CPT Code Information for Quantitative, Transcutaneous: Total Hemoglobin, Carboxyhemoglobin, and Methemoglobin

The following information describes terminology and codes when billing for transcutaneous total hemoglobin, carboxyhemoglobin or methemoglobin and is provided for convenience only. It is not a substitute for a comprehensive review of coding, coverage, and payment policies. Please consult your local payer regarding specific reimbursement guidance and billing criteria.

**CPT Code**

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>CPT Code</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin (Hgb), quantitative, transcutaneous</td>
<td>88738</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin</td>
<td>88740</td>
<td>January 1, 2009</td>
</tr>
<tr>
<td>Methemoglobin</td>
<td>88741</td>
<td>January 1, 2009</td>
</tr>
</tbody>
</table>

**Medicare National Limitation Amount (NLA)**

Effective January 1, 2016: The Medicare NLA for CPT Codes 88738, 88740 and 88741 is $6.83 per measurement. Other payers may reimburse at a different rate.

**Excluded from CLIA Certification**

CPT codes 88738, 88740 and 88741 are excluded from CLIA edits. No CLIA certificate or certificate of waiver is required to perform and bill for these CPT codes.

**ICD-9 and ICD-10 Diagnosis Codes**

Providers are required to include diagnosis codes with each claim to describe the patient’s condition and why the service or procedure is reasonable and necessary. ICD-9 codes and, beginning October 1, 2015, ICD-10 codes are to be used.

**Definitions**

NCCI Code Edits: The Medicare National Correct Coding Initiative (NCCI) edits were established to promote national correct coding methodologies for Part B claims. The NCCI Policy Manual addresses, among other things, code pairs that should not be performed at the same encounter and medically unlikely numbers or quantities of the same service on a single day. In some clinical circumstances, NCCI-associated modifiers may be permitted. Supporting documentation must be in the beneficiary’s medical record.

**PLEASE NOTE**

The information in this guide should not be considered to be either legal or reimbursement advice. Masimo makes no statement, promise or guarantee that the codes or other information in this guide is comprehensive, will remain timely, will be appropriate for the services provided, or will result in reimbursement. It is the provider’s responsibility to determine and submit appropriate codes, charges and modifiers for services that are rendered, in consultation with Medicare or other third-party payers, as applicable. Payers may have their own coverage, coding and billing requirements and providers should verify current requirements and policies before filing any claims.

**Questions**

For more information go to www.codemap.com/masimo.