



Provider Notice #0033

Date: 9/27/04

**Subject: 2004 CPT-4 and HCPCS Updates
Effective 10/18/04**

The 2004 updates to the Current Procedural Terminology – 4th Edition (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II and local Level III codes are effective for Medi-Cal and PHC for dates of service on or after 10/18/04. Some of the policy changes are indicated below:

Orthotics and Prosthetics

Deleted and Replacement HCPCS Codes

The following are deleted HCPCS codes and their 2004 replacement codes. The policy of the deleted codes applies to the replacement codes:

<u>Deleted</u>	<u>Replacement</u>
L0476, L0478, L0500 – L0510 L0520 – L0620 and L0960	K0630 – K0649
L1885	E1810
K0556 – K0559	L5673, L5679, L5681, L5683

The information is reflected in the Medi-Cal Provider manual pages *orthocd1 3 thru 6 and 9 (Part 2)* and *orthocd2 6 (Part 2)*.

Billing and Reimbursement Restrictions

The following new and existing orthotic appliance HCPCS codes are reimbursable to podiatrists:

L1907, L1950, L1951, L1971, L4350, L4360 and L4386

Bilateral Appliances

The following orthotic and prosthetic HCPCS codes may be billed for bilateral appliances. All claims for these codes must be billed with modifiers –RT and/or –LT.

E1810, L1831, L1907, L1951, L1971, L3917, L5673, L5679, L5681, L5683

Knee Device Code Change

HCPCS code E1810 replaces code L1885. This code will be subject to the same provisions as orthotic HCPCS codes.

Reimbursement Restrictions for New Orthotic and Prosthetic HCPCS Codes

The following HCPCS codes have Medi-Cal frequency restrictions:

- L5673, L5679, L5681 and L5683 are limited to two within a six month period.
- L1831 is limited to four within a six month period
- E1810, L0861, L1907, L1951, L1971 and L3917 are limited to one within a 12 month period
- K0619 and K0630 – K0649 are limited to two in a 12 month period

Note: All frequency restrictions are for “any provider” except HCPCS code L1831

Lower Extremity Orthoses (HCPCS Code L2999)

Orthotic fracture appliances HCPCS codes L2102, L2104, L2122 and L2124 have been deleted with no replacement codes. Providers should use code L2999 (lower extremity orthoses, NOS) to bill for items previously defined by the deleted codes. Code L2999 requires prior authorization and is billed “By Report”

Anesthesia

CPT-4 code 01958 (anesthesia for external cephalic version procedure) may be billed as general or regional, or as a combination of both.

CPT-4 code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is a Medi-Cal benefit.

Surgery

The following are deleted CPT-4 codes and their 2004 replacement codes. The policy of the deleted codes applies to the replacement codes, unless otherwise noted.

<u>Deleted</u>	<u>Replacement</u>
36488 – 36491	36555 – 36556, 36568 – 36569, 36580 and 38584*
36493	36597
36530	36563
36531	36575 – 36576, 36578, 36581 – 36582 and 36584 – 36585
36532	36590
36533	36557 – 36561, 36565 – 36566 and 36570 – 36571
36534	36575 – 36578, 36581 – 36583 and 36585
36535	36589
36536	36595
36537	36596
47134	47140

*CPT-4 codes 36555 – 36556, 36568 – 36569, 36580 and 36584 are NOT exempt from modifier -51.

This updated information is reflected on the Medi-Cal manual replacement pages *anest 6 (Part 2), eval 14 (Part2)* and *surg cardio 2 (Part 2)*.

Stab Phlebectomy Maximum Reimbursement

Reimbursement for any combination of CPT-r codes 37765, 37766 (stab phlebectomy of varicose veins) or 37799 (unlisted procedure, vascular surgery – if billed for fewer than 10 phlebectomy incisions) will be paid only up to the amount of the code with the highest maximum allowable amount if billed for the same date of service, any provider.

Duplicate Payment: Combination codes

Reimbursement will be made for only one code or set of codes in the following combinations when billed for the same date of service, any provider:

01996 v. 64449
35697 v. 33877
36550 v. 36595 and/or 36596
36582, 36583, 36585 v. 36578
36838 v. 35512, 35522, 36832, 37607, or 37618
43259 v. 76975
53500 v. 52000
57425 v. 57280

Add-on Codes

The following CPT-r codes are “add-on” codes and must be billed on the same claim with the corresponding code:

<u>Add-on Code</u>	<u>Corresponding Code(s)</u>
22534	22532, 22533
31632*	31628
31633*	31629
63103	63101, 63102

*Codes 31632 and 31633 may only be billed each once per day, regardless of the number of biopsies performed.

Note: These add-on codes are not subject to the multiple procedure reimbursement cutback.

Diagnostic restrictions

The following surgical implantation procedure codes have diagnostic restrictions as noted:

- CPT-4 codes 61867 (craniotomy with neurostimulator electrode implantation; first array) and 61868 (...each additional array) for Parkinson's Disease, tremors, epilepsy, convulsions
- HCPCS code S2230 (magnetic component of hearing device) for hearing loss, sensorineural hearing loss
- HCPCS code S2235 (auditory brain stem implant) for hearing loss, acoustic neurofibromatosis

Radiology

Codes Requiring Split Bill Modifiers

The following new CPT-4 radiology codes are split-billable and must be billed with the appropriate modifier (-26, -99, -TC, or -ZS): 70557 – 70559, 75998, 76937, 76940, 78804 and 79403.

The following new HCPCS radiopharmaceutical codes are 100% professional and must be billed with modifier -26: A9525 and A9528 – A9532.

Maximum Reimbursement: Code Combinations

Reimbursement for the following combinations of CPT-4 codes will be paid only up to the amount of the code with the highest maximum allowable amount if billed for the same date of service, any provider:

- 70250 v. 70260
- 70557 v. 70558 v. 70559
- 78802 v. 78804

Duplicate Payment: Combination Codes

Reimbursement will be made for only one CPT-4 code or set of codes in the following combinations when billed for the same date of service any provider:

- 70557 – 70559 v. 61751, 76393, 76394
- 76003 v. 75998
- 76937 v. 76942

- 76940 v. 76986
- 76942 v. 43232, 43237, 43238, 43242, 45341, 45342 or 76975
- 76975 v. 43231, 43232, 43237, 43238, 43242, 43259, 45341, 45342 or 76942
- 79403 v. 79400

Add-on Codes

The following CPT-4 codes are “add-on” codes and must be billed on the same claim with the corresponding code:

<u>Add-on Code</u>	<u>Corresponding Code(s)</u>
76082	76090, 76091
76083	76092

Pathology/Laboratory

Deleted and Replacement CPT-4 Codes

The following are deleted CPT-4 codes and their 2004 replacement codes. The policy of the deleted codes applies to the replacement codes.

<u>Deleted</u>	<u>Replacement</u>
89350	89220
89355	89225
89360	89230
89365	89235
89399	89240

The updated information is reflected on the Medi-Cal manual page *rates max lab 8 (Part 2)*.

Codes Requiring Split Bill Modifiers

The following new CPT-4 and HCPCS pathology codes are split-billable and must be billed with the appropriate modifier (-26, -00, -TC, or -ZS: 84156 – 84157, 85055, 85396, 87269, 87329, 87660, 88112, 88361, 89220, 89225, 89230, 89235, 89240, and S3820.

Diagnostic Restrictions

HCPCS code S3820 (BRCA1 and BRCA2 gene sequence analysis) has diagnosis restrictions for current or historical malignant neoplasms of the breast.

Medicine

Injections Diagnostic Restrictions

The following new HCPCS injection codes have diagnostic restrictions:

- C9208 (agalsidase), C9209 (laronidase) and S0159 (agalsidase) for lipidoses
- Q4077 (treprostinil) for acute or chronic heart disease
- S0140 (saquinavir) and S0141 (zalcitabine) for HIV

Vaccines for Children Program Immunization Code

CPT-4 code 90655 (influenza virus vaccine, preservative-free, for children 6 to 35 months of age) is reimbursable under the Vaccines For Children program and must be billed with modifiers –SL (state supplied vaccine) and –SK (high risk). Documentation of the reason for the preservative-free formulation must be maintained in the patient’s medical record.

The updated information is reflected on the Medi-Cal manual pages *modified 4 (Part 2)*, *respire 5 (Part 2)* and *vaccine 3 (Part2)*.

Duplicate Payment: Combination Codes.

Reimbursement will be made for only CPT-4 code 95990 or 95991 (refill and maintenance of implant pump or reservoir for drug delivery) when billed for the same date of service, any provider

Ambulance

Local level HCPCS code X0004 (Ambulance night visit) will be deleted and replaced by national HCPCS code A0800.