Miscellaneous Coding Policies – State Health Programs	
Category	**Coding Edit**
Add-On Code	HCPCS add-on codes are always performed in conjunction with a primary procedure and should never be reported as standalone services. If the primary procedure is not allowed, then the add-on code is also not allowed
Allergy	Evaluation and management (E&M) services for established patients are included in allergy immunotherapy unless a significant, separately identifiable service is performed
Anesthesia	The daily management of post-operative analgesia is considered part of the global services for other major anesthesia services
	Anesthesiologists are required to utilize the appropriate anesthesia CPT does rather than surgical codes
Assistant Surgeon	Health Net denies assistant surgeon services for certain procedures where the concept of assistant surgeon does not apply
Bilateral Procedures	The appropriate billing method for procedures that are bilateral in nature is to bill the procedure on a two claim lines: one line with the modifier 50 with 1 unit of service and the second line without a modifier 50 with 1 unit of service
	Only procedures that can be billed as bilateral should have modifier 50
Bundled Services	There are a number of services/supplies for which payment is bundled into the payment for other related services, whether specified or not. The list of bundled services is based on Centers for Medicare and Medicaid Services' (CMS') National Physician Relative Value File
	The codes included in the bundled services policy are from the CMS National Physician Fee Schedule list and are updated as CMS makes updates on a quarterly bases. Services with RVUs are routinely denied or bundled into other payable services unless they are billed alone and the provider has not billed any services within 12 months for the same member
	A digital rectal exam is considered a bundled service and, therefore, is not eligible for separate payment
Cardiology	Cardiac blood pool imaging is included in myocardial perfusion studies
	PTCA is included in the services for the transcatheter placement of intracoronary stent
	Abdominal autography performed at the time of a cardiac catheterization or percutaneous cardiac interventional procedure is included in the primary procedure
	The insertion of the cardioverter-defibrillator and/or electrodes includes an electronic analysis of the device

	Catheterization of the vena cava is included in the surgical interruption of the vena cava
	The insertion of a pacemaker or cardioverter-defibrillator includes the electronic analysis and reprogramming of the device
	Nuclear imaging of the heart can only be performed in an office or hospital setting
	E&M services are included in pacemaker analysis unless a significant, separately identifiable service is performed
	Pulmonary perfusion imaging is included with myocardial perfusion studies when both are performed at the same time
	When a patient is on continuous monitoring in the hospital, emergency room, or any monitored unit, the interpretation of telemetric rhythm strips is considered to be part of the E&M services
	A non-invasive physiologic study is included in an E&M service unless a significant, separately identifiable service is performed
	Electrocardiogram (EKG) interpretations are considered part of the medical decision-making component of an E&M services performed in any setting and should not be reported separately. Electrocardiogram interpretations are allowed in addition to an E&M service performed in a hospital setting or emergency room setting. Should multiple providers render EKG interpretations, only one reimbursement is provided, to the provider who submits the first claim. The reading must be substantially separate and independent of the usual E&M services. Documentation of a written/dictated report must be available upon request for audit purposes, and medical necessity for EKG testing must be met
Chiropractic Services	Chiropractic manipulation is considered for reimbursement once per day, per patient
CMS Coverage	Pre-administration services for intravenous immunoglobulin (IVIG) infusion must be reported with the IVIG itself
	Medical nutrition therapy is included in the monthly dialysis services
	Codes for measurement for reporting purposes (status M codes for CMS) are not reimbursed
	Active wound care service(s) require the appropriate therapy service modifier, when the service is performed by a therapist
	Transportation of portable X-ray equipment and personnel must be reported with an appropriate radiological procedure
	Presbyopia-correcting intraocular lens inserted in lieu of the conventional IOL is not eligible for reimbursement
CMS National Coverage Determination (NCD) Policy	Services and supplies must be reported with an appropriate diagnosis code
	Services and supplies are considered for reimbursement when reported at an appropriate frequency
	Cellular therapy is not covered
	Services reported with modifiers are considered for reimbursement when reported with appropriate modifiers

	Intragastric hypothermia using gastric freezing is not covered
	Laetrile, amygdalin and vitamin B-17 are not covered
	Magnetic resonance spectroscopy is not covered
	Prolotherapy is not covered
	The code that accurately describes the service performed should be reported
	Services, supplies and medications must be reported with an appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying service and no contractions, reported for appropriate indications and reported with appropriate places of service
	Services and supplies considered for reimbursement when reported with an appropriate place of service
Co-Surgeon	Co-surgeon services should not be billed for procedures where the concept of co-surgeon does not apply
Dental Rule	Dental anesthesia services (D codes) are included in intraoral anesthesia services (00170)
Dermatology	PUVA is only allowed for the following diagnoses: chronic kidney disease, unspecified pruritic disorders, psoriasis, arthropathy, dyshidrosis, malignant mast cell tumors, mycosis fungoides, Seazry disease, pityriasis rosea, other alopecia, acne, or vitiligo
	Debridement, paring, biopsy, shaving, and destruction of benign or premalignant lesions is included in Moh's surgery
Devices and Supplies	Certain imaging agents are applicable to only specific diagnostic or therapeutic imaging services. When imaging agents are billed alone or with imaging services that are not consistent with their use, the imaging agents are denied
Diagnosis – Gender	Certain procedure and diagnosis, by definition or nature of the procedure, are limited to the treatment of one gender
Drugs	Certain medication codes have been assigned a maximum number of units that may be billed based on pharmacology guidelines
	Epogen/Procrit must be reported with an appropriate diagnosis code
Duplicate	Claims that have already been paid should not be resubmitted
	Lab services are only reimbursed to one provider. When both a physician and a laboratory bill for the same lab service, only one provider is reimbursed
Evaluation and Management (E&M) Services	E&M services are included in chemotherapy administration unless they are separate services
	A new patient office visit should only be billed when the patient has not had any previous services in the last 3 years by that provider, including other providers in the same group with the same specialty
	One E&M service is considered for reimbursement per day per provider
	If an inpatient consult is performed within 7 days of another inpatient consult, then the second consult should be billed as an inpatient follow-up consult

	An inpatient admission is allowed once every 7 days unless there is a discharge service between the two admissions
	Initial observation care codes should not be billed on consecutive days
	Unusual travel, physician direction of EMS, ECG monitoring, and ambulatory blood pressure monitoring are included in critical care transport services
	Providers may only bill one E&M service on the same day. Taking care of a problem or abnormality is considered part of the global service when a preventive medicine service is performed unless the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, in which case the latter service should be billed with modifier 25
	Emergency room visits are included in critical care visits
	The following services are included in critical care services during interfacility transport for pediatric patients (99289-99290): routine venous access, blood collection, arterial puncture, naso- or oro-gastric tube placement, chest X-ray interpretation, temporary transcutaneous pacing, ventilation assist and management, CPAP or CNP, pulse oximetry, and analysis of computer data
	In-hospital or out-of-hospital mandated on-call services are included in other services performed
	Instructing a patient on the proper use of medication or devices is included in E&M services
	Services provided at the request of the patient in a location other than the physician's office are included in the office E&M services
	After-hours services are only payable at the same time as office E&M services
	Office visits are included in smoking and tobacco-use cessation counseling unless they are separately identifiable services
	The initial preventative physical examination (IPPE) and the electrocardiogram performed as a part of the IPPE examination should only be reported once per lifetime
	Care plan oversight services are included in monthly ESRD
	Services, supplies and medications must be reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying service and no contradictions, reported for appropriate indications and reported with appropriate places of service
	Observation care services are considered for reimbursement when reported with the appropriate initial observation or discharge codes
Frequent Policy	Services, supplies and medications must be reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying service and no contradictions, reported for appropriate indications and reported with appropriate places of service

Gastroenterology	Colorectal cancer screening done by colonoscopy is included in non-screening colonoscopies
	A portion of the work associated with a gastric analysis procedure is included in an upper GI endoscopy. Report the gastric analysis procedure with modifier –52
General Surgery	Repair of an umbilical hernia is included in the repair of an incisional or ventral hernia
	Partial mastectomy codes should be billed with an appropriate cancer diagnosis
Global Obstetrical Package	Only one delivery code is allowed every 240 days. This excludes multiple gestation delivery and related assistant surgeon(s) for these procedures when done on the same day
	E&M services and procedures performed within the six-week postpartum period are included in the payment for the delivery code
Global Surgery	The Global Surgery package includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. The global surgery package applies only to surgical procedures that have post-operative global periods of 0, 10 and 90 days. The global surgery concept applies only to primary surgeons and co-surgeons. The global surgery package includes preoperative and same day E&M visits after the decision is made to operate and all post-operative E&M visits and procedures for 10-day and 90-day global surgeries related to the primary procedure
	Intravenous access and infusion/injection procedures for anesthesia, intra-operative care, and post-operative pain management are included in the global surgical package
Hand Surgery	A ganglion excision or an excision of a tendon sheath of the wrist is included in a carpal tunnel neuroplasty
Health Plan Policy Rules	Office services provided on an emergency basis are not payable at the same time as a preventive office visit
	Supplies and materials billed by providers are only covered for the office place of service
	The CMS physician voluntary reporting program codes G8006-G8186 and G9050-G9130 are for informational and reporting purposes only. They are considered to be included in other services provided to the member
	Supplies and materials billed by providers are only covered for the office place of service. However, syringes, needles, alcohol, betadine, surgical trays, and miscellaneous surgical supplies are not separately payable to providers in the office place of service when billed with laboratory or pathology services
	Services, supplies and medications are considered for reimbursement when reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying services, and no contraindications
	HCPCS codes S0000-S9999 are not payable except as recognized by Health Net Medi-Cal
Home Health/Home Infusion	Add-on codes must be reported with the corresponding primary code on the same date of service

ICD-9 Guidelines	An encounter for chemotherapy or immunotherapy should not be the sole diagnosis for chemotherapy. The underlying disorder should also be listed
	Manifestation diagnoses should be reported with another diagnosis code indicating the underlying disease
	Services must be reported with an appropriate diagnosis code
Incident To Services	Incident To services are those services furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury to the physician's patient. Incident To services, as defined by CMS, should only be billed in the physician's office
Laboratory	Laboratory panel codes should be billed when the components of the panel are performed. Both the lab panel code and the component codes should not be billed
	Laboratory panels are not eligible for reimbursement when submitted with reduced service or discontinued service modifiers
Laboratory & Pathology	Laboratory and pathology services are included in hospital E&M services
Maximum Units	All procedure codes are assigned a maximum number of units that may be billed on a single date of service. Health Net has assigned maximum units based on one or more of the following criteria: CMS' maximum units per day list, the procedure code definition or nomenclature, the anatomical site, clinical guidelines, or determinations made by expert specialty panels
Modifier Policy	Only valid modifiers are considered for reimbursement
Multiple Procedure Reduction	When more than one procedure is billed for the same date of service, the procedure with the highest RVUs is reimbursed at 100% of the allowed amount. Subsequent procedures are reimbursed at 50% of the allowed amount based on principles of multiple procedure reduction
National Correct Coding Initiative (CCI) Policy Manual	Established patient E&M services are included in cardiac stress tests, transthoracic echocardiography, and myocardial perfusion imaging unless a significant, separately identifiable service was performed
	The introduction of an intravenous needle or catheter is included in a venipuncture
	CCI edits applied to CPT codes are applied to analogous HCPCS codes (or their HCPCS code counterparts)
	Claims are subject to policies that appear in the narrative sections of CMS' CCI policy manual
Nephrology	Epoetin Alpha is covered for the following diagnoses: anemia in end-stage renal disease, hypertensive heart and/or renal disease, or chronic renal failure
Neurology	No more than four sensory nerve conduction studies should be required for the diagnosis of carpal tunnel syndrome

	Electromyogram (EMG) and nerve conduction studies are considered diagnostic services and should not be reported with therapy modifiers such as GN, GP, and GO
	Somatosensory evoked potential studies are considered for reimbursement when reported with an appropriate diagnosis code
	Services, supplies and medications are considered for reimbursement when reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying services, and no contraindications
	Digital analysis of electroencephalogram (EEG) is considered from reimbursement when reported with an appropriate EEG service
Obstetrics and Gynecology	Saline infusion hysterography includes pelvic echography
	Insertion of cervical dilator is included in the global obstetrical package
	For multiple gestation vaginal deliveries (including vaginal deliveries after previous cesarean section), the global care code that includes antepartum, postpartum and delivery care should only be used once. The codes for delivery alone should be used to indicate the birth of the additional gestation(s)
	The global delivery code for babies delivered by cesarean section is considered to include one or more babies. The additional work to deliver more than one baby via cesarean section is considered to be part of that global service
	Services, supplies and medications are considered for reimbursement when reported with appropriate diagnosis codes, patient age, frequency, number of units, related or qualifying services, and no contraindications
	Ultrasounds for multiple gestations should be billed with multiple gestational diagnoses
Once per lifetime services	Services performed once in a lifetime are considered for reimbursement once per member
Ophthalmology	When a patient is over 8-years-old, the sensorimotor exam with multiple measurements of ocular deviation with interpretation and report is considered to be included in the E&M services both general and ophthalmologic
	Radial keratotomy and keratomileusis are only covered for anomalous corneal size/shape or keratoconus
	Photodynamic therapy requires performance of fluorescein angiography
Orthopedic	The following procedures are considered to be an integral part of primary orthopedic or neurosurgical procedures: intravenous fluid administration; explorations of applicable cavity; isolation, retraction and protection of anatomical structures; nerve stimulation; fluoroscopy; cultures; wound closure; scar revision; and cast applications

	Open treatment of a knee dislocation with primary ligamentous repair is included in arthroscopically aided anterior or posterior cruciate ligament repair/augmentation or reconstruction
	The deep excision of a bone cyst or benign tumor includes the partial or superficial excision of a bone cyst or benign tumor
	An injection of a major joint billed with Hylan G-F 20 or sodium hyaluronate is only allowed with the following diagnoses: osteoarthritis or osteoarthrosis of the knee and lower leg
	Removal of a knee prosthesis includes a synovectomy, removal of a foreign body, a capsulotomy, knee ligament reconstruction, partial excision of the bone, a chondroplasty, and an arthrotomy with biopsy
	A knee immobilizer is included in a double-upright knee orthosis
	An arthroscopy with an abrasion arthroplasty is included in an arthroscopy with menisectomy if they are in the same compartment
	Exploration of spinal fusion is included in more comprehensive spine procedures
	Diagnostic shoulder arthroscopy is included in more comprehensive shoulder procedures
Otolaryngology	Tympanostomy for patients older than age 13 should be performed in an office setting
Physical Medicine	Vasopneumatic compression therapy is considered for reimbursement when used for treatment of lymphedema
	Therapeutic procedures or therapeutic activities, in any combination, are only allowed up to four units per date of service
	For physical therapists, E&M services are included in physical therapy modalities and therapeutic procedures
	Physical therapists should use physical therapy evaluation codes, not E&M codes
	Neurostimulator application or physical/occupational therapy re-evaluation is included in unattended electrical stimulation
	Application of unattended electrical stimulation is included in application of manual electrical stimulation
	Unattended electrical stimulation (97014) cannot be billed with other electrical stimulation procedures (G0281 or G0329) because they are mutually exclusive procedures
	Chiropractic manipulative treatment services require specific skills and are therefore limited to providers trained in Chiropractic medicine
	Therapy and athletic training evaluations are considered for reimbursement once a month
Place of Service	Medical supplies, surgical supplies and durable medical equipment may only be billed by the physician in an office setting. In the outpatient or inpatient settings the facility is responsible for the supplies and billing

	E&M codes need to be billed for a place of service consistent with the code definition
	Certain procedures are only appropriate for the inpatient setting
	Emergency department visits are only allowed for place of service 23
	Home care visits are only allowed for place of service 12
	Casts and strappings provided by physical or occupational therapists in a skilled nursing facility are included in the payment to the facility
	In an office setting, a presbyopia-correcting intraocular lens must be reported with an appropriate cataract removal surgical service
	CMS has identified procedures that are rarely or never performed in a non-facility setting. Health Net denies these procedures if they are billed in the office
	Monthly home dialysis services are eligible for reimbursement when performed in the appropriate place of service
Podiatry	Trimming and debridement of nails and benign hyperkeratotic lesions are allowed if they are accompanied by a diagnosis for a fungal infection of the nail or other diagnoses that put the patient at some risk for a complication, such as diabetes or peripheral vascular disease
	Use of codes for examination of the feet for diabetic members with peripheral neuropathy and loss of protective sensation (G0245-G0247) is reserved only for diabetic members with neurological manifestations
	Within the podiatry specialty, there is a set of services that may be rendered by that specialty under the state's licensure. Other services are considered to be outside of the scope of services for that specialty
Procedure Code Definition	When a procedure is described by both a CPT and a HCPCS code, only one of these codes should be billed
	The newborn metabolic screening panel includes galactose, hemoglobin electrophoresis, hydroxprogesterone 17-d, phenylalanine, and total thyroxine
	The services for orthotic management and training are included in the fitting or dispensing of the orthotic
	The EKG as a component of the initial preventive physical examination consists of the tracing and the interpretation. When tracing and interpretation are reported separately, they are combined into the overall EKG for reimbursement
Procedure – Age	Removal of sutures under anesthesia is limited to members under age 7
	Certain procedure codes by definition are limited to specific ages
Procedure – Gender	Certain procedure codes, by definition or nature of the procedure, are limited to the treatment of one gender
Professional, Technical and Global Services	Interpretation of most radiologic procedures done in an inpatient or emergency room setting are payable only to radiologists

	Only the professional component is covered when a diagnostic test or radiologic service is performed in an inpatient or outpatient place of service
	Payment for a global ECG is only covered in the physician's office
	Low osmolar contrast media is only covered for patients of extreme age or when there is a contraindication to the use of ionic contrast
	Procedures that are professional component only in nature should not be billed with modifier 26 or TC (technical component)
	Procedures that are technical component only in nature should not be billed with modifier TC or 26
	Providers are not reimbursed for technical only component services provided in the inpatient or outpatient hospital locations
	Physicians are only reimbursed for the professional component of exercise testing when done in an inpatient or outpatient facility
	Physicians are only reimbursed for the report and interpretation portion of a 24-hour ECG when done in an inpatient or outpatient facility
	Physicians are only reimbursed for the report and interpretation portion of a 30-day patient demand event recording when done in an inpatient or outpatient facility
	The professional component of certain radiologic procedures performed in the outpatient facility are only covered when performed by the radiologist
	Only one provider should bill for the professional component of a given procedure
	Only laboratory services that have a professional component may be reported with a modifier 26
	Only services that have a professional and technical component may be billed with modifiers 26 and TC respectively
	Procedures that are professional only should not be billed with a modifier TC
	Professional and technical component modifiers require the use of a code that is appropriate for the modifier
	The Professional component of certain radiologic procedures is eligible for reimbursement one time by radiologists or other appropriate specialists
Radiation Oncology	Continuing medical physics consultation should only be billed weekly
	An E&M service is included in radiation oncology services unless it is a separately identifiable service
	Radiation treatment management represents 5 treatments
	Therapeutic port films are only allowed once every 7 days
Radiology	Indications for performing a bone density measurement study include but are not limited to osteopenia, osteoporosis, ovarian failure, and fractures

	Provision of diagnostic radiopharmaceutical substances is included in the supply of the radiopharmaceutical diagnostic agents
	Radiopharmaceuticals and imaging agents need to be billed with appropriate imaging procedures
	Interpretation of X-rays is included in hospital E&M services
	Radiologic exam of the hand includes the X-ray exam of the wrist
	Complete radiologic exam of the pelvis includes the X-ray exam of the hip
	Digital subtraction angiography needs to be done in conjunction with a related imaging procedure
	A single spot film of the spine is considered to be included in a more comprehensive specific, spinal X-ray procedure
	MRI and CT scans of the same anatomic region are considered to be mutually exclusive procedures performed on the same day
	A CT angiogram and magnetic resonance angiogram of the same anatomic region are considered to be mutually exclusive procedures performed on the same day
	MRI and arthrography of the temporomandibular joint are considered to be mutually exclusive procedures performed on the same day
	Thyroid imaging without vascular flow and thyroid imaging with vascular flow are considered to be mutually exclusive procedures when performed on the same day
	A complete ultrasound of the abdomen includes an examination of the retro-peritoneum
	A CT or DEXA study of the axial skeleton is included in the DEXA study of the appendicular skeleton
	A magnetic resonance angiogram of the pelvis and abdomen are mutually exclusive when performed on the same day
	Plain X-rays of specific regions are included in bone age and bone length studies and in osseous surveys
	Myocardial infarct scanning is mutually exclusive of cardiac blood pool imaging performed on the same day
Separate Procedures	Fluoroscopy is only a separate procedure when it is not performed as an integral part of another service
	Procedures that are defined as separate procedures should not be billed when they are performed as part of another major service
	A service designated as a separate procedure is considered an integral component of the total service
Split Surgical Care	Care split between providers should be reported appropriately to define preoperative care only (modifier 56), surgical care only (modifier 54), and post-operative care only (modifier 55)
	Emergency physicians who perform a surgical procedure with any global period in the emergency department should report the procedure as surgical care only (modifier 54) unless they also provide the post-operative care

Surgery	Venipuncture and exchange transfusion procedures are included in laboratory tests
	Removal of mammary implant material is included in the periprosthetic capsulectomy
	IV infusion during an observation stay is included in any surgical procedure
	Introduction of a needle or catheter in a vein and blood collection services are not covered for providers in the inpatient and outpatient hospital settings
Urology	Injection procedure for pyelography is included in the change of a pyelostomy or nephrostomy tube
	When a post-void residual volume is measured in the bladder after urodynamic testing, the ultrasound performed to obtain this value is limited. The complete pelvic ultrasound should not be used for this measurement
	Ureteral stenting is considered to be part of endoscopic procedures involving the ureter with tumor resection
	Bladder irrigation is included as part of other endoscopic or open procedures of the bladder
	When an initial approach to a procedure is unsuccessful, and an alternative approach is undertaken, the successful approach is considered for reimbursement
	Prostate cancer screening is eligible for reimbursement once annually
Vaccines	Zoster vaccination is limited to members ages 60 and older. For a complete description of the medical policy, select Medical Policies located under Policies and Procedures on the Health Net provider Web site at www.healthnet.com/provider