

CHAPTER XII

SUPPLEMENTAL SERVICES HCPCS LEVEL II CODES A0000 - V9999

NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICAID SERVICES

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Chapter XII
Supplemental Services
HCPCS Level II Codes A0000 - V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the HCPCS codes in the range A0000-V9999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services performed. This type of unbundling is incorrect coding.

The HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to HCPCS Level II codes are clarified in this Chapter.

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare & Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicaid fiscal agents.

The presence of a HCPCS/CPT code in an NCCI PTP edit or of an MUE value for a HCPCS/CPT code does not necessarily indicate that the code is covered by any or all state Medicaid programs.

In October 2012, CMS implemented a new NCCI methodology for Medicaid - i.e., NCCI PTP edits for durable medical equipment (DME).

The Medicaid NCCI program has also implemented additional edits in the original five methodologies that are unique to Medicaid NCCI - e.g., edits for codes that are noncovered or otherwise not separately payable by the Medicare program (e.g., H, S and T series HCPCS codes).

B. Evaluation and Management (E&M) Services

Physician services can be categorized as either major surgical procedures, minor surgical procedures, non-surgical procedures, or evaluation and management (E&M) services. This section summarizes some of the rules for reporting E&M services in relation to major surgical, minor surgical, and non-surgical procedures. Even in the absence of NCCI PTP edits, providers should bill for their services following these rules.

The Medicaid NCCI program uses the same definition of major and minor surgery procedures as the Medicare program.

- Major surgery - those codes with 090 Global Days in the "Medicare Physician Fee Schedule Database / Relative Value File"
- Minor surgery - those codes with 000 or 010 Global Days

The Medicare designation of global days can be found on the Medicare/ National Physician Fee Schedule/ PFS Relative Value Files page of the CMS Medicare website at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html>

Select the calendar year and the file name with highest alphabetical suffix - e.g., RVUxxD - for the most recent version of the fee schedule. In the zip file, select document PPRRVU...xlsx" and refer to "Column O, Global Days".

An E&M service is separately reportable on the same date of service as a major or minor surgical procedure under limited circumstances.

If an E&M service is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are

included in the global package for the procedure and are not separately reportable. There are currently no NCCI PTP edits based on this rule.

In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform a minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional During a Postoperative Period").

Many non-surgical procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code.

Other non-surgical procedures are not usually performed by a physician and have no physician work associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most non-surgical procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the non-surgical procedure but cannot include any work inherent in the non-surgical procedure, supervision of others performing the non-surgical procedure, or time for interpreting the result of the non-surgical procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as a non-surgical procedure is correct coding.

C. Medical Services

1. The HCPCS code M0064 describes a brief face-to-face office visit with a practitioner licensed to perform the service for the sole purpose of monitoring or changing drug prescriptions used in the treatment of psychiatric disorders. HCPCS code M0064 is not separately reportable with CPT codes 90785-90853 (psychiatric services). (HCPCS code M0064 was deleted January 1, 2015.)

2. The HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an evaluation and management (E&M) service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E&M service is not separately reportable. However, if a significant, separately identifiable E&M service is performed to evaluate other medical problems, both the screening pap smear and the E&M service may be reported separately. Modifier 25 should be appended to the E&M CPT code indicating that a significant, separately identifiable E&M service was rendered.

3. The HCPCS code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E&M) services under certain circumstances. If a covered reasonable and medically necessary E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported.

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However, if the covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

4. Under the NCCI program, HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an evaluation and management code (CPT codes 99201-99499).

5. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82) and A9526 (Nitrogen N-13 Ammonia) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

6. The HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic) describes a radiopharmaceutical utilized for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI PTP-associated modifier. The HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

7. The HCPCS code A4220 describes a refill kit for an implantable pump. It should not be reported separately with CPT codes 95990 (refilling and maintenance of implantable pump..., spinal ...or brain...) or 95991 (refilling and maintenance of implantable pump..., spinal ...or brain...requiring physician or other qualified health care professional) since payment for these two CPT codes includes the refill kit.

Similarly, HCPCS code A4220 should not be reported separately with CPT codes 62369 (Electronic analysis of programmable,

implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill) or 62370 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)) since payment for these two CPT codes includes the refill kit.

8. The HCPCS code E0781 describes an ambulatory infusion pump utilized by a patient for infusions outside the physician office or clinic. It is a misuse of this code to report the infusion pump typically utilized in the physician office or clinic.

9. The HCPCS codes G0422 and G0423 (intensive cardiac rehabilitation; . . . per session) include the same services as the cardiac rehabilitation CPT codes 93797 and 93798 but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as six hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) should not be reported separately for the same patient encounter. However, medical nutrition therapy services covered by a state Medicaid program and performed at a separate patient encounter on the same date of service may be reported separately. The state Medicaid covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation service.

Under the NCCI program, physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation services and are not separately reportable. If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported utilizing an NCCI PTP-associated modifier.

10. Pulmonary rehabilitation (HCPCS code G0424) includes therapeutic services and all related monitoring services to improve respiratory function.

It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)). Pulmonary rehabilitation should not be reported with HCPCS codes G0237 (therapeutic procedures to increase strength or endurance of respiratory muscles (includes monitoring)), G0238 (therapeutic procedures to improve respiratory function (includes monitoring)), or G0239 (therapeutic procedures to improve respiratory function or increase strength (includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)).

Under the NCCI program, physical or occupational therapy services performed at the same patient encounter as pulmonary rehabilitation services are included in the pulmonary rehabilitation services and are not separately reportable. If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as pulmonary rehabilitation services, both types of services may be reported utilizing an NCCI PTP-associated modifier. Similarly physical and occupational therapy services are not separately reportable with therapeutic pulmonary procedures for the same patient encounter.

Medical nutrition therapy services (CPT codes 97802-97804) performed at the same patient encounter as a pulmonary rehabilitation or pulmonary therapeutic service are included in the pulmonary rehabilitation or pulmonary therapeutic service and are not separately reportable. If a physician provides a state Medicaid covered medical nutrition service to a beneficiary on the same date of service as a pulmonary rehabilitation or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition therapy service may be separately reportable with an NCCI PTP-associated modifier. The state Medicaid covered medical nutrition service cannot be reported at the same patient encounter as the pulmonary rehabilitation or pulmonary therapeutic service.

11. SEE SECTION L, PARAGRAPH 13 FOR TELEHEATH SERVICES.

12. HCPCS code G0434 (drug screen..., by CLIA waived test or moderate complexity test, per patient encounter) is utilized to report urine drug screening performed by a test that is CLIA waived or CLIA moderate complex. The code is reported with only one (1) unit of service regardless of the number of drugs screened. HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened. If a provider performs urine drug screening, it is generally not necessary for that provider to send an additional specimen from the patient to another laboratory for urine drug screening for the same drugs.

For a single patient encounter only G0431 or G0434 may be reported. The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter. HCPCS code G0431 describes a more extensive procedure than HCPCS code G0434. Physicians should not unbundle urine drug screen testing and report HCPCS codes G0431 and G0434 for the same patient encounter. *(HCPCS codes G0431 and G0434 were deleted January 1, 2016.)*

For Calendar Year 2016, urine drug presumptive testing should have been reported with HCPCS codes G0477-G0479 or with CPT codes 80300-80304. These codes differ based on the level of complexity of the testing methodology. Only one code from the G code range should have been reported per date of service. Codes 80300-80304 should not have been reported on the same date of service as codes G0477-G0479. Codes 80300-80304 and G0477-G0479 were deleted January 1, 2017.

Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing could have been reported with HCPCS codes G0480-G0483 or CPT codes 80320-80377 or 83992. The G codes differ based on the number of drug classes including metabolites tested. Only one code from the G code range may be reported per date of service. Codes 80320-80377 or 83992 should not be reported on the same date of service as codes G0480-G0483.

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13. HCPCS code G0416 describes surgical pathology, including gross and microscopic examination of prostate needle biopsy specimens. If a state Medicaid program uses this code, the state Medicaid program may require that this code, rather than CPT code 88305, be utilized to report surgical pathology on prostate needle biopsy specimens. If HCPCS code G0416 is used, any and all submitted prostate needle biopsy specimens from a single patient should be reported with one unit of service.

14. Blood products are described by HCPCS level II P codes. If a P code describes an irradiated blood product, CPT code 86945 (irradiation of blood product, each unit) should not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) should not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (frozen blood, each unit; freezing...), 86931 (frozen blood, each unit; thawing), and/or 86932 (frozen blood, each unit; freezing (includes preparation) and thawing) should not be reported separately since the P code includes the freezing and thawing processes.

If a P code describes a pooled blood product, CPT code 86965 (pooling of platelets or other blood products) should not be reported separately since the P code includes the pooling of the blood products. If the P code describes a "frozen" plasma product, CPT code 86927 (fresh frozen plasma, thawing, each unit) should not be reported separately since the P code includes the thawing process.

15. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. If a state Medicaid program uses these codes, they should not be reported separately with an evaluation and management (E&M), psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 should not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI PTP-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a

separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening services". Where CPT codes 99408 and 99409 are covered by state Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409. Codes 99408/99409 should not be reported in addition to codes G0396/G0397.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS codes (e.g., G0442 (annual alcohol misuse screening, 15 minutes), G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS code, the HCPCS code is not separately reportable.

For example, if a patient presents with symptoms suggestive of depression, the provider should not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

16. HCPCS code G0269 describes placement of an occlusive device into a venous or arterial access site after an open or percutaneous vascular procedure. Payment for this service is included in the payment for the vascular procedure.

17. HCPCS code V2790 (amniotic membrane for surgical reconstruction, per procedure) should not be reported separately with CPT codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since payment for these two CPT codes includes the amniotic membrane.

D. Wheelchairs and Related Items

Codes for wheelchair bases describe complete products. Codes for wheelchair options, accessories, or seating systems describe items that can either be added to a complete wheelchair base or substituted for an existing component on a wheelchair base.

The following principles apply to items provided on the same date of service:

1. Two different wheelchair bases should not be reported separately.
2. The code for a wheelchair option or accessory must be compatible with the type of wheelchair that is provided. For example, a sip and puff drive control interface (e.g., HCPCS code E2325) should not be reported with a Group 1 power wheelchair (e.g., HCPCS code K0813-K0816).
3. The code for a wheelchair repair or replacement part should not be reported at the time of initial issue of a wheelchair base. For example, a replacement motor (e.g., HCPCS code E2368) should not be reported with a power wheelchair base.
4. A wheelchair option or accessory should not be reported separately if it is included in the payment for the wheelchair base. For example, a complete footrest assembly (e.g., HCPCS code K0045) should not be reported with a wheelchair base.
5. A separate code for a wheelchair seat cushion should not be reported with any power wheelchair that has captain's chair style seating, with any power operated vehicle (POV), or with a rollabout chair or transport chair.
6. Two codes for items in the same general category of wheelchair options, accessories, or seating systems should not be reported separately. For example, different types of power seating systems (e.g., HCPCS codes E1002-E1008) should not be reported separately.
7. A wheelchair option, accessory, or seating component should not be reported separately if it is included in the payment for another item. For example, a solid seat insert (e.g., HCPCS code E0992) should not be reported with a wheelchair seat cushion (e.g., HCPCS codes E2601-E2610, E2622-E2625).

E. Other Durable Medical Equipment

The following principles apply to items provided on the same date of service:

1. Different types of similar equipment should not be reported separately. For example, a wheeled walker (e.g., HCPCS codes E0141, E0143) should not be reported with a non-wheeled walker (e.g., HCPCS codes E0130, E0135).

2. Codes that describe items that are components of other codes should not be reported separately. For example, oxygen contents (e.g., HCPCS codes E0441, E0442) should not be reported with rented oxygen equipment (e.g., HCPCS codes E0424, E0439).

3. Accessories must be compatible with the specific type of equipment provided. For example, a replacement interface for a nasal mask used with a continuous positive airway pressure (CPAP) device (e.g., HCPCS code A7032) should not be reported with a full face mask used with a CPAP device (e.g., HCPCS code A7030).

F. Spinal and Limb Orthoses

An orthosis base code describes a complete orthosis. An orthosis addition code describes items that can either be added to a complete orthosis or substituted for an existing component of an orthosis.

The following principles apply to items provided on the same date of service:

1. Two different orthosis base codes for the same anatomical region should not be reported for the same limb. For example, only one hand finger orthosis (HFO) base code (e.g., HCPCS codes L3912, L3913, L3921, L3923, L3929) should be reported for the same limb.

2. Orthoses from different anatomical regions that overlap cannot be worn at the same time. For example, a code for a unilateral hip knee ankle foot orthosis (HKAF0) (e.g., HCPCS codes L2070-L2090) should not be reported with an ankle foot orthosis (AFO) (e.g., HCPCS codes L1900-L1990) for the same leg.

3. Most orthoses from adjacent anatomical regions cannot be worn at the same time. For example, a code for a hip

orthosis (HO) (e.g., HCPCS code L1686) should not be reported with a KAFO (e.g., HCPCS codes L2000-L2038) for the same leg because the HO extends to the mid thigh and the KAFO begins at the mid thigh and therefore both cannot be worn at the same time.

4. Addition codes can only be used with certain types of base orthosis codes. For example, a code that describes an "addition to TLSO" (e.g., HCPCS codes L1210-L1290) should not be reported with a lumbar sacral orthosis (LSO) (e.g., HCPCS codes L0628-L0640).

G. Limb Prostheses

A prosthesis base code describes a complete prosthesis. A prosthesis addition code describes items that can either be added to a complete prosthesis or substituted for an existing component of a prosthesis.

The following principles apply to items provided on the same date of service:

1. Only one complete prosthesis should be reported for the same limb. For example, an above knee (AK) prosthesis (e.g., HCPCS codes L5200-L5230) and a below knee (BK) prosthesis (e.g., HCPCS codes L5100, L5105) should not be reported for the same limb.

2. Only one component in the same category (e.g., an electric hand [e.g., HCPCS codes L6880, L7007, L7008] or a non-electric terminal device [e.g., HCPCS codes L6703-L6722] for an upper limb prosthesis) should be reported for the same limb.

3. Codes that represent components of other codes should not be reported for the same limb. For example, batteries (e.g., HCPCS codes L7360, L7364, L7367) and a charger (e.g., HCPCS codes L7362, L7366, L7368) are included in electrical components (e.g., HCPCS codes L7007-L7261) at initial issue and should not be reported separately.

4. Components for different amputation levels (e.g., an above knee [AK] socket [e.g., HCPCS code L5631] and a below knee [BK] socket [e.g., HCPCS code L5645]) should not be reported for the same limb.

5. Addition codes that do not match the base prosthesis code should not be reported. For example, a BK addition (e.g.,

HCPCS code L5655) should not be reported with an AK base prosthesis (e.g., HCPCS codes L5200-5230) for the same leg.

6. Certain addition codes should not be reported with preparatory or immediate prosthesis base codes. For example, an electric hand (e.g., HCPCS code L7007) should not be reported with a preparatory prosthesis (e.g., HCPCS codes L6584-L6586).

H. Orthopedic Shoes and Inserts

The following principles apply to items provided on the same date of service:

1. Different types of foot orthotics or different types of shoes should not be reported for the same foot. For examples, a silicone gel insert (e.g., HCPCS code L3003) and a Plastazote insert (e.g., HCPCS code L3002) should not be reported for the same foot.

2. Addition codes which are standard features of shoes should not be reported separately. For example, a new standard rubber heel (e.g., HCPCS code L3460) should not be reported with a shoe (e.g., HCPCS codes L3215-L3222) for the same foot.

3. Different shoe modifications of the same type (e.g., two different sole wedges [e.g., HCPCS codes L3360 and L3370]) should not be reported for a shoe for the same foot.

I. Hearing Aids

The following principles apply to items provided on the same date of service:

1. Only one type of binaural hearing aid may be reported. For example, a behind the ear BICROS hearing aid (e.g., HCPCS code V5220) should not be reported with a behind the ear digital binaural hearing aid (e.g., HCPCS code V5261).

2. Only one type of monaural hearing device may be reported for the same ear. For example, a digital monaural behind the ear hearing aid (e.g., HCPCS code V5257) should not be reported with a digital monaural in the ear hearing aid (e.g., HCPCS code V5256) for the same ear.

3. A binaural hearing aid (e.g., HCPCS code V5220) should not be reported with a monaural hearing aid (e.g., HCPCS code V5256).

4. Similar assistive listening devices should not be reported separately. For example, an fm/dm system assistive listening device with a loop induction receiver (e.g., HCPCS code V5283) should not be reported with an assistive device with a Bluetooth receiver (e.g., HCPCS code V5286).

5. Codes that are components of other codes should not be reported separately. For example, a transmitter microphone (e.g., HCPCS code V5290) should not be reported with a binaural fm/dm system assistive listening device (e.g., HCPCS code V5282).

J. Eyeglasses

The following principles apply to items provided on the same date of service:

1. Different types of similar items should not be reported for the same eye. For example, a plano to +/- 4.00d bifocal lens (e.g., HCPCS code V2200) should not be reported with a similar lens with 0.12-2.00 cylinder (e.g., HCPCS code V2203) for the same eye.

2. Certain addition codes are incompatible with specific lens codes. For example, bifocal segment width over 28 mm (e.g., HCPCS code V2219) should not be reported with a trifocal lens (e.g., HCPCS codes V2300-V2399) for the same eye.

3. Different types of similar features (e.g., HCPCS codes V2710 and V2715 for prism add-on) should not be reported for the same eye.

K. Therapeutic Shoes for Diabetics

The following principles apply to items provided on the same date of service:

1. Only one pair of shoes should be reported on the same date of service.

2. Inserts and modifications for therapeutic shoes for diabetics (HCPCS codes A5500, A5501) should be reported with HCPCS codes A5503-A5513. They should not be reported with L3xxx codes for orthopedic shoes.

3. Inserts and modifications for orthopedic shoes (HCPCS codes L3201-L3253) should be reported with HCPCS codes L3000-L3170 and L3254-L3649. They should not be reported with A55xx codes for diabetic shoes.

L. Urological Supplies

The following principles apply to items provided on the same date of service:

1. Only one type of indwelling catheter, intermittent catheter, or external catheter should be reported on the same date of service.

2. Intermittent catheters should not be reported with supplies that are used with indwelling or exdwelling catheters.

3. Exdwelling catheters should not be reported with supplies that are used with indwelling catheters.

M. Medically Unlikely Edits (MUEs)

1. The MUEs are described in Chapter I, Section V.

Providers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. The MUEs were set so that such occurrences should be uncommon. If a provider does this frequently for any HCPCS/CPT code, the provider may be coding units of service incorrectly. The provider should consider contacting his/her national health care organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national health care organization, provider, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

2. MUE values of HCPCS codes for discontinued drugs are zero (0).

3. The MUE value of HCPCS codes describing compounded inhalation drugs is zero (0) because compounded drugs are not FDA approved.

4. In 2011 new HCPCS code J0171 (injection, adrenalin, epinephrine, 0.1 mg) replaced deleted HCPCS code J0170

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(injection, adrenalin, epinephrine, up to 1 ml ampule). HCPCS code J0170 was often reported incorrectly. A 1 ml ampule of adrenalin/ epinephrine contains 1.0 mg of adrenalin/epinephrine in a 1:1,000 solution. However, a 10 ml prefilled syringe with a 1:10,000 solution of adrenalin/epinephrine also contains only 1.0 mg of adrenalin/epinephrine. Thus a physician must recognize that ten (10) units of service for HCPCS code J0171 correspond to a 1 ml ampule or 10 ml of a prefilled syringe (1:10,000 (0.1 mg/ml) solution).

5. There are two HCPCS codes describing injectable dexamethasone. HCPCS code J1094 (injection, dexamethasone acetate, 1 mg) is no longer manufactured and has an MUE value of zero(0). HCPCS code J1100 (injection, dexamethasone sodium phosphate, 1 mg) is currently available. When billing for dexamethasone, physicians should be careful to report the correct formulation with the correct HCPCS code.

6. Based on the code descriptor, HCPCS code J3471 (injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 units)) should not be reported with more than 999 units of service. Therefore, if a physician utilizes more than 999 USP units of the product described by J3471, the physician may report HCPCS code J3471 on more than one line of a claim appending modifier 59 to additional claim lines and should report no more than 999 units of service on any one claim line. HCPCS code J3472 (injection, hyaluronidase, ovine, preservative free, per 1000 USP units) should be not used for this drug.

7. HCPCS codes G0406-G0408 describe follow-up inpatient consultation services via telehealth and HCPCS codes G0425-G0427 describe emergency or initial inpatient telehealth consultation services via telehealth. These codes should not be reported by a practitioner on the same date of service that the practitioner reports a face-to-face evaluation and management code. These codes are utilized to report telehealth services that if performed with the patient physically present would be reported with corresponding CPT codes.

Since follow-up inpatient consultation services with a patient present are reported utilizing per diem CPT codes 99231-99233, HCPCS codes G0406-G0408 may only be reported with a single unit of service per day.

Since initial inpatient consultation services with a patient present are reported utilizing per diem CPT codes 99231-99233, HCPCS codes G0425-G0427 may only be reported with a single unit

of service per day when reporting inpatient telehealth consultation services. However, if HCPCS codes G0425-G0427 are utilized to report emergency department services, reporting rules are comparable to CPT codes 99281-99285.

8. If a HCPCS drug code descriptor defines the unit of service as "per dose", only one (1) UOS may be reported per drug administration procedure even if more than the usual amount of drug is administered. For example, HCPCS code J7321 (Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose) describes a drug that may be injected into the knee joint. Only one (1) UOS may be reported for injection of the drug into each knee joint even if the amount of injected drug exceeds the usual amount of drug injected.

9. The MUE values for HCPCS codes G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) are one (1) since the UOS for each code is defined as "per patient encounter" and the likelihood that a patient needs this type of testing at more than one encounter on a single date of service is very small. These codes include all drug screening at the patient encounter and should not be reported with multiple UOS. *(HCPCS codes G0431 and G0434 were deleted January 1, 2016.)*

For Calendar Year 2016, urine drug presumptive testing should have been reported with HCPCS codes G0477-G0479 or with CPT codes 80300-80304. These codes differ based on the level of complexity of the testing methodology. Only one code from the G code range should have been reported per date of service. Codes 80300-80304 should not have been reported on the same date of service as codes G0477-G0479. Codes 80300-80304 and G0477-G0479 were deleted January 1, 2017.

Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483 or CPT codes 80320-80377 or 83992. The G codes differ based on the number of drug classes including metabolites tested. Only one code from the G

code range may be reported per date of service. Codes 80320-80377 or 83992 should not be reported on the same date of service as codes G0480-G0483.

10. HCPCS codes Q9951 and Q9965-Q9967 describe low osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered. HCPCS code Q9951 (Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml) is often incorrectly reported for low osmolar contrast material products with lower iodine concentrations. Similarly HCPCS codes Q9958-Q9964 describe high osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered.

11. MUE values for surgical procedures that may be performed bilaterally are based on the NCCI coding principle that a bilateral surgical procedure should be reported on one line of a claim with modifier 50 and one (1) unit of service. This coding principle does not apply to non-surgical diagnostic and therapeutic procedures.

12. For H, S, and T series HCPCS codes, MUE values are based on the description of the unit of service in the code descriptor (e.g., per hour, per diem). If an individual state has defined the unit of service for a HCPCS code differently (e.g., per 15 minutes instead of per diem), the state may request permission from CMS to deactivate that MUE.

13. If the unit of service for evaluation and/or management service is not defined in an H, S, or T series HCPCS code descriptor (e.g., code H1000 - Prenatal care, at-risk assessment), the MUE value is usually based on a UOS of per visit. If an individual state has defined the unit of service for a HCPCS code differently (e.g., per hour), the state may request permission from CMS to deactivate that MUE.

14. When providing items for arms, legs, or other paired organs, the appropriate anatomical HCPCS modifier (e.g., RT - right side, LT - left side) should be appended to the HCPCS code.

15. HCPCS code K0462 (Temporary replacement for patient owned equipment being repaired, any type) may be reported with one (1) unit of service (UOS) for each item of patient owned equipment that is being repaired. Component parts of a patient

owned piece of equipment being repaired should not be reported separately. For example, if a patient owned CPAP (continuous positive airway pressure) blower requires repair, the supplier may report one (1) UOS for K0462. The supplier should not report an additional UOS for an integral humidifier even if it also requires repair. The supplier should not report an additional UOS for a detachable humidifier unless it also requires repair at the same time.

16. Generally only one unit of service for an item of durable medical equipment (DME) (e.g., oxygen concentrator, wheelchair base) may be paid on a single date of service. Payment for backup or duplicate durable medical equipment is not generally allowed. More than one unit of service may be paid on a single date of service for accessories and supplies related to DME when appropriate. Prosthetics and orthotics may also be paid with more than one unit of service on a single date of service if the items are for different limbs.

17. HCPCS code P9604 describes a flat rate one way travel allowance for collection of medically necessary laboratory specimen (s) drawn from a home bound or nursing home bound patient. A round trip should be reported with modifier LR and one (1) unit of service (UOS) rather than two (2) UOS. The reported UOS should be prorated for multiple patients drawn at the same address and for stops at the homes of Medicaid and non-Medicaid patients.

N. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, or providers, eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicaid rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them.

2. *MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.*

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the National Correct Coding Initiative Policy Manual for Medicaid Services, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. With the exception of moderate conscious sedation (see below), the NCCI program does not allow separate reporting of anesthesia for a medical or surgical procedure when it is provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-~~62320-62327~~, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-~~96377~~) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

The NCCI program allows separate reporting for moderate conscious sedation services (CPT codes ~~99151-99153~~) when it is provided by the same physician performing a medical or surgical procedure.

Under the NCCI program, drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

Under the NCCI program, postoperative pain management is not separately reportable when it is provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, ~~62320-62327~~, 64400-64489, and 96360-~~96377~~ describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI PTP-associated modifier if performed in a non-facility site of service.

6. The global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a surgical procedure.

7. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of incisions for surgical procedures. Closure/repair of a surgical incision is included in the global surgical package. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes (CPT codes 12001-13153) should not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable.

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However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

9. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

10. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI PTP-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI PTP-associated modifiers should generally not be utilized.

11. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

12. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or Medicaid NCCI policy for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI PTP-associated modifier if appropriate.