

## Q2 HCPCS Level I and II Update (April 1, 2022)

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Note: Please note that the general code descriptions included are provided to assist with interpreting and navigating the content; providers are responsible for referencing the appropriate codebooks for up-to-date full descriptions when considering which code is appropriate to bill for the services rendered.

### Annual Code Additions

#### **Blood**

The following plasma codes have special billing policies

C9090, C9507

#### **C9090**

Ryplazim® (plasminogen, human-tvmh) is plasma-derived human plasminogen indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia).

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Patient must be 11 months of age or older
- Must be prescribed by or in consultation with a geneticist, hematologist, or specialist with experience in treating hypoplasminogenemia
- Patient has a diagnosis of plasminogen deficiency type 1 shown by at least 2 of the following:
  - Biallelic mutations in the plasminogen (PLG) gene confirmed by genetic testing
  - A baseline plasminogen activity level less than 45 percent of normal
  - A documented history of typical lesions and symptoms (for example, liginous conjunctivitis, liginous gingivitis and tonsillar lesions, liginous airway disease, liginous lesions of the hands and feet, impaired wound healing, etc.)
- For patients with respiratory tract involvement, spirometry measurements (forced expiratory volume in 1 second (FEV1), forced vital capacity (FVC), peak expiratory flow, and FEV1/FVC ratio) at baseline and every four weeks

Initial authorization is for 12 months

#### Continued therapy

- Patient continues to meet initial approval criteria
- Patient has shown clinical benefit as evidenced by at least one of the following:
  - Improvement in lesion number or size from baseline.
  - Absence of new lesions compared to baseline.
  - Improvement in wound healing.

- Improvement in spirometry measurements from baseline if respiratory tract involvement.

Reauthorization is for 12 months.

Modifiers SA, UD, U7 and 99 are allowed.

ICD-10 CM diagnosis code E88.02 is required on the claim.

### **C9507**

COVID-19 convalescent plasma is human plasma collected by the U.S. Food and Drug Administration (FDA) registered or licensed blood establishments from individuals whose plasma contains high titers of anti-SARS-CoV-2 antibodies, and who meet all donor eligibility requirements (21 CFR 630.10 and 21 CFR 630.15) and qualifications.

Convalescent plasma is qualified and labeled as having high titer anti-SARSCoV-2 antibodies based on testing accepted by FDA under an EUA. Qualification of COVID-19 convalescent plasma as high titer is based on serologic correlates of neutralizing activity, i.e., the ability of the donor antibodies to block infection by reference strains of the SARS-CoV-2 virus in laboratory tests.

#### Authorized Use

FDA has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product, COVID-19 convalescent plasma with high titers of anti-SARS-CoV-2 antibodies, for the treatment of COVID-19 in patients with immunosuppressive disease or receiving immunosuppressive treatment, in either the outpatient or inpatient setting.

Available data suggests that use of COVID-19 convalescent plasma with high titers of anti-SARS-CoV-2 antibodies may be effective in treating COVID-19 in patients with immunosuppressive disease or receiving immunosuppressive treatment. For the purposes of this EUA, immunosuppressive treatment does not include immunosuppressive treatment administered specifically for the purpose of treating COVID-19 (for example: systemic corticosteroids, interleukin-6 inhibitors).

#### Limitations of Authorized Use

COVID-19 convalescent plasma is not authorized to treat immunocompetent patients with COVID-19. Results from randomized controlled trials in hospitalized patients indicate that these patients are unlikely to benefit from COVID-19 convalescent plasma. In addition, alternative therapies in immunocompetent patients prior to hospitalization are authorized for emergency use and have more consistently demonstrated clinical benefit.

#### Dosage

- Health care providers will administer COVID-19 convalescent plasma according to standard hospital procedures and institutional medical and nursing practices.
- Clinical dosing may first consider starting with one unit of COVID-19 convalescent plasma (about 200 ml), with administration of additional convalescent plasma units based on the prescribing physician's medical judgment and the patient's clinical response.
- Patients with impaired cardiac function and heart failure may require a smaller volume or more prolonged transfusion times.

Modifiers SA, UD, U7 and 99 are allowed.

Effective for dates of service on or after December 28, 2021.

## **Chemotherapy**

The following plasma codes have special billing policies

C9091, J9071, J9273, J9359

### **C9091**

Fyarro™ (sirolimus protein-bound) is an inhibitor of mechanistic target of rapamycin kinase (mTOR) indicated for the treatment of adult patients with locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa).

An approved *Treatment Authorization Request (TAR)* is required for reimbursement.

Fyarro is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an oncologist
- Patient must have a histologically confirmed diagnosis of malignant perivascular epithelioid cell tumor (PEComa) that is either metastatic or locally advanced and for which surgery is not a recommended option
- Patient must have one or more measurable target lesions by CT scan or MRI.
- Patient must not have been previously treated with an mTOR inhibitor (for example, sirolimus, everolimus, temsirolimus, etc.)
- Patient has an Eastern Cooperative Oncology Group (ECOG) performance status 0 or 1
- Patient must have adequate hematological, cardiac, hepatic and kidney functions
- Patient is a male or a non-pregnant and non-breast feeding female
- Patient does not have uncontrolled diabetes defined as HbA1c greater than 8 percent despite adequate therapy
- Patient does not have lymphangioleiomyomatosis (LAM)

Initial approval is for six months.

Continued therapy

- Patient has shown clinical benefit as evidenced by lack of disease progression or reduction in tumor size or spread
- Patient does not have unacceptable toxicity such as severe myelosuppression, severe infection, severe hypokalemia, ILD/non-Infectious pneumonitis, severe hemorrhage, hypersensitivity reactions, etc.

Reauthorization is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

Frequency of billing equals 100 mg/m<sup>2</sup> administered on days 1 and 8 of each 21-day cycle.

### **J9071**

Cyclophosphamide injection is an alkylating drug indicated for treatment of malignant diseases, malignant lymphomas, Hodgkin's disease, lymphocytic lymphoma, mixed-cell type lymphoma, histiocytic lymphoma, Burkitt's lymphoma; multiple myeloma, leukemias, mycosis fungoides, neuroblastoma, adenocarcinoma of ovary, retinoblastoma, breast carcinoma.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Cyclophosphamide is considered medically necessary when all of the following criteria are met:

- Must be used for FDA-approved indications and dosing regimens
- Patient has a diagnosis of one of the following malignant diseases:
  - Malignant lymphomas (Stages III and IV of the Ann Arbor staging system), Hodgkin's disease, lymphocytic lymphoma (nodular or diffuse), mixed-cell type lymphoma, histiocytic lymphoma, Burkitt's lymphoma
  - Multiple myeloma
  - Leukemias: chronic lymphocytic leukemia, chronic granulocytic leukemia (it is usually ineffective in acute blastic crisis), acute myelogenous and monocytic leukemia, acute lymphoblastic (stem-cell) leukemia (cyclophosphamide given during remission is effective in prolonging its duration)
  - Mycosis fungoides (advanced disease)
  - Neuroblastoma (disseminated disease)
  - Adenocarcinoma of the ovary
  - Retinoblastoma
  - Carcinoma of the breast
- Patient does not have hypersensitivity to cyclophosphamide
- Patient does not have urinary outflow obstruction

Approval is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

### **J9273**

Tivdak™ (tisotumab vedotin-tftv) is a tissue factor-directed antibody and microtubule inhibitor conjugate indicated for the treatment of adult patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy.

Modifiers SA, UD, U7 and 99 are allowed.

### **J9359**

Zynlonta® (Loncastuximab Tesirine-lpyl) is a CD19-directed antibody and alkylating agent conjugate indicated for the treatment of adult patients with relapsed or refractory large B-

cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma.

Modifiers SA, UD, U7 and 99 are allowed.

Frequency of billing equals 0.15 mg/kg every three weeks for two cycles, then 0.075 mg/kg every three weeks for subsequent cycles.

## **Durable Medical Equipment (Durable Medical Equipment)**

The following DME have special billing policies.

E2102, K1031, K1032, K1033

### **E2102**

HCPCS code E2102 is a benefit for patients two years of age and older. The code is non-taxable and is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services.

A *Treatment Authorization Request* (TAR) is required for reimbursement.

Modifier NU or RB is required on the claim.

Frequency is limited to once in five years.

### **K1031**

The code is taxable and is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services. The code may not be reimbursed in conjunction with HCPCS code E0651.

A *Treatment Authorization Request* (TAR) is required for reimbursement.

ICD-10 CM diagnosis code I89.0 or Q82.0 is required on the claim.

Modifier NU, RB or RR is required.

Frequency is limited to once in five years.

### **K1032**

The code is taxable and is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services. The code may not be reimbursed in conjunction with HCPCS codes K1033 or E0667.

A *Treatment Authorization Request* (TAR) is required for reimbursement.

ICD-10 CM diagnosis code I89.0 or Q82.0 is required on the claim.

Modifier NU is required.

Frequency is limited to once in five years.

### **K1033**

The code is taxable and is reimbursable for Presumptive Eligibility for Pregnant Women (PE4PW) services. The code may not be reimbursed in conjunction with HCPCS codes K1032 or E0669.

A *Treatment Authorization Request* (TAR) is required for reimbursement.

ICD-10 CM diagnosis code I89.0 or Q82.0 is required on the claim.

Modifier NU is required.

Frequency is limited to once in five years.

## **Proprietary Laboratory Analyses (PLA)**

The following PLA codes have special billing policies

0311U, 0312U, 0314U, 0321U

### **0311U**

This code is reimbursable

Presumptive Eligibility for Pregnant Women (PE4PW) services.

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to one unit per day.

### **0321U**

This code is reimbursable

Presumptive Eligibility for Pregnant Women (PE4PW) services.

Modifiers 33, 90 and 99 are allowed.

Frequency is limited to one unit per day.

## **Injection**

The following injection codes have special billing policies.

J0219, J0491, J0879, Q0221

### **J0219**

Nexviazyme® (avalglucosidase alfa-ngpt) is a hydrolytic lysosomal glycogen-specific enzyme indicated for the treatment of patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).

An approved *Treatment Authorization Request* (TAR) is required for reimbursement. The TAR must include clinical documentation that demonstrates the following:

- Must be used for FDA-approved indications and dosages.
- Patient must be one year of age or older
- Must be prescribed by or in consultation with a neurologist, geneticist or other physician with specialty in treating Pompe disease
- Patient must have a diagnosis of late-onset Pompe disease confirmed by one or both of the following:
  - Llysosomal acid alpha-glucosidase (GAA) enzyme deficiency from any tissue source (for example skin fibroblast or muscle)
  - Genetic testing with two confirmed GAA gene variants
- Patient has documented baseline results of Forced Vital Capacity (FVC) and/or six Minute Walk Test (6MWT)

- Patient is not concurrently taking Alglucosidase Alfa (Lumizyme)

Initial authorization is for twelve months.

#### Continued therapy

- Patient has shown clinical benefit as evidence by at least one of the following:
- Change in FVC (percent predicted) in the upright position from baseline.
- Change in total distance walked in six minutes (six Minute Walk Test, [6MWT]) from baseline.

Reauthorization is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

ICD-10 CM diagnosis code E74.02 is required on the claim.

Frequency of billing:

- Greater than or equal to 30 kg, 20 mg/kg (of actual body weight) every two weeks
- Less than 30 kg, 40 mg/kg (of actual body weight) every two weeks

#### **J0491**

Saphnelo (anifrolumab-fnia) is a type I interferon (IFN) receptor antagonist indicated for the treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE), who are receiving standard therapy.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

The TAR must include clinical documentation that demonstrates all of the following:

- Must be used for FDA-approved indications and dosages
- Patient must be eighteen years of age or older
- Must be prescribed by or in consultation with a rheumatologist, dermatologist, nephrologist, pulmonologist, or other SLE treatment specialist
- Patient has a diagnosis of moderate to severe SLE
- Patient has fulfilled at least 4 of the 11 American College of Rheumatology (ACR) classification criteria for SLE
- Patient was seropositive for antinuclear antibodies, anti-double-stranded DNA (anti-dsDNA) antibodies, or anti-Smith antibodies
- Patient is receiving stable treatment with at least one of the following:
  - Glucocorticoids (for example, Prednisone, Methylprednisone, etc.)
  - An Antimalarial Agent (hydroxychloroquine or chloroquine)
  - Immunosuppressants (Azathioprine, Mycophenolate Mofetil, Mycophenolic Acid, Methotrexate, etc.)
- Patient does not have active severe lupus nephritis or neuropsychiatric SLE
- Patient does not have any of the following:
  - Serious or active infection

- Concurrent therapy with a biologic medication such as belimumab or intravenous cyclophosphamide

**Initial approval is for twelve months.**

Continued therapy

- Patient continues to meet initial approval criteria.
- Patient has shown positive clinical response as evidenced by one or more of the following:
  - Improvement in all organs with disease activity at baseline with no new flares.
  - Reduction in the dosages of oral corticosteroids from baseline.
  - Decrease in symptoms or stabilization in at least one SLE related disease manifestation from baseline.

Reauthorization is for twelve months.

Modifiers SA, UD, U7 and 99 are allowed.

Frequency of billing is 300 mg/300 units every twenty-eight days.

Maximum billing unit(s) equal 300 mg/300 units.

**J0879**

Korsuva™ (difelikefalin) is a kappa opioid receptor agonist indicated for the treatment of moderate-to-severe pruritus associated with chronic kidney disease (CKD-aP) in adults undergoing hemodialysis (HD).

An approved *Treatment Authorization Request* (TAR) is required for reimbursement

Korsuva is considered medically necessary when all of the following criteria are met:

- Must be used for FDA approved indications and dosages
- Patient must be 18 years of age or older
- Patient has end-stage renal disease (ESRD) and has been on hemodialysis 3 times per week for at least 3 months.
- Patient has at least 2 single-pool Kt/V measurements equal to or greater than 1.2, or at least 2 urea reduction ratio measurements equal to or greater than 65 percent, or 1 single pool Kt/V measurement equal to or greater than 1.2 and 1 urea reduction ratio measurement equal to or greater than 65 percent on different dialysis days during the prior 3 months period.
- Patient has completed the following assessments at baseline:
  - Mean baseline Worst Itching Intensity NRS indicative of moderate to severe uremic pruritus
- Patient has tried and failed the following unless contraindicated or clinically inappropriate:
  - Emollients and/or topical analgesics (if dry skin)
  - Oral antihistamines (for example diphenhydramine, hydroxyzine, loratadine, etc.)
  - Gabapentin or pregabalin



- Patient cannot undergo or does not respond to UVB therapy
- Patient is not scheduled to receive kidney transplant
- Patient does not have pruritus only during the dialysis session (by patient report)
- Patient is not receiving ongoing ultraviolet B

**Initial approval is for 6 months**

Continued treatment:

- Patient has experienced reduction of itch intensity as evidenced by one of the following:
  - Improvement from baseline in intensity of itch measured using Numerical Rating Scale (WI-NRS) or other standard scale
  - Improvement from baseline in itch-related quality of life as assessed by standard scale
- Patient does not have adverse events from prior treatments

Reauthorization is for twelve months.

Frequency of billing equals 0.5 mcg/kg at the end of each HD treatment.

**Q0221**

Evusheld™ (tixagevimab co-packaged with cilgavimab) is for the pre-exposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and pediatric individuals (12 years of age and older weighing at least 40 kg):

- Who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual infected with SARS-CoV-2 **and**;
  - Who have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments **and** may not mount an adequate immune response to COVID-19 vaccination **or**;
  - For whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s).

Billing:

- Since the initial supply is purchased by the federal government and distributed free to providers, providers must not bill code Q0220 or Q0221 for the cost of EVUSHELD
- DHCS will reimburse for the cost of administration (infusion) when billed with administration code M0220 or M0221.

**Ophthalmology**

C9092, C9093, Q5124

**C9092**

Xipere™ (triamcinolone acetonide injectable suspension) is indicated for the treatment of macular edema associated with uveitis.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an ophthalmologist
- Patient has a diagnosis of macular edema associated with non-infectious uveitis
- Patient does not have uveitis due to infections such as herpes simplex or herpes zoster
- Documentation of patients' best corrected visual acuity (BCVA) at baseline and periodically during treatment
- Patient will not concomitantly use intravitreal corticosteroid injections or intravitreal corticosteroid implant
- Patient does not have untreated intraocular pressure or uncontrolled glaucoma
- Patient has tried and failed topical and oral corticosteroids unless contraindicated or clinically inappropriate
- Dose does not exceed 4 mg (1 vial) per eye every 12 weeks

Initial authorization is for six months (two injections per eye)

#### Continued therapy

- Patient continues to meet initial approval criteria
- Patient has absence of unacceptable toxicity from the drug such as glaucoma, increase in intraocular pressure, cataracts, etc.
- Patient has experienced clinical response as evidenced improvement or stabilization in best corrected visual acuity from baseline.

Six months (two injections per eye).

Modifiers UD and 99 are allowed.

Frequency of billing equals 4 mg/4 units each eye as a single dose every three months.  
Maximum billing unit(s) equals 4 mg/4 units each eye as a single dose.

#### **C9093**

Susvimo™ (ranibizumab injection) is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of patients with Neovascular (wet) Age-related Macular Degeneration (AMD) who have previously responded to at least two intravitreal injections of a VEGF inhibitor.

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Susvimo is considered medically necessary when all of the following conditions are met:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an ophthalmologist

- Patient has a diagnosis of Neovascular (wet) Age-related Macular Degeneration (AMD) within the prior nine months
- Patient has received three or more doses of anti-VEGF intravitreal agents in the affected eye within the prior six months and demonstrated a response to an anti-VEGF intravitreal agent (for example, aflibercept, bevacizumab, brolucizumab, etc.)
- Documentation of distance Best Corrected Visual Acuity (BCVA) score at baseline and periodically during treatment
- Supplemental treatment with 0.5 mg intravitreal ranibizumab injection may be administered in the affected eye if clinically necessary
- Patient does not have active ocular or periocular infections
- Patient does not have active intraocular inflammation

Initial authorization is for six months

#### Continued therapy

- Patient continues to meet initial approval criteria
- Patient has shown clinical response as evidenced by improvement from baseline in distance Best Corrected Visual Acuity (BCVA) score
- Patient does not have unacceptable toxicity such as endophthalmitis, rhegmatogenous retinal detachment, implant dislocation, vitreous hemorrhage, conjunctival retraction, conjunctival erosion, and conjunctival bleb.

Reauthorization is for six months.

Modifier RT or LT is required on the claim. Modifiers UD and 99 are allowed.

Frequency of billing equals 2 mg/20 units each eye every 24 weeks. Maximum billing unit(s) equals 2 mg/20 units each eye.

#### **Q5124**

Byooviz™ (ranibizumab-nuna) is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of patients with:

- Neovascular (Wet) Age-Related Macular Degeneration (AMD)
- Macular Edema Following Retinal Vein Occlusion (RVO)
- Myopic Choroidal Neovascularization (mCNV)

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Byooviz is considered medically necessary when all of the following conditions are met:

- Must be used for FDA-approved indications and dosages
- Patient must be 18 years of age or older
- Must be prescribed by or in consultation with an ophthalmologist
- Patient has a diagnosis of:
  - Neovascular (Wet) Age-Related Macular Degeneration (AMD)

- Macular Edema Following Retinal Vein Occlusion (RVO)
- Myopic Choroidal Neovascularization (mCNV)
- Patient has tried and failed an intravitreal vascular endothelial growth factor (VEGF) inhibitor (eg, bevacizumab, ranibizumab, aflibercept) unless contraindicated or clinically inappropriate
- Documentation of patient's best corrected visual acuity (BCVA) score at baseline and periodically during treatment

Initial authorization is for six months (three months for mCNV)

### Continued Therapy

- Patient continues to meet initial approval criteria
- Patient has experienced a clinically significant positive benefit as evidence by at least one of the following:
  - Improvement in best corrected visual acuity (BCVA) score from baseline
  - Minimal observable CNV lesion growth
  - Detained neovascularization.
- Patient has an absence of unacceptable toxicity such as endophthalmitis, retinal detachments, increases in intraocular pressure (IOP) and arterial thromboembolic events.

Reauthorization is for six months (three months for mCNV)

Modifier RT or LT is required. Modifiers UD and 99 are allowed.

Frequency of billing equals 0.5 mg/5 units in each eye every 28 days. Maximum billing unit(s) equals 0.5 mg/5 units in each eye.

## **Radiology**

### **The following radiology code has special billing policy**

#### **A9574**

ExEm<sup>®</sup> Foam (air polymer-type A) intrauterine foam is an ultrasound contrast agent indicated for sonohysterosalpingography to assess fallopian tube patency in women with known or suspected infertility

An approved *Treatment Authorization Request* (TAR) is required for reimbursement.

Must submit clinical documentation to substantiate the following:

- Must be used for FDA-approved indications and dosages
- Patient must be female and 18 years of age or older
- Patient must have a known or suspected infertility
- Patient must have a negative pregnancy test within the 24 hours before ExEm Foam administration
- Patient does not have a known or suspected lower genital tract inflammation or infection

- Patient has not had a gynecologic procedure within the 30 days prior
- Patient does not have vaginal bleeding
- Patient does not have known or suspected reproductive tract neoplasia

Authorization is for three months.

Modifiers UD and 99 are allowed.

## **Skin Substitutes**

The following skin substitute codes have special billing policies:

A2011, A2012, A2013, A4100, Q4224, Q4225, Q4256, Q4257, Q4258

**A2011, A2012, A2013, A4100, Q4224, Q4225, Q4256, Q4257, Q4258**

An approved *Treatment Authorization Request* (TAR) is required for reimbursement

Modifiers U7 and 99 are allowed.

## **Annual Code Deletions**

**Table of HCPCS Annual Code Deletions**

Subject	Deleted Code
Chemotherapy	C9084 (replaced by J9359) C9087 (replaced by J9071)
Injection	C9085 (replaced by J0219) C9086 (replaced by J0491)
Laboratory/Pathology	0097U 0151U
Clinical Decision Support Mechanism	G1009
Other	M1145 (effective 2/28/2022)

## **Modifiers**

FT (National description changed)

Unrelated evaluation and management (e/m) visit on the same day as another e/m visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (Report when an e/m visit is furnished within the global period but is unrelated, or when one or more additional e/m visits furnished on the same day are unrelated).