HCPCS Code A4266 Details

Code Symbols

♀ : Female

I : Not payable by Medicare

Code Descriptor

Diaphragm for contraceptive use

Fee Schedule

Medicare Physician Fee Schedules (MPFS)	
Sources:	2019 National Physician Fee Schedule Relative Value File, GPCI19, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2019, MCR-MUE-PractitionerServices
Publisher:	CMS
Effective:	July 01, 2019
Medicare Carrier/Locality:	ALASKA** 01-02102
Conversion Factor:	36.0391

Note: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

Code Status I
I = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)

Medicare Fees					
	National	**Adjusted**	**26**	**TC**	**53**
Facility	$0.00	$0.00	$0.00	$0.00	$0.00
Non Facility	$0.00	$0.00	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.00	0.00			0.00
PE RVU:	0.00	0.00			0.00
Malpractice RVU:	0.00	0.00			0.00

Total RVU:	0.00	0.00	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.00	0.00			0.00
PE RVU:	0.00	0.00			0.00
Malpractice RVU:	0.00	0.00			0.00
Total RVU:	0.00	0.00	0.00	0.00	0.00

Global & Other Info	
	Global Split
Preoperative %:	0
Intraoperative %:	0
Postoperative %:	0
Total RVU:	0
Global Period (days):	XXX
XXX = The global concept does not apply to the code.	
Radiology Diagnostic Tests :	99
99 = Concept does not apply	
PC/TC Indicator :	9
9 = Not Applicable--Concept of a professional/technical component does not apply	
Endoscopic Base Code :	None

Modifier Guidelines		
	Modifier	**Rules(Click on rules for Details)**
MULT PROC	51	Concept does not apply
51 = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes		
9 = Concept does not apply		
BILAT SURG	50	Concept does not apply
50 = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.		

9 = Concept does not apply		
ASST SURG	80	Concept does not apply
80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).		
9 = Concept does not apply		
CO-SURG	62	Concept does not apply
62 = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.		
9 = Concept does not apply		
TEAM SURG	66	Concept does not apply
66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.		
9 = Concept does not apply		
MINIMUM ASST SURG	81	Concept does not apply.
81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
9 = Concept does not apply.		
ASST SURG (QUALIFIED RESI. NA)	82	Concept does not apply
82 = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)		
9 = Concept does not apply.		
PHYSICIAN SUPERVISION	*PS	Concept does not apply.
PS = This field is for use in post payment review.		
9 = Concept does not apply		

Medically Unlikely Edits

Source: 2019 Medically Unlikely Edits (MUE)

Publisher: CMS

Date: July 01, 2019

Services	MUE	MAI	MUE Rationale
Practitioner Services	0	3	CMS Policy
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	0	3	CMS Policy

MAI 1: Line Edit
MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy
MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

LCD Details

LCD Details for A4266

The chosen state has no LCD for this code/title. Please search All States to see if another state has an LCD for this code/title.

Article Details for A4266

The chosen state has no Article for this code/title. Please search All States to see if another state has an Article for this code/title.

MEDICARE CCI

0 - Can NOT be billed under any circumstances
1 - A CCI-associated modifier on the Col. 2 code will override the edit.

Col B Code	Reason Edit	Modifier Indicator
No data avaliable.		

Medicaid CCI Edits Alert

0 - Can NOT be billed under any circumstances
1 - A CCI-associated modifier on the Col. 2 code will override the edit.

Col B Code	Reason Edit	Modifier Indicator
No data avaliable.		

ICD-10 Crossref

Z30.02 Counseling and instruction in natural family planning to avoid pregnancy
Z30.09 Encounter for other general counseling and advice on contraception
Z30.49 Encounter for surveillance of other contraceptives
Z30.8 Encounter for other contraceptive management
Z30.9 Encounter for contraceptive management, unspecified
Z92.0 Personal history of contraception

CPT Crossref

No data available.

Modifier Crossref

99
Multiple Modifiers

CR
Catastrophe/disaster related

FB
Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)

FP
Service provided as part of family planning program

GK
Reasonable and necessary item/service associated with a ga or gz modifier

GY
Item or service statutorily excluded, does not meet the definition of any medicare benefit or, for non-medicare insurers, is not a contract benefit

GZ
Item or service expected to be denied as not reasonable and necessary

KX
Requirements specified in the medical policy have been met

QJ
Services/items provided to a prisoner or patient in state or local custody, however the state or local government, as applicable, meets the requirements in 42 cfr 411.4 (b)

HCPCS Lay Terms

Providers use this code to report a diaphragm, or a domed device that fits over the cervix and is a method of contraception in women.

Clinical Responsibility

This code illustrates a diaphragm, which is a cap or cup made up of plastic or rubber that serves as a method of protection or contraception in women. The diaphragm fits inside the vagina over the woman's cervix. The cervix is a narrow bottom portion of the uterus that connects the uterus with the vagina. This acts as a method of contraception where the covering over the cervix prevents the sperm from meeting an egg and thus prevents pregnancy. Females commonly use this type of cervical cap with a spermicide jelly or cream that makes the sperm nonmotile.

Terminology

Cervical cap: A soft rubber cap with a rim that fits around the cervix.

Dialysis: The process of purification of blood by using a dialysis machine as a substitute for the normal function of the kidneys.

Ostomy: A surgical procedure to divert urine or feces in which a provider creates a small opening, called a stoma, from the urinary bladder, stomach, or intestines to the body surface; types of ostomies include cystostomy, gastrostomy, ileostomy, enterostomy, and colostomy.

Urinary incontinence: The inability to hold urine; often caused by weakness of the sphincter muscles, which often occurs after surgery such as for prostate cancer.

Uterus: A pear shaped organ in females, located in the lower abdomen; also known as the womb.

Vagina: The muscular canal extending from the uterus, or womb, to the external genital opening, or introitus; also known as the birth canal.

Tips

Healthcare Common Procedure Coding System, or HCPCS, codes that begin with an A, represent medical and surgical

supplies, including supplies to help treat patients with urinary incontinence, ostomies, respiratory problems, and patients receiving dialysis.

Medicare does not cover this code. Third party payers may or may not cover this code. Check with the payer for their individual coverage and reporting guidelines.