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[1]

Descriptor[2]	Hemoglobin (Hgb), quantitative, transcutaneous	Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin	Hemoglobin, quantitative, transcutaneous, per day; methemoglobin
CPT Code[2]	88738	88740	88741
Effective Date[2]	January 1, 2010	January 1, 2009	January 1, 2009
NCCI Code Edits[3,4]	NCCI edits address claims for 88738 when submitted on the same date of service by the same provider with the following CPT codes: 85013, 85014, 85018, 85025, 85027, 88740 or 88741.	NCCI edits address claims for 88740 when submitted on the same date of service by the same provider with the following CPT codes: 82375, 82376 or 88738.	NCCI edits address claims for 88741 when submitted on the same date of service by the same provider with the following CPT codes: 83045, 83050 or 88738.
	The Medically Unlikely Edit (MUE) claim line limit for 88738 is 1 unit of service for practitioners, ASCs and 2 units for hospital outpatient departments.	The MUE frequency edit for 88740 and 88741 is 1 unit of service per provider per date of service for practitioners, ambulatory surgical centers (ASCs) and hospital outpatient departments.	

MEDICARE NATIONAL LIMITATION AMOUNT (NLA)[2]

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[5]

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[6]

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.[2] 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.

Transcutaneous: passing, entering, or made by penetration through the skin[7]

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.

Transcutaneous measurements of hemoglobin, carboxyhemoglobin, and methemoglobin are not intended to replace laboratory blood testing. Blood samples should be analyzed by laboratory instruments prior to clinical decision-making. ***See Instructions for use for prescribing information, including indications, contraindications, warnings and precautions.***

QUESTIONS

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

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[1] CPT copyright 2015 American Medical Association. CPT is a registered trademark of the American Medical Association. [2] 2016 CMS Clinical Laboratory Fee Schedule. Available at https://www.cms.gov/ClinicalLabFeeSched/02_ClinLab.asp Medicare fee schedule amounts in the following states differ from the NLA: LA = $4.73; WA = $6.28; OH & WV; $5.50; and WY = $6.45. Medicare payments for tests performed in certain locations, such as the hospital setting, may be packaged into the payment for other services. [3] National Coding Correct Initiative Policy Manual for CMS Services. [4] CMS NCCI Edits – Physician and Hospital Outpatient PPS, version 22.0 effective date January 1, 2016. [5] CPT-4 Codes Excluded from CLIA Edits (Within 8000 Series); https://www.cms.gov/CLIA/downloads/CpT4exc.pdf [6] International Classification of Diseases, 9th Revision.
[7] "Transcutaneous". Merriam-Webster® Medical Dictionary.Merriam-webster.com. Web.2 Apr 2015.

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