRICTIVE DEVI |
| **64.94** | FITTING OF EXTERNAL PROSTHESIS OF PENIS |
| **64.95** | INSERT/REPLACE OF INTERNAL PENILE PROST |
| **64.97** | INSERT/REPLACE INFLAT PENILE PROSTHESIS |
| **64.98** | PENILE OPERATION NEC |
| **68.31** | LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY |
| **68.39** | OTH&UNSPEC SUBTOTAL ABDOMINAL HYSTERECTMY |
| **68.40** | TOTAL ABD HYSTERECTOMY |
| **68.41** | LAPAROSCOPIC TOTAL ABDOMINAL HYSTERECTOM |
| **68.49** | OTH&UNSPEC TOTAL ABDOMINAL HYSTERECTOMY |
| **68.51** | LAPAROSCOP ASSIST VAGINL HYSTERTMY(LAVH) |
| **68.59** | OTHER & UNSPECIFIED VAGINAL HYSTERECTOMY |
| **68.60** | RADICAL ABD HYSTERECTOMY |
| **68.61** | LAPAROSCOPIC RADI ABDOMINAL HYSTERECTOMY |
| **68.69** | OTH&UNSPEC RADICAL ABDOMINAL HYSTERECTOM |
| **68.70** | RADICAL VAG HYSTERECTOMY |
| **68.71** | LAPARASCOPIC RADICAL VAGINAL HYSTERECTOM |
| **68.79** | OTH&UNSPEC RADICAL VAGINAL HYSTERECTOMY |
| **68.80** | PELVIC EVISCERATION |
| **68.90** | HYSTERECTOMY, OTHER AND UNSPECIFIED |
| **85.31** | UNILAT REDUCT MAMMOPLAST |
| **85.32** | BILAT REDUCT MAMMOPLASTY |
| **85.34** | UNILAT SUBQ MAMMECT NEC |
| **85.36** | BILAT SUBQ MAMMECTOM NEC |
| **85.53** | UNILATERAL BREAST IMPLANT |
| **85.54** | BILATERAL BREAST IMPLANT |
| **85.60** | MASTOPEXY |
| **85.70** | TOTAL RECONSTRUCTION OF BREAST |
| **85.89** | MAMMOPLASTY NEC |
| **85.93** | REVISION OF IMPLANT OF BREAST |
| **85.95** | INSERTION BREAST TISSUE EXPANDER |
| **86.83** | SIZE REDUCTION PLASTIC OPERATION |

# ICD-9 Codes Requiring Support Documentation

| ICD-9 | Code Description |
|---|---|
| **03.99** | SPINE CANAL STRUC OP NEC |
| **05.9** | OTHER NERVOUS SYSTEM OPS |
| **06.94** | THYROID REIMPLANTATION |
| **06.98** | OTHER THYROID OPERATIONS |
| **06.99** | OTHER PARATHYROID OPS |
| **07.45** | ADRENAL REIMPLANTATION |
| **08.52** | BLEPHARORRHAPHY |
| **08.59** | ADJUST LID POSITION NEC |
| **08.70** | LID RECONSTRUCTION NOS |
| **08.89** | EYELID REPAIR NEC |
| **10.99** | CONJUNCTIVAL OP NEC |
| **18.79** | PLASTIC REP EXT EAR NEC |
| **21.99** | NASAL OPERATION NEC |
| **27.59** | MOUTH PLASTIC MOUTH REPAIR NEC |
| **44.39** | GASTROE NTEROSTOMY NEC |
| **47.99** | APPENDICEAL OPS NEC |
| **63.99** | CORD/EPID/VAS OPS NEC |
| **64.99** | MALE GENITAL OP NEC |
| **66.97** | BURY FIMBRIAE IN UTERUS |
| **69.01** | D&C FOR PREG TERMI |
| **69.51** | ASPIRAT CURET-PREG TERMI |
| **69.93** | INSERTION OF LAMINARIA |
| **71.90** | OTHER FEMALE GENITAL OPS |
| **74.91** | HYSTEROTOMY TO TERMIN PG |
| **75.0** | INTRA-AMNION INJ FOR AB |
| **76.69** | FACIAL BONE REPAIR NEC |
| **85.87** | NIPPLE REPAIR NEC |
| **85.94** | BREAST IMPLANT REMOVAL |
| **85.96** | REMOVAL OF BREAST TISSUE EXPANDER |
| **85.99** | BREAST OPERATION NEC |
| **86.81** | REPAIR FACIAL WEAKNESS |
| **86.84** | RELAXATION OF SCAR |
| **86.89** | SKIN REPAIR & PLASTY NEC |
| **86.93** | INSERTION OF TISSUE EXPANDER |