



Provider Notice: #0049 Revised

Date: 10/5/05

Subject: 2005 CPT-4/HCPCS Updates Effective 11/1/05

The 2005 updates to the Current Procedural Terminology (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) are effective for Medi-Cal and PHC for dates of service on or after 11/1/05.

Acupuncture

Deleted and Replacement Codes

The following are deleted CPT-4 codes and their 2005 replacement codes

Deleted Codes	Replacement Codes
97780	97810, 97811
97781	97813, 97814

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 services, any provider.

- 97810 and 97811 vs. 97813 and 97814

Add on Codes

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

<u>Add-on Code</u>	<u>Primary Service Code</u>
97811	97810
97814	97813

Anesthesia

New anesthesia CPT-4 code 00561 (anesthesia for procedures on heart, pericardial sac, and great vessels of chest: with pump oxygenator, under one year of age) may be reimbursed only for children younger than 1 year of age. Claims

for code 00561 require both the anesthesia start and stop times and the appropriate anesthesia modifier.

Cochlear Implant Supplies

HCPCS codes L8621 and L8622 (batteries) will not be Medi-Cal benefits

Durable Medical Equipment

HCPCS Code Additions

A7045, E0849, E1039, E1229, E1239, E2205, E2206, E2291 – E2294, E2368 – E2370, E2601 – E2621, E8000 – E8002

HCPCS Code Deletions

E0454, E1012, E1013, K0059, K0060, K0061, K0081, K0627, K0650, K0668, S8182, S8183

Deleted and Replacement HCPCS Codes

The following are deleted HCPCS DME codes and their 2005 replacement codes. The policy of the deleted code(s) applies to the replacement code(s).

<u>Delete Code(s)</u>	<u>Replacement Code(s)</u>
K0627	E0849
K0059 – K0061	E2205
K0081	E2206
E1012	E2292
E1013	E2294
K0650 – K0666	E2601 – E2617, respectively
K0668	E2619

Billing and Reimbursement Restrictions for Select DME HCPCS Codes

New HCPCS code A7045 (exhalation port for positive airway device) is a supply for another DME item and may only be purchased as a replacement for patient-owned equipment. Code A7045 must be billed with modifier –NU (new equipment [purchase]). Reimbursement is limited to one in a 12-month period.

Code E0637 (patient lift, combination sit to stand system, any size, with seat lift, with or without wheels) must now be billed “By Report” and requires an authorization.

Code E0849 (traction equipment, cervical, free-standing stand/frame) is “By Report” and requires an authorization and is taxable.

Codes E8000 – E8002 (gait trainers) are “By Report” and require an authorization and are reimbursable only for recipients 65 year of age and younger.

Billing and Reimbursement Restrictions for Select Wheelchair and Wheelchair Accessories Codes

Codes E1229, E1239, E2291 – E2294, E2609 – E2610 and E2617 – E2618 are “By Report” and require an authorization.

Codes E2205 and E2206 are not separately reimbursable with codes E1161, E1229, E1231 – E1238, K0001 – K0007 and K0009 when billed during the same month of service.

Code E2368 is not separately reimbursable with codes E1239, K0010 – K0012 and K0014 when billed for the same month of service.

Purchase Frequency Restrictions for Select DME Codes

The following DME HCPCS codes have purchase restrictions as noted:

- Codes E2291 – E2294 and E2601 – E2621 are limited to one in a 12-month period.
- Codes E2205 and E2206 are limited to two in a 12-month period.
- Codes E0849, E1039, E1229, E1239, E2368 – E2370 and E8000 – E8002 are limited to one in three years.

Benefits for CCS Clients

The following new DME HCPCS codes are benefits for California Children’s Services (CCS) clients only:

- E0463 and E0464 (ventilator)
- E0639 (movable patient lift)
- E0640 (fixed patient lift)

These codes may be reimbursed for Medi-Cal recipients (21 years of age or older) only with an approved authorization.

Reimbursement Restrictions

Ventilator codes E0463 and E0464 may only be rented (bill with modifier –RR [rental]).

Patient lift codes E0639 and E0640 are taxable. Purchase reimbursement is limited to one in three years.

Special Power Wheelchair Interfaces

New DME modifier-KC (replacement of special power wheelchair interface) is activated for use with HCPCS codes E2320 – E2322 and E2327 (special interface for power wheelchair). Claims for these codes must now be billed “By Report” with modifier –NU

or –RR at the time the wheelchair is initially purchased or rented. Reimbursement will be the lesser of the amount billed or the maximum allowable for modifier –NU or –RR, as appropriate. Subsequent claims for the replacement of these special interfaces must be billed with modifier –RP/-NU/-KC or –RR/-KC in that specific order. Reimbursement will be the lesser of the amount billed or the maximum allowable for modifier –KC. Following are the modifier-specific reimbursement rates for these codes:

HCPCS Code	Rental Rates		Purchase Rates	
	-RR	-RR/-KC	-NU	-RP/-NU/-KC
E2320	\$102.59	\$139.07	\$1025.90	\$1390.58
E2321	\$158.92	\$223.10	\$1589.10	\$2231.00
E2322	\$141.03	\$236.26	\$1410.36	\$2362.59
E2327	\$261.24	\$342.08	\$2612.38	\$3420.77

Drugs, Injections

New HCPCS Codes

The following new HCPCS codes are Medi-Cal benefits:

<u>Code</u>	<u>Description</u>
J0135*	Adalimumab, 20mg
J2357*	Omalizumab, 5mg
J2794***	Risperidone, long acting, 0.5mg
J3396**	Verteporfin, 0.1mg

*Codes J0135 and J2357 require a PHC authorization.

Claims for code J3396 must be billed in conjunction with ICD-9 diagnosis code 362.52 (exudative senile macular degeneration) **AND requires prior authorization. Providers must document in the *Reserved For Local Use* field (Box 19) of the claim both the Body Surface Area (BSA) of the recipient and the dose administered. Code J3396 must be billed in quantities of either 150 (15mg) or 300 (30mg).

***Code J2794 is a covered Medi-Cal benefits and must be authorized and paid for by EDS and NOT PHC. This is carved out of PHC’s contract with the state of California.

HCPCS Code Deletions

S0107, S0159, C9208, C9209, C9210

Medicine

CPT-4 Code Additions

92620, 92621, 92625, 93745, 93890, 93892, 93893, 95928, 95929, 95978, 95979

CPT-4 Code Deletions

91032, 91033, 92589, 97601

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:

- 92620, 92621 vs. 92506
- 92625 vs. 92562
- 93745 vs. 93741 – 93742
- 93890 – 93893 vs. 93886, 93888

Reimbursement Restrictions for Select Medicine Codes

New CPT-4 Transcranial Doppler codes 93890, 93892 and 93893 are limited to four procedures each, per year, and are restricted to the following ICD-9 diagnosis codes: 282.6 – 282.69 (sickle cell disease), 348.8 (other conditions of the brain), 430 (subarachnoid hemorrhage) and 433.00 – 433.91 (occlusion and stenosis of pre-cerebral arteries).

New CPT-4 codes 95928 and 95929 (central motor evoked potential studies) are limited to a total for both codes of four procedures, per year.

Orthotics and Prosthetics

HCPCS Code Additions

L1932, L2005, L2232, L4002, L5685, L5856, L5857, L6694 – L6698, L7181

HCPCS Code Deletions

L2435, L5674, L5675, L5846, L5847, L5989, L8490

Deleted and Replacement HCPCS Codes

The following are deleted HCPCS prosthetics codes and their 2005 replacement codes. The policy of the deleted code applies to the replacement code.

Delete Codes	Replacement Code
L5674, L5675	L5685

Reimbursement Restrictions for New Orthotic and Prosthetic Codes

The following new HCPCS codes have Medi-Cal policy and/or frequency restrictions as noted:

- Code L4002 is limited to 16 per year.
- Codes L1932, L2005 and L5856 – L5857 are limited to one in three years.
- Codes L2232, L5685, L6694 – L6698 and L7181 are limited to two in three years.

- Codes L2005, L2232, L6694 – L6698 and L7181 are "By Report" and require prior authorization.
- Codes L1932, L2232, L4002 and L5685 are reimbursable to podiatrists.

Pathology

CPT-4 Code Additions

82045, 82656, 83009, 83630, 84163, 84166, 86064, 86335, 86379, 86587, 87807, 88184, 88185, 88187, 88188, 88189, 88360

CPT-4 Code Deletions

88180

Codes Requiring Split-Bill Modifiers

The following CPT-4 pathology codes are split billable and must be billed with the appropriate modifier (-26, -TC, -ZS or -99): 82045, 85656, 83009, 83630, 84163, 84166, 86064, 86335, 86379, 86587, 87807 and 88360.

New CPT-r code 87807 (infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus) is a Clinical Laboratory Improvement Amendments (CLIA)- waived test when billed with modifier -QW (CLIA-waived tests).

New CPT-4 pathology codes 88184 – 88185 (flow cytometry, cell surface) are 100% technical services and must be billed with modifier -TC (technical component).

New CPT-4 pathology codes 88187 – 88189 (flow cytometry, interpretation) are 100% professional services and must be billed with modifier -26 (professional component).

Reminder: All CPT-4 codes that do not begin with "88" are capitated to Quest Diagnostics. CPT-4 codes that begin with "88" are payable by PHC.

Radiology

CPT-4 Code Additions

75960, 76077, 76510, 76820, 76821, 78811, 78812, 78813, 78814, 78815, 78816, 79005, 79101, 79445

CPT-4 Code Deletions

78810, 78990, 79000, 79001, 79020, 79030, 79035, 79100, 79400, 79420, 79900

Deleted and Replacement CPT-4 Codes

The following are deleted CPT-4 codes and their 2005 replacement codes. The policy of the deleted code applies to the replacement code(s).

<u>Deleted Code(s)</u>	<u>Replacement Code(s)</u>
78810	78811 – 78816
79020, 79030, 79035	79005
79100, 79400	79101

Codes Requiring Split Bill Modifiers

The following CPT-4 radiology codes are split-billable and must be billed with the appropriate modifier (-26, -TC, -ZS, or -99): 75960, 76510, 76820, 76821, 78811 – 78816, 79005, 79101 and 79445.

Reimbursement Restrictions for Select CPT-4 Radiology Codes

Radiology code 75960 transcatheter introduction of intravascular stent[s]) is a new benefit.

Code 76077 will not be a Medi-Cal benefit.

Reimbursement for fetal Doppler velocimetry, CPT-4 codes 76820 (umbilical artery) and 76821 (middle cerebral artery), is limited to once in 180 days, but second and subsequent claims may be reimbursed if documentation justifies medical necessity. Code 76820 must be billed with ICD-9 diagnosis codes 656.50 – 656.53 (poor fetal growth). Code 76821 must be billed with diagnosis codes 656.10 0 656.23 (excessive fetal growth). These codes may not be reimbursed to Alternative Birthing Centers.

Positron Emission Tomography (PET) scans are reimbursable only with CPT-4 codes 78459, 78608, 78609 and 78811 – 78816. These codes are split billed and require a modifier. Providers must receive prior authorization for both the professional and technical component before billing for a PET scan. Only one of these codes may be reimbursed to any provider for the same recipient, same date of service.

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:

- 79101 vs. 36400, 36410, 79403, 90780, 96408
- 79445 vs. 96420

Surgery

CPT-4 Code Additions

11004, 11005, 11006, 11008, 19296, 19297, 19298, 27412, 27415, 29866, 29867, 29868, 31454, 31546, 31620, 31636, 31637, 31638, 32019, 34803, 36475, 36476, 36478, 36479, 36818, 37205, 37206, 37207, 37208, 43257, 43644, 43645, 43845, 45391, 45392, 46947, 50391, 52402, 57267, 57283, 58356, 58956, 63050, 63051, 63295, 66711

CPT-4 Code Deletions

35161, 35162, 35582, 50559, 50578, 50959, 50978, 52347

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:

- G0364 vs. 38220 – 38221
- 11008 vs. 11000 – 11001, 11010 – 11044
- 19296 vs. 19160, 19162
- 27412 vs. 20926, 27331, 27570
- 29866 vs. 29870 – 29871, 29874 – 29875, 29877, 29884 (same session*) or 29866 vs. 29879, 29885 – 29887 (same compartment*)
- 29867 vs. 27415
- 29867 vs. 27570, 29870 – 29871, 29874 – 29875, 29877, 29884 (same session*)
or
29867 vs. 29879, 29885 – 29887 (same compartment*)
- 29868 vs. 29870 – 29871, 29874 – 29875, 29880, 29883 – 29884 (same session*)
or
29868 vs. 29881 – 29882 (same compartment*)

* Documentation is required in the *Reserved For Local Use* field (Box 19) of the claim to justify a different session and/or different compartment if billing code 29866, 29867, or 29868 with other codes listed.

- 31545/31546 vs. 31540, 31541, 69990
- 31546 vs. 20926
- 32019 vs. 32000 – 32005, 32020, 36000, 36410, 62318 – 62319, 64450, 64470, 64475
- 36475/36476 vs. 36000 – 36005, 36410, 36425, 36478, 36479, 37204, 75894, 76000 – 76003, 76937, 76942, 93970 – 93971
- 36478/36479 vs. 36000 – 36005, 36410, 36425, 36475 – 36476, 37204, 75894 76000 – 76003, 76937, 76942, 93970 – 93971
- 36818 vs 36819 – 36821, 36830 (during unilateral upper extremity surgery)
- 36819 vs. 36818, 36820, 36821, 36830 (during unilateral upper extremity surgery)
- 43644 vs. 43846, 49320
- 43645 vs. 49320, 43847
- 43845 vs. 43633, 43847, 44130, 49000
- 45391/45392 vs. 45330, 45341 – 45342, 45378, 76872
- 58356 vs. 58100, 58120, 58340, 76700, 76856
- 58956 vs. 49255, 58150, 58180, 58262 – 58263, 58550, 58661, 58700, 58720, 58900, 58925, 58940
- 63050/63051 vs. 22600, 22614, 22840 – 22842, 63001, 63015, 63045, 63048, 63295 (same segments)
- 63295 vs. 22590 – 22614, 22840 – 22844, 63050 – 63051 (same segments)
- 66711 vs. 66990

Reimbursement Restrictions for Select CPT-4 Surgery Codes

The following surgery codes have reimbursement restrictions as noted:

Codes 19296 – 19298, 29866, 29867, 29868, 31620, 31636, 31637, 31638, 32019, 45391 and 45392 are not reimbursable for assistant surgeon services.

Codes 37205 – 37208 are now Medi-Cal benefits.

Code 52402 is reimbursable for males only. This code is not reimbursable for assistant surgeon services.

Code 57267 is reimbursable for females only.

Codes 57283 and 58565 are reimbursable only for females 21 years of age or older.

Add-On Codes

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

<u>Add-on Code</u>	<u>Primary Procedure Code(s)</u>
11008	11004 – 11006
19297	19160 or 19162
31620	31622 – 31638
31637	31636
36476	36475
36479	36478
37206	37205
37208	37207
57267	45560 or 57240 – 57265
63295	63172 – 63173, 63185, 63190 or 63200 – 63290

Note: These add-on codes are not subject to the multiple surgery rate reduction pricing methodology when billed with the primary service code.

Surgical Services

HCPCS Code Additions

G0364

HCPCS Code Deletions

S2130, S2131

Reimbursement Restrictions for Select Surgical Services

New HCPCS codes C9718 and C9719 (kyphoplasty) are Medi-Cal benefits.

New HCPCS code G0364 (bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service) is reimbursable to non-physician medical practitioners, but is not reimbursable for assistant surgeon services.

If CPT-4 codes 36818 and 36819 are billed for bilateral upper extremity open arteriovenous anastomoses performed at the same surgical session, providers must bill with modifier –50 (bilateral procedure) or –59 (distinct procedural service), as appropriate.

New CPT-4 codes 37215 (transcatheter placement of intravascular stent[s], cervical carotid artery, percutaneous; with distal embolic protection) and 37216 (without distal embolic protection) are Medi-Cal benefits and subject to the following criteria:

- High-risk patient with symptomatic narrowing of carotid artery of 70% or more, or
- Patient at high risk for carotid endarterectomy that has symptomatic carotid artery stenosis between 50 and 70%, or
- Asymptomatic high-risk patient with carotid artery stenosis of 80% or more.

Codes 37215 and 37216 are limited to providers and facilities that have been determined competent by the Centers for Medicare & Medicaid Services (CMS) to perform the appropriate evaluation, stent procedure and necessary follow-up care.

Vaccines for Children Program

New CPT-4 code 90656 (influenza vaccine [for recipients 3 years of age and older]) is reimbursable under the Vaccines For Children (VFC) program and must be billed with modifiers –SK (high risk) and –SL (state supplied vaccine).

CPT-4 code 90700 (DTaP vaccine) is now restricted to recipients younger than seven years of age.