National Correct Coding Policy Manual for Medicare Part B Carriers Version 10.3 Effective Date: October 1, 2004

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INTRODUCTION
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Introduction

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) was enacted. Section 6102 of P.L. 101-239 amended Title XVIII of the Social Security Act (the Act) by adding a new section 1848, Payment for Physicians' Services. This section of the Act provided for replacing the previous reasonable charge mechanism of actual, customary, and prevailing charges with a resource-based relative value scale (RBRVS) fee schedule that began in 1992.

With the implementation of the Medicare Fee Schedule, it was increasingly important to assure that uniform payment policies and procedures were followed by all carriers so that when the same service is rendered in various carrier jurisdictions, it is paid for in the same way. In addition, accurate coding and reporting of services by physicians was a major concern to guarantee proper payment.

Purpose

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and review of current coding practice.

Although the NCCI was initially developed for use by Medicare Carriers to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries to process Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI.

CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an “Advanced Beneficiary Notice” (ABN) form to seek payment from a Medicare beneficiary. Furthermore,

since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a “Notice of Exclusions from Medicare Benefits” (NEMB) form.

Correct Coding

Procedures should be reported with the HCPCS/CPT codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment.

Correct coding requires reporting a group of procedures with the appropriate comprehensive code. Examples of unbundling are described below:

- Fragmenting one service into component parts and coding each component part as if it were a separate service. For example the correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach is inappropriate.

- Reporting separate codes for related services when one comprehensive code includes all related services. An example of this type is coding a total abdominal hysterectomy with or without removal of tubes, with or without removal of ovaries (CPT code 58150) plus salpingectomy (CPT code 58700) plus oophorectomy (CPT code 58940) rather than using the comprehensive CPT code 58150 for all three related services.

- Breaking out bilateral procedures when one code is appropriate. For example, bilateral mammography is coded correctly using CPT code 76091 rather than incorrectly submitting CPT code 76090-RT for right mammography and CPT code 76090-LT for left mammography.

- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate. A laboratory should bill CPT code 80048,(Basic metabolic panel), when coding for a calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen performed as automated multichannel tests. It would be inappropriate to report CPT codes 82310, 82374, 82435, 82565, 82947, 84132, 84295 and/or 84520 in addition to the CPT code 80048 unless one of these laboratory tests was performed at a different time of day to obtain follow-up results, in which case a modifier –91 would be utilized.

- Separating a surgical approach from a major surgical service. For example, a provider should not bill CPT code 49000 for exploratory laparotomy and CPT code 44150 for total abdominal colectomy for the same operation because the exploration of the surgical field is included in the CPT code 44150.

Policy Manual Conditions and Format

The National Correct Coding Policy Manual and edits have been developed for application to services billed by a single provider for a single patient on the same date of service.

It is important to recognize that the National Correct Coding Initiative represents a more comprehensive approach to unifying coding practices than the previous “rebundling” program instituted by CMS, formerly HCFA, in 1992. An understanding of the general policies is necessary to understand the different types of code pair edits that are listed in the Initiative.

The National Correct Coding Policy Manual and Edits were initially based on evaluation of procedures referenced in the 1994 *CPT Manual* and HCPCS Level II codes. An ongoing refinement program has been developed to address annual changes in CPT codes and instructions, either additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes will occur based on changes in technology, in standard medical practice and from continuous input from the AMA and various specialty societies.

The National Correct Coding Policy Manual includes a Table of Contents, an Introduction, and 13 narrative chapters. As shown

in the Table of Contents, each chapter corresponds to a separate section of the *CPT Manual* except Chapter I which contains general correct coding policies, Chapter XII which addresses HCPCS Level II codes under the Part B Carriers' jurisdiction, and Chapter XIII which summarizes Category III codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

This policy manual in general utilizes paraphrased descriptions of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA's *Current Procedural Terminology* (*CPT*) *Manual* and CMS's HCPCS Level II code descriptors for complete definitions of the codes.

This policy manual and the edits were developed for the purpose of encouraging consistent and correct coding and of controlling inappropriate payment. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Edit Development and Review Process

The NCCI undergoes constant refinement publishing four versions annually. Medicare Carriers implement the versions effective January 1, April 1, July 1, and October 1. Changes in NCCI come from three sources: (1) additions, deletions or modifications to CPT or HCPCS Level II codes or *CPT Manual* instructions; (2) CMS policy initiatives; and (3) comments from the AMA, national or local medical/surgical societies, Medicare contractor medical directors, providers, billing consultants, etc.

CMS notifies the AMA and national medical/surgical societies of the quarterly changes in NCCI. Additionally, CMS seeks comment from national medical/surgical societies before implementing many types of changes in NCCI. Although national medical/surgical societies generally agree with changes CMS makes to NCCI, CMS carefully considers those adverse comments received. When CMS decides to proceed with changes in NCCI contrary to the comments of national medical/surgical societies, it does so after due consideration of those comments and other information available to CMS.

Sources of Information about NCCI

The CMS website contains:

1) a copy of the National Correct Coding Policy Manual for Medicare Part B Carriers (http://www.cms.hhs.gov/physicians/cciedits/nccmanual.asp);
2) a listing of all NCCI edits (http://www.cms.hhs.gov/physicians/cciedits/default.asp); and
3) NCCI Questions and Answers (http://www.cms.hhs.gov/medlearn/ncci.asp).

Correspondence to CMS about NCCI and its Contents

The NCCI is maintained for CMS by a Program Safequard Contractor (PSC), Reliance Safeguard Solutions,Inc., and its subcontractor, AdminaStar Federal, Inc. If you have concerns regarding the content of the edits or this manual, please submit your comments in writing to:

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CMS makes all decisions about the contents of NCCI and this manual. Correspondence from AdminaStar Federal reflects CMS's policies on coding and NCCI.

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CHAPTER I
GENERAL CORRECT CODING POLICIES
FOR
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Chapter I
General Correct Coding Policies

A. Introduction

The Physicians' *Current Procedural Terminology (CPT)* developed by the American Medical Association and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The codes in the *CPT Manual* are copyrighted by the AMA, and updated annually by the CPT Editorial Panel based on input from the AMA Advisory Committee which serves as a channel for requests from various providers and specialty societies. The purpose of both coding systems and annual updates is to communicate specific services rendered by physicians and other providers, usually for the purpose of claim submission to third party (insurance) carriers. A multitude of codes is necessary because of the wide spectrum of services provided by various medical care providers. Because many medical services can be rendered by different methods and combinations of various procedures, multiple codes describing similar services are frequently necessary to accurately reflect what service a physician performs. While often only one procedure is performed at a patient encounter, multiple procedures are performed at the same session at other times. In the latter case, the pre-procedure and post-procedure work does not have to be repeated and, therefore, a comprehensive code, describing the multiple services commonly performed together, can be defined.

Third party payers have adopted the CPT coding system for use by providers to communicate payable services. It therefore becomes more important to identify the various potential combinations of services to accurately adjudicate claims.

There are two sets of National Correct Coding Initiative tables, column 1/column 2 correct coding (formerly known as comprehensive/component) edits and mutually exclusive edits. All edits consist of code pairs that are arranged in column 1 and column 2 of the tables. All edits are included in the first table except those meeting the criteria for mutually exclusive code edits (Chapter I, Section P). Edits based on the criteria for “Gender-Specific Procedures” (formerly “Designation of Sex”) (Chapter I, Section Q) are also included in the mutually exclusive code edit tables. The column 2 code in both tables is

not payable with the column 1 code unless the edit permits use of a modifier associated with NCCI (Chapter I, Section E). The correct coding edit table contains many edits where the column 2 code is a component of the column 1 comprehensive code. However, this table also contains many edits where there is no comprehensive/component relationship, but the column 1 code and column 2 code should not be reported together for other reasons.

The following policies encompass general issues/coding principles that are to be applied in all subsequent chapters. Specific examples are stated to clarify the policy but do not represent the only code or service that is included in the policy.

B. Coding Based on Standards of Medical/Surgical Practice

In order for this system to be effective, it is essential that the coding description accurately describe what actually transpired at the patient encounter. Because many physician activities are so integral to a procedure, it is impractical and unnecessary to list every event common to all procedures of a similar nature as part of the narrative description for a code. Many of these common activities reflect simply normal principles of medical/surgical care. These "generic" activities are assumed to be included as acceptable medical/surgical practice and, while they could be performed separately, they should not be considered as such when a code descriptor is defined. Accordingly, all services integral to accomplishing a procedure will be considered included in that procedure.

Many of these generic activities are common to virtually all procedures. On other occasions, some are integral to only a certain group of procedures but are still essential to accomplish these particular procedures. Accordingly, it would be inappropriate to separately code these services based on standard medical and surgical principles.

Some examples of generic services integral to standard of medical/surgical services would include:

- Cleansing, shaving and prepping of skin
- Draping of patient; positioning of patient
- Insertion of intravenous access for medication
- Sedative administration by the physician performing the procedure (see Chapter II, Anesthesia section, for the separate policy)

- Local, topical or regional anesthetic administered by physician performing procedure
- Surgical approach, including identification of anatomical landmarks, incision, evaluation of the surgical field, simple debridement of traumatized tissue, lysis of simple adhesions, isolation of neurovascular, muscular (including stimulation for identification), bony or other structures limiting access to surgical field
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, dressings, pumps into same site
- Surgical closure
- Application, management, and removal of postoperative dressings including analgesic devices (peri-incisional TENS unit, institution of Patient Controlled Analgesia)
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, transcription as necessary to document the services provided
- Surgical supplies, unless excepted by existing CMS policy

In the case of individual services, there are numerous specific services that may typically be involved in order to accomplish a column 1 procedure. Generally, performance of these services represents the standard of practice for a more comprehensive procedure and the services are therefore to be included in that service.

Because many of these services are unique to individual CPT coding sections, the rationale for correct coding will be described in that particular section. The principle of the policy to include these services into the column 1 procedure remains the same as the principle applied to the generic service list noted above. Specifically, these principles include:

1. The service represents the standard of care in accomplishing the overall procedure.

2. The service is necessary to successfully accomplish the column 1 procedure; failure to perform the service may compromise the success of the procedure.

3. The service does not represent a separately identifiable procedure unrelated to the column 1 procedure planned.

Specific examples consist of:

Medical:

1. Procurement of a rhythm strip in conjunction with an electrocardiogram. The rhythm strip would not be separately reported if it was procured by the same physician performing the interpretation, since it is an integral component of the interpretation.

2. Procurement of upper extremity (brachial) Doppler study in addition to lower extremity Doppler study in order to obtain an "ankle-brachial index" (ABI). The upper extremity Doppler would not be separately reported.

3. Procurement of an electrocardiogram as part of a cardiac stress test. The electrocardiogram would not be separately reported if procured as a routine serial EKG typically performed before, during, and after a cardiac stress test.

Surgical:

1. Removal of a cerumen impaction prior to myringotomy. The cerumen impaction is precluding access to the tympanic membrane and its removal is necessary for the successful completion of the myringotomy.

2. Performance of a bronchoscopy prior to a thoracic surgery (e.g. thoracotomy and lobectomy). Assuming that a diagnostic bronchoscopy has already been performed for diagnosis and biopsy and the surgeon is simply evaluating for anatomic assessment for sleeve or more complex resection, the bronchoscopy would not be separately reported. Essentially, this "scout" endoscopy represents a part of the assessment of the surgical field to establish anatomical landmarks, extent of disease, etc. If an endoscopic procedure is done as part of an open procedure, it is not separately reported. However, if an endoscopy is performed for purposes of an initial diagnosis on the same day as the open procedure, the endoscopy is separately reported. In the case where the procedure is performed for diagnostic purposes immediately prior to a more definitive procedure, modifier -58 may be utilized to indicate that these procedures are staged or planned services. Additionally, if endoscopic procedures are performed on distinct, separate areas at the same session, these procedures would be reported separately. For example, a thoracoscopy and mediastinoscopy, being separate endoscopic

procedures, would be separately reported. On the other hand, a cursory evaluation of the upper airway as part of bronchoscopic procedure would not be separately reported as a laryngoscopy, sinus endoscopy, etc.

3. Lysis of adhesions and exploratory laparotomy reported with colon resection or other abdominal surgery. These procedures represent gaining access to the organ system of interest and are not separately reported.

C. Medical/Surgical Package

As a result of the variety of surgical, diagnostic and therapeutic non-surgical procedures commonly performed in medical practice, the extent of the *CPT Manual* has grown. The need for precise definitions for the various combinations of services is further warranted because of the dependence of providers on CPT coding for reporting to third party payers. When a Resource-Based Relative Value System (RBRVS) is used in conjunction with CPT coding, the necessity for accurate coding is amplified. In general, most services have pre-procedure and post-procedure work associated with them; when performed at a single patient encounter, the pre-procedure and post-procedure work does not change proportionately when multiple services are performed. Additionally, the nature of the pre-procedure and post-procedure work is reasonably consistent across the spectrum of procedures.

In keeping with the policy that the work typically associated with a standard surgical or medical service is included in the *CPT Manual* code description of the service, some general guidelines can be developed. With few exceptions these guidelines transcend a majority of CPT descriptions, irrespective of whether the service is limited or comprehensive.

1. A majority of invasive procedures require the availability of vascular and/or airway access; accordingly, the work associated with obtaining this access is included in the pre-procedure services and returning a patient to the appropriate post-procedure state is included in the procedural services. Intravenous access, airway access (e.g. HCPCS/CPT codes 36000, 36400, 36410) are frequently necessary; therefore, CPT codes describing these services are not separately reported when performed in conjunction with a column 1 procedure. Airway access is associated with general anesthesia, and no CPT code is available for elective intubation. The CPT code 31500 is not to

be reported for elective intubation in anticipation of performing a procedure as this represents a code for providing the service of emergency intubation.

Furthermore, CPT codes describing services to gain visualization of the airway (nasal endoscopy, laryngoscopy, bronchoscopy) were created for the purpose of coding a diagnostic or therapeutic service and are not to be reported as a part of intubation services.

When vascular access is obtained, the access generally requires maintenance of an infusion or use of an anticoagulant (heparin lock injection) (e.g. CPT codes 90780 - 90784). These services are necessary for the maintenance of the access and are not to be separately reported. Additionally, use of an anticoagulant for access maintenance cannot be separately reported (e.g. CPT code 37201).

In some situations, more invasive access services (central venous access, pulmonary artery access) are performed with a specific type of procedure. Because this is not typically the case, the codes referable to these services may be separately reported.

Placement of central access devices (central lines, pulmonary artery catheters, etc.) involve passage of catheters through central vessels and, in the case of PA catheters, through the right ventricle; additionally, these services often require the use of fluoroscopic support. Separate reporting of CPT codes for right heart catheterization, first order venous catheter placement or other services which represent a separate procedure, is not appropriate when the CPT code that describes the access service is reported. General fluoroscopic services necessary to accomplish routine central vascular access or endoscopy cannot be separately reported unless a specific CPT code has been defined for this service.

2. When anesthesia is provided by the physician performing the primary service, the anesthesia services are included in the primary procedure (CMS Anesthesia Rules). If it is medically necessary for a separate provider (anesthesiologist/ anesthetist) to provide the anesthesia services (e.g. monitored anesthesia care), a separate service may be reported.

3. Most procedures require cardiopulmonary monitoring, either by the physician performing the procedure or an anesthesiologist/certified registered nurse anesthetist. Because

these services are integral and routine, they are not to be separately reported. This may include cardiac monitoring, intermittent EKG procurement, oximetry or ventilation management (e.g. CPT codes 93000, 93005, 93040, 93041, 94656, 94760, 94761, 94770). These services, when integral to the monitoring service, are not to be separately reported.

4. When, in the course of a procedure, a non-diagnostic biopsy is obtained and subsequently excision, removal, destruction or other elimination of the biopsied lesion is accomplished, a separate service cannot be reported for the biopsy procurement as this represents part of the removal. When a single lesion is biopsied multiple times, only one biopsy removal service should be reported. When multiple distinct lesions are non-endoscopically biopsied, a biopsy removal service may be reported for each lesion separately with a modifier, indicating a different service was performed or a different site was biopsied (see Section E of Chapter I for definition of modifier -59). The medical record (e.g. operative report) should indicate the distinct nature of this service. However, for endoscopic biopsies of lesions, multiple biopsies of multiple lesions are reported with one unit of service regardless of how many biopsies are taken. If separate biopsy removal services are performed on separate lesions, and it is felt to be medically necessary to submit pathologic specimens separately, the medical record should identify the precise location of each biopsy site. If the decision to perform a more comprehensive procedure is based on the biopsy result, the biopsy is diagnostic, and the biopsy service may be separately reported.

5. In the performance of a surgical procedure, it is routine to explore the surgical field to determine the anatomic nature of the field and evaluate for anomalies. Accordingly, codes describing exploratory procedures (e.g. CPT code 49000) cannot be separately reported. If a finding requires extension of the surgical field and it is followed by another procedure unrelated to the primary procedure, this service may be separately reported using the appropriate CPT code and modifiers.

6. When a definitive surgical procedure requires access through abnormal tissue (e.g. diseased skin, abscess, hematoma, seroma, etc.), separate services for this access (e.g. debridement, incision and drainage) are not reported. For example, if a patient presents with a pilonidal cyst and it is determined that it is medically necessary to excise this cyst, it would be appropriate to submit a bill for CPT code 11770

(excision of pilonidal cyst); it would not, however, be appropriate to also report CPT code 10080 (incision and drainage of pilonidal cyst), as it was necessary to perform the latter to accomplish the primary procedure.

7. When an excision and removal is performed ("-ectomy" code), the approach generally involves incision and opening of the organ ("-otomy" code). The incision and opening of the organ or lesion cannot be separately reported when the primary service is the removal of the organ or lesion.

8. There are frequently multiple approaches to various procedures, and are often clusters of CPT codes describing the various approaches (e.g. vaginal hysterectomy as opposed to abdominal hysterectomy). These approaches are generally mutually exclusive of one another and, therefore, not to be reported together for a given encounter. Only the definitive, or most comprehensive, service performed can be reported. Endoscopic procedures are often performed as a prelude to, or as a part of, open surgical procedures. When an endoscopy represents a distinct diagnostic service prior to an open surgical service and the decision to perform surgery is made on the basis of the endoscopy, a separate service for the endoscopy may be reported. Modifier -58 may be used to indicate that the diagnostic endoscopy and the open surgical service are staged or planned procedures.

9. When an endoscopic service is performed to establish the location of a lesion, confirm the presence of a lesion, establish anatomic landmarks, or define the extent of a lesion, the endoscopic service is not separately reported as it is a medically necessary part of the overall surgical service. Additionally, when an endoscopic service is attempted and fails and another surgical service is necessary, only the successful service is reported. For example, if a laparoscopic cholecystectomy is attempted and fails and an open cholecystectomy is performed, only the open cholecystectomy can be reported; if appropriate, modifier -22 may be added to indicate “unusual procedural services”.

10. A number of CPT codes describe services necessary to address the treatment of complications of the primary procedure (e.g., bleeding or hemorrhage). When the services described by CPT codes as complications of a primary procedure require a return to the operating room, they may be reported separately; generally, due to global surgery policy, they should be reported

with modifier -78 indicating that the service necessary to treat the complication required a return to the operating room during the postoperative period. When a complication described by codes defining complications arises during an operative session, however, a separate service for treating the complication is not to be reported. An operative session ends upon release from the operating or procedure suite (as defined in MCM §4821 or online internet manual Pub.100-4, 12-§40.1).

D. Evaluation and Management Services

All CPT and HCPCS Level II codes have a global surgery indicator. The separate payment for Evaluation and Management (E & M) services provided on the same day of service as procedures with a global surgery indicator of "000," "010," or "090" is covered by global surgery rules.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E & M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E & M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E & M service on the same day of service which may be reported by appending modifier –25 to the E & M code. This E & M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier –25 to a significant, separately identifiable E & M service when performed on the same date of service as an "XXX" procedure is correct coding.

E. Modifiers and Modifier Indicators

1. In order to expand the information provided by CPT codes, a number of modifiers have been created by the AMA, and the CMS. These modifiers, in the form of two characters, either numbers, letters, or a combination of each, are intended to transfer

specific information regarding a certain procedure or service. Modifiers are attached to the end of a HCPCS/CPT code and give the physician a mechanism to indicate that a service or procedure has been modified by some circumstance but is still described by the code definition.

Like CPT codes, the use of modifiers (either AMA or CMS-defined modifiers) requires explicit understanding of the purpose of each modifier. It is also important to identify when the purpose of a modifier has been expanded or restricted by a third party payer. It is essential to understand the specific meaning of the modifier by the payer to which a claim is being submitted before using it.

There are modifiers created by either the AMA or the CMS which have been designated specifically for use with the correct coding and mutually exclusive code pairs. These modifiers are -E1 through -E4, -FA, -F1 through -F9, -LC, -LD, -LT, -RC, -RT, -TA, -T1 through -T9, -25, -58, -59, -78, -79, and -91. When one of these modifiers is used, it identifies the circumstances for which both services rendered to the same beneficiary, on the same date of service, by the same provider should be allowed separately because one service was performed at a different site, in a different session, or as a distinct service. Modifier -59 will be explained in greater detail in this section. In addition, pertinent information about three other modifiers, the –22, the –25, and the -58 is provided.

a. **Modifier -22:** Modifier -22 is identified in the *CPT Manual* as “unusual procedural services.” By definition, this modifier would be used in unusual circumstances; routine use of the modifier is inappropriate as this practice would suggest cases routinely have unusual circumstances. When an unusual or extensive service is provided, it is more appropriate to utilize modifier -22 than to report a separate code that does not accurately describe the service provided.

b. **Modifier -25**: Modifier –25 is identified in the *CPT Manual* as a “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service”. This modifier may be appended to an evaluation and management (E & M) code reported with another procedure on the same day of service. The NCCI includes edits bundling E & M codes into various procedures not covered by

global surgery rules. If in addition to the procedure the physician performs a significant and separately identifiable E & M service beyond the usual pre-procedure, intra-procedure, and post-procedure physician work, the E & M may be reported with modifier –25 appended. The E & M and procedure(s) may be related to the same or different diagnoses.

c. **Modifier -58:** Modifier -58 is described as a "staged or related procedure or service by the same physician during the postoperative period." It indicates that a procedure was followed by another procedure or service during the postoperative period. This may be because it was planned prospectively, because it was more extensive than the original procedure or because it represents therapy after a diagnostic procedural service. When an endoscopic procedure is performed for diagnostic purposes at the time of a more comprehensive therapeutic procedure, and the endoscopic procedure does not represent a "scout" endoscopy, modifier -58 may be appropriately used to signify that the endoscopic procedure and the more comprehensive therapeutic procedure are staged or planned procedures. From the National Correct Coding Initiative perspective, this action would result in the allowance and reporting of both services as separate and distinct.

d. **Modifier -59:** Modifier -59 has been established for use when several procedures are performed on different anatomical sites, or at different sessions (on the same day). The specific language according to the *CPT Manual* is:

Modifier -59: "Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier '59' is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier '59'. Only if no more descriptive modifier is available, and the use of modifier '59' best explains the circumstances, should modifier '59' be used."

When certain services are reported together on a patient by the same physician on the same date of service, there may be a perception of "unbundling," when, in fact, the services were performed under circumstances which did not involve this practice at all. Because carriers cannot identify this based simply on CPT coding on either electronic or paper claims, modifier -59 was established to permit services of such a nature to bypass correct coding edits if the modifier is present. Modifier -59 indicates that the procedure represents a distinct service from others reported on the same date of service. This may represent a different session, different surgery, different site, different lesion, different injury or area of injury (in extensive injuries). Frequently, another, already established modifier has been defined that describes this situation more specifically. In the event that a more descriptive modifier is available, it should be used in preference to modifier -59.

Example: If a patient requires placement of a flow directed pulmonary artery catheter for hemodynamic monitoring via the subclavian vein, it would be appropriate to submit the CPT code 93503 (Insertion and placement of flow directed catheter, e.g. Swan-Ganz for monitoring purposes) for the service. If, later in the day, the catheter must be removed and a central venous catheter is inserted through the femoral vein, the appropriate code for this service would be CPT code 36010 (Introduction of catheter, superior or inferior vena cava). Because the pulmonary artery (PA) catheter requires passage through the vena cava, it may appear that the service for the PA catheter was being "unbundled" if both services were reported on the same day. Accordingly, the central venous catheter code should be reported with modifier -59 (CPT code 36010–59) indicating that this catheter was placed in a different site as a different service on the same day.

Other examples of the appropriate use of modifier -59 are contained in the individual chapter policies.

Modifier –59 is often misused. The two codes in a code pair edit often by definition represent different procedures. The provider cannot use modifier –59 for such an edit based on the two codes being different procedures. However, if the two procedures are performed at separate sites or at separate patient encounters on the same date of service, modifier –59 may be appended. Additionally, modifier –59 cannot be used with E & M services (CPT codes 99201-99499) or radiation treatment management (CPT code 77427).

Example: The column 1/column 2 code edit with column 1 code 38221 (bone marrow biopsy) and column 2 code 38220(bone marrow, aspiration only) are two distinct procedures when performed at separate anatomic sites or separate patient encounters. In these circumstances, it would be acceptable to use modifier –59. However, if both 38221 and 38220 are performed through the same skin incision at the same patient encounter which is the usual practice, modifier –59 should NOT be used. Although 38221 and 38220 are different procedures, they are bundled when performed through the same skin incision at a single patient encounter.

2. Each NCCI edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI-associated modifiers can be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant.

NCCI-associated modifiers include:

- anatomical modifiers of -E1-E4, -FA, -F1-F9, -LC, -LD, -RC, -LT, -RT, -TA, -T1-T9;
- global surgery modifiers of -25, -58, -78,-79;and
- other modifiers -59, -91.

It is very important that NCCI-associated modifiers only be used when appropriate. In general these circumstances relate to separate patient encounters, separate anatomic sites or separate specimens. (See the prior discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g. eyes, ears, extremities, lungs, kidneys) have modifier indicators of "1" because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pair edits should not be reported with NCCI-associated modifiers when performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI edit indicates that the two codes cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations as recognized by coding conventions. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous

structures, NCCI-associated modifiers generally should not be utilized.

F. Standard Preparation/Monitoring Services

Anesthesia services require certain other services to prepare a patient prior to the administration of anesthesia and to monitor a patient during the course of anesthesia. The advances in technology allow for intraoperative monitoring of a variety of physiological parameters. Additionally, when monitored anesthesia care is provided, the attention devoted to patient monitoring is of a similar level of intensity so that general anesthesia may be established if need be. The specific services necessary to prepare and monitor a patient vary among procedures, based on the extent of the surgical procedure, the type of anesthesia (general, MAC, regional, local, etc.), and the surgical risk. Although a determination as to medical necessity and appropriateness must be made by the physician performing the anesthesia, when these services are performed, they are included in the anesthesia service. Because it is recognized that many of these services may occur on the same date of surgery but are not performed in the course of and as part of the anesthesia provision for the day, in some cases these codes will be separately paid by appending modifier -59, indicating that the service rendered was independent of the anesthesia service.

G. Anesthesia Service Included in the Surgical Procedure

Under the CMS Anesthesia Rules, Medicare does not allow separate payment for the anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical service. For example, separate payment is not allowed for the surgeon’s performance of local, regional, or other anesthesia including nerve blocks if the surgeon also performs the surgical procedure.

CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia should not be reported in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician. Examples of improperly reported services that are bundled into the anesthesia service when anesthesia is provided by the physician performing the medical or surgical service include introduction of needle or intracatheter into a vein (CPT code 36000),

venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780). However, if these services are not related to the delivery of an anesthetic agent, they may be reported separately.

H. HCPCS/CPT Procedure Code Definition

The format of the *CPT Manual* includes descriptions of procedures which are, in order to conserve space, not listed in their entirety for all procedures. The partial description is indented under the main entry, and constitutes what is always followed by a semicolon in the main entry. The main entry then encompasses the portion of the description preceding the semicolon. The main entry applies to and is a part of all indented entries which follow with their codes. An example is:

70120	Radiologic examination, mastoids; less than three views per side
70130	complete, minimum of three views per side

The common portion of the description is "radiologic examination, mastoids" and this description is considered a part of both codes. The distinguishing part of each of these codes is that which follows the semicolon.

In some procedure descriptions, the code definition specifies other procedures that are included in this comprehensive code. CPT procedure code 58291 is an example. Since the code description for CPT code 58291 states that the code includes removal of tube(s)and/or ovary(s), it follows that salpingo-oophorectomy (CPT code 58720) cannot be reported with CPT code 58291.

In addition, a code description may define a correct coding relationship where one code is a part of another based on the language used in the descriptor. Some examples of this type of correct coding by code definition are:

1. "Partial" and "complete" CPT codes are reported. The partial procedure is included in the complete procedure.

2. "Partial" and "total" CPT codes are reported. The partial procedure is included in the total procedure.

3. "Unilateral" and "bilateral" CPT codes are reported. The unilateral procedure is included in the bilateral procedure.

4. "Single" and "multiple" CPT codes are reported. The single procedure is included in the multiple procedure.

5. “With” and “without” CPT codes are reported. The “without” procedure is included in the “with” procedure.

I. HCPCS/CPT Coding Manual Instruction/Guideline

Each of the six major sections of the *CPT Manual* and several of the major subsections include guidelines that are unique to that section. These directions are not all inclusive or limited to definitions of terms, modifiers, unlisted procedures or services, special or written reports, details about reporting separate or multiple procedures and qualifying circumstances. These instructions appear in various places and are found at the beginning of each major section, at the beginning of subsections, and before or after a series of codes or individual codes. They define items or provide explanations that are necessary to appropriately interpret and report the procedures or services and to define terms that apply to a particular section. Notations are made in parentheses when CPT codes are deleted or cross-referenced to another similar code so that the provider has better guidance in the appropriate assignment of a CPT code for the service. Providers should not report CPT codes that are contrary to *CPT Manual* instructions.

J. Separate Procedure

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure, can be performed separately but should not be reported when a related service is performed. (e.g. A “separate procedure” should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice.) The "separate procedure" designation is used with codes in the surgery (CPT codes 10000-69999), radiology (CPT codes 70000-79999) and medicine (CPT codes 90000-99199) sections. When a related procedure is performed, a code with the designation of "separate procedure" is not to be reported with the primary procedure.

Example: If the code identified as a "separate procedure" is reported with a related procedure code, such as when a

sesamoidectomy, thumb or finger (CPT code 26185) is reported with an excision or curettage of a bone cyst or benign tumor of the proximal, middle, or distal phalanx of the finger with autograft (CPT code 26215), then the sesamoidectomy (separate procedure) should not be reported. The "separate procedure" is commonly performed as an integral component of a more comprehensive service and usually represents a procedure in an anatomically related area that the physician performs through the same incision or orifice, at the same site, or using the same approach.

In the case where a “separate procedure” is performed on the same day but at a different session, or at an anatomically unrelated site, the “separate procedure” code may be reported in addition to a code for a procedure that would be related if performed at the same patient encounter or at an anatomically-related site. Modifier –59 should be included indicating that this service was, in fact, a separate service.

In other sections of the *CPT Manual*, the word "separate" is used in a phrase identified as "separate or multiple procedures" with a different meaning.

K. Family of Codes

In a family of codes, there are two or more component codes that are not reported separately because they are included in a more comprehensive code as members of the code family. Comprehensive codes include certain services that are separately identifiable by other component codes. The component codes as members of the comprehensive code family represent parts of the procedure that should not be listed separately when the complete procedure is done. However, the component codes are considered individually if performed independently of the complete procedure and if not all the services listed in the comprehensive codes were rendered to make up the total service. If all multiple services described by a comprehensive code are performed, the comprehensive code should be reported. It is not appropriate to report the separate component codes individually nor is it appropriate to report the component code(s) with the comprehensive code.

L. More Extensive Procedure

When procedures are performed together that are basically the same, or performed on the same site but are qualified by an

increased level of complexity, the less extensive procedure is included in the more extensive procedure. In the following situations, the procedure viewed as the more complex would be reported:

1. "Simple" and "complex" CPT codes reported; the simple procedure is included in the complex procedure at the same site.

2. "Limited" and "complete" CPT codes reported; the limited procedure is included in the complete procedure at the same site.

3. "Simple" and "complicated" CPT codes reported; the simple procedure is included in the complicated procedure at the same site.

4. "Superficial" and "deep" CPT codes reported; the superficial procedure is included in the deep procedure at the same site.

5. "Intermediate" and "comprehensive" CPT codes reported; the intermediate procedure is included in the comprehensive procedure at the same site.

6. "Incomplete" and "complete" CPT codes reported; the incomplete procedure is included in the complete procedure at the same site.

7. "External" and "internal" CPT codes reported; the external procedure is included in the internal procedure at the same site.

M. Sequential Procedure

An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. There may be separate CPT codes describing each service. The second procedure is usually performed because the initial approach was unsuccessful in accomplishing the medically necessary service; these procedures are considered "sequential procedures". Only the CPT code for one of the services, generally the more invasive service, should be reported. An example of this situation is a failed laparoscopic cholecystectomy, followed by an open cholecystectomy at the same session. Only the code for the successful procedure, in this case the open cholecystectomy, should be reported.

N. Laboratory Panel

When all component tests of a specific organ or disease oriented laboratory panel (e.g. CPT codes 80074,80061) are reported separately, they should be reported with the comprehensive panel code that includes the multiple component tests. The individual tests that make up a panel are not to be separately reported.

Example: CPT code 80061 (Lipid panel) includes the following tests:

CPT code 82465:	Cholesterol, serum or whole blood, total
CPT code 83718:	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
CPT code 84478:	Triglycerides

When all 3 tests are performed, the panel test (CPT code 80061) should be reported in place of the individual tests.

O. Misuse of Column 2 Code with Column 1 Code

In general, CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating “with or without” a service.) A provider should not report a CPT code out of the context for which it was intended. Providers who are familiar with procedures or services described in areas or sections of CPT will understand the specific language of the descriptor as well as the intent for which the code was developed. On the other hand, a provider who, for example, is unfamiliar with an area of CPT may fail to understand the intent of certain codes. Either intentionally or unintentionally, a provider may report a service or procedure using a CPT code that may be construed to describe the service/procedure but that, in no way, was intended to be used in this fashion.

CPT codes describing services or procedures that would not typically be performed with other services or procedures but may be construed to represent other services have been identified and

paired with the column 1 CPT codes. Additionally, pairs of codes have been identified which would not be reported together because another code more accurately describes the services performed.

Example: CPT code 20550 (“Injection(s); tendon sheath, ligament”) is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g. 20520 for simple removal of foreign body in muscle or tendon sheath) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure.

P. Mutually Exclusive Procedure

There are numerous procedure codes that are not to be reported together because they are mutually exclusive of each other. Mutually exclusive codes are those codes that cannot reasonably be done in the same session. An example of a mutually exclusive situation is when the repair of the organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be reported. A second example is the reporting of an "initial" service and a "subsequent” service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time.

CPT codes that are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs that should not be reported together.

In order to identify these code pairs, an independent table of mutually exclusive codes has been developed as part of the NCCI. This table differs from the correct coding table of column 1 and column 2 codes. Although the codes are listed as column 1 and column 2 codes, the column 2 code is not a component or part of the column 1 code. Rather the two codes cannot be reported at the same time.

Q. Gender-Specific Procedure (formerly Designation of Sex)

Many procedure codes have a gender-specific classification within their narrative. These codes are not reported with codes having

the opposite gender designation because this would reflect a conflict in gender classification either by the definition of the code descriptions themselves (as they appear in the *CPT Manual*) or by the fact that the performance of these procedures on the same patient would be anatomically impossible.

The sections that this policy pertains to are the male and female genital procedures. Other codes indicate in their definition that a particular gender classification is required for the use of that particular code. An example of this situation would be CPT code 53210 for total urethrectomy including cystostomy in a female as opposed to CPT code 53215 for the male. Both of these procedures are not to be reported together. Some other examples of these code pairs are: 53210-53250, 52275-52270, and 57260-53620. These specific edits have been included in the Mutually Exclusive Table because both procedures of a code pair edit cannot be performed on a single patient. (See Section P in this chapter for more explanation of mutually exclusive codes.)

R. Add-on Codes

The CPT coding system identifies certain codes as “add-on” codes which describe a service that can only be reported in addition to a primary procedure. *CPT Manual* instructions specify the primary procedure code(s) for some add-on codes. For other add-on codes, the primary procedure code(s) is(are) not specified, and generally, these are identified with the statement: "List separately in addition to code for primary procedure". The basis for these CPT codes is to enable providers to separately identify a service that is performed in certain situations as an additional service or a commonly performed supplemental service complementary to the primary procedure.

In general, NCCI does not include edits with most add-on codes because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure. (i.e., If an edit prevents payment of the primary procedure code, the add-on code will also not be paid.) However, NCCI does include edits for some add-on codes when coding edits related to the primary procedures must be supplemented. Examples include edits with add-on codes 69990 (microsurgical techniques requiring use of operating microscope) and 95920 (intraoperative neurophysiology testing).

Incidental services that are necessary to accomplish the primary procedure (e.g. lysis of adhesions in the course of an open cholecystectomy) are not separately reported. Certain complications with an inherent potential to occur in an invasive procedure are, likewise, not separately reported unless resulting in the necessity for a significant, separate procedure to be performed. For example, control of bleeding during a procedure is considered part of the procedure and is not separately reported.

Add-on codes frequently specify codes or ranges of codes with which they are to be used. It would be inappropriate to use these with codes other than those specified. On occasion, a procedure described by a CPT code is modified or enhanced, either due to the unique nature of the clinical situation or due to advances in technology since the code was first published. When CPT codes are not labeled as add-on codes in the manner described above, they are not to be reported unless the actual procedure is, in fact, performed. Using non-supplemental codes that approximate part of a more comprehensive procedure but do not describe a separately identifiable service is not appropriate.

Example: If, in the course of interpreting an echocardiogram, an ejection fraction is estimated, it would be inappropriate to code a cardiac blood pool imaging with ejection fraction determination (CPT code 78472) in addition to an echocardiography code (CPT code 93307.) Although the cardiac blood pool imaging does determine an ejection fraction, it does so by nuclear gaiting techniques which are not used in an echocardiogram.

In other cases codes are interpreted as being supplemental to a primary code without an explicit statement in the *CPT Manual* that the code is an add-on code. Unless the code is explicitly identified in such a fashion, it would be improper as a coding convention to submit a primary procedure code as an add-on code.

S. Excluded Service

Because some procedures are identified as excluded from coverage under the Medicare program as "excluded services", there is no need to address the issue of correct coding with these codes. In the development of National Correct Coding Policy and Correct Coding Edits, these excluded services have been ignored.

T. Unlisted Service or Procedure

The codes listed after each section and/or subsection which end in -99 (or a single -9 in a few cases) are used to report a service that is not described in any code listed elsewhere in the *CPT Manual*. Because of advances in technology or physician expertise with new procedures, a code may not be assigned to a procedure when the procedure is first introduced as accepted treatment. The unlisted service or procedure codes are then necessary to code the service. Every effort should be made to find the appropriate code to describe the service and frequent use of these unlisted codes instead of the proper codes is not appropriate. Correct code assignment would occur after the documentation has been reviewed and bundling of code pairs would then take place based on the changed code or correctly submitted code. For the most part, the unlisted service or procedure codes have not been included in the Correct Coding Policy or Edits because of the multiple procedures that can be assigned to these codes.

U. Modified, Deleted, and Added Code Pairs/Edits

Correct coding (column 1/column 2) and mutually exclusive code pairs/edits have been developed based on the coding conventions defined in the American Medical Association's *CPT Manual* instructions and CPT code descriptions, national and local Medicare policies and edits, the coding guidelines developed by national societies, the analysis of standard medical and surgical practice, and the review of provider billing patterns and current coding practice. Prior to initial implementation, the proposed code pairs/edits underwent scrutiny by Medicare Part B carriers and physicians including Carrier Medical Directors, representatives of the American Medical Association's CPT Advisory Committee, and other national medical and surgical societies. As a part of the ongoing refinement of the National Correct Coding Initiative, a process has been established to address annual changes in CPT and HCPCS Level II codes and manual instructions such as additions, deletions, and modifications of existing codes and guidelines. Additionally, ongoing changes occur based on changes in technology, and standard medical practice, and from continuous input from the AMA, and various specialty societies. During the refinement process, correspondence is received from the AMA, national medical societies, CMS Central and Regional Offices, Contractor Medical Directors, Medicare Part B carriers, individual providers,

physicians’ consultants and other interested parties. The comments and recommendations are evaluated and considered for possible modification or deletion of existing code pairs/edits or additions of new code pairs/edits. Subsequently based on the contributions from these sources, CMS Central Office decides which code pairs/edits are modified, deleted, or added.

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CHAPTER II
ANESTHESIA SERVICES
CPT CODES 00000-09999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter II
Anesthesia Services
CPT Codes 00000 - 09999

A. Introduction

Anesthesia care conventionally includes all services associated with the administration of analgesia/anesthesia, provided by an anesthesiologist and/or certified registered nurse anesthetist (CRNA)[1] to a patient undergoing a surgical or other invasive procedure so that intervention can be undertaken. This may involve local, regional, epidural, general anesthesia or monitored anesthesia care (MAC), and usually involves administration of anxiolytics or amnesia-inducing medications. Additionally, anesthesia care includes preoperatively evaluating the patient with a sufficient history and physical examination so that the risk of adverse reactions can be minimized, planning alternative approaches to accomplishing anesthesia and answering all questions regarding the anesthesia procedure asked by the patient.

The anesthesiologist assumes responsibility for the post-anesthesia recovery period which is included in the anesthesia care package. It encompasses all care until the patient is released to the surgeon or another physician; this point of release generally occurs at the time of release from the post-anesthesia recovery area.

B. Standard Anesthesia Coding

The following policies reflect national Medicare correct coding guidelines for anesthesia services.

1. Principles of Medicare coding for anesthesia services involving administration of anesthesia are reported by the use of the anesthesia five-digit CPT procedure codes (00100-01860). These codes specify "Anesthesia for" followed by a general area of surgical intervention. Subsequent CPT codes (01905-01933) are unique to anesthesia for interventional radiology. Several CPT codes (01990-01999) describe miscellaneous anesthesia services.

[1]In the following, the term CRNA is to be interpreted as including anesthesiologists' assistants.

Anesthesia services are provided by or under the supervision of a physician. These services may include, but are not limited to, general or regional anesthesia and monitoring of physiological parameters during local or peripheral block anesthesia with sedation (when medically necessary), or other supportive services in order to afford the patient anesthesia care deemed optimal by the anesthesiologist during any procedure.

Anesthesia codes describe a general anatomic area or service which usually relates to a number of surgical procedures, often from multiple sections of the *CPT Manual*. For Medicare purposes, only one anesthesia code is reported unless the anesthesia code is an add-on code. In this case, both the code for the primary anesthesia service and the anesthesia add-on code are reported according to *CPT Manual* instructions. It is acceptable to bill the code that accurately describes the anesthesia for the procedure which has the highest basic unit value.

2. Another unique characteristic of anesthesia coding is the reporting of time units for time spent delivering anesthesia. In contrast to some evaluation and management services which can be coded based on time, payment for anesthesia services varies with or increases with increments of time. In addition to billing a basic unit value for an anesthesia service, the units of service reflecting the time of anesthesia attendance are reported. Anesthesia time involves the continuous actual presence of the anesthesiologist and starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision. Non-monitored interval time may not be considered for calculation of time units.

Example: A patient who undergoes a cataract extraction may require monitored anesthesia care (see below). This may require administration of a sedative in conjunction with a peri/retrobulbar injection for regional block anesthesia. Subsequently, an interval of 30 minutes or more may transpire during which time the patient does not require monitoring by an anesthesiologist/certified registered nurse anesthetist. After this period, monitoring will commence again for the cataract extraction and ultimately the patient will be released to the surgeon’s care or to recovery. The time that may be reported would include the time for the monitoring during the block and during the procedure. The interval time and the recovery time

are not to be included in the time unit calculation. Also, if unusual services, not bundled into the anesthesia service, are required, the time spent delivering these services before anesthesia time begins or after it ends may not be included as reportable anesthesia time.

However, if it is medically necessary for the anesthesiologist/CRNA to be in direct one to one observation, monitoring the patient during the interval time, and not billing any other service, the time can be included.

3. It is standard medical practice for an anesthesiologist/CRNA to provide a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service. The time spent in performing the evaluation is included in the base unit of the code and therefore, is not included as anesthesia time. If surgery is canceled, either because of other circumstances or because of findings on the preoperative evaluation by the anesthesiologist and cancellation occurs subsequent to the preoperative evaluation, payment may be allowed to the anesthesiologist for an evaluation and management service and the appropriate E & M code (usually a consultation code) may be reported.

Similarly, routine postoperative evaluation is included in the basic unit for the anesthesia service. Additional time units would be inappropriate and evaluation and management codes are not to be used in addition to the anesthesia code. Postoperative evaluation and management services related to the surgery are not separately payable to the anesthesiologist except in the circumstance where the anesthesiologist is providing significant, separately identifiable services such as ongoing critical care services, postoperative pain management services, or extensive unrelated ventilator management. Management of epidural or subarachnoid drug administration (CPT code 01996) is separately payable on dates of service subsequent to surgery but not on the date of surgery. If the only service provided is management of epidural/subarachnoid drug administration, then an evaluation and management service is not appropriate in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day irrespective of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or CRNA may be able to bill for this service, only one payment will be made per day. Postoperative

pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesiologist unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesiologist.

In certain circumstances critical care services are provided by the anesthesiologist. It is currently national CMS policy that CRNAs cannot be reimbursed for evaluation and management services in the critical care area. In the case of anesthesiologists, the routine immediate postoperative care is not separately reported except as described above. Procedural services such as placement of lines, emergency intubation (outside of the operating suite), etc. are payable to anesthesiologists as well as CRNAs if these procedures are furnished within the parameters of appropriate state licensing laws.

4. One principle of CPT coding is that if a service is usually provided as part of a more comprehensive service, then it should be included in and be considered part of the service. The advances in technology allow for intraoperative monitoring of a variety of physiological parameters. The following preparation/monitoring services are integral to anesthesia services in general and are not to be separately reported:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of external devices necessary for cardiac monitoring, oximetry, capnography, temperature, EEG, CNS evoked responses (e.g. BSER), doppler flow.
- Placement of peripheral intravenous lines necessary for fluid and medication administration.
- Placement of airway (endotracheal tube, orotracheal tube, etc.).
- Laryngoscopy (direct or endoscopically) for placement of airway (endotracheal tube, etc.).
- Placement of naso-gastric or oro-gastric tube.

- Intraoperative interpretation of monitored functions (blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (arterial blood gases such as pH, pO_2, pCO_2, bicarbonate, hematology, blood chemistries, lactate, etc.) by the anesthesiologist/CRNA.
- Nerve stimulation for determination of level of paralysis or localization of nerve(s). Codes for EMG services are for diagnostic purposes for nerve dysfunction; to report these codes a complete report must be present in the medical record.

When the following CPT codes are reported with an anesthesia code, it is assumed that these services are being reported as part of the anesthesia service and so will not be paid in addition to the anesthesia code. Because it is recognized that many of these procedures may occur on the same date of surgery but are not performed in the course of and as part of the anesthesia provision for the day, these codes will be separately paid only if modifier -59 is appended to the code, indicating that the service rendered was independent of the anesthesia service.

CPT codes describing services that, when performed as part of the anesthesia service, would be considered included in the anesthesia code include the following partial list:

- 31505, 31515, 31527 (Laryngoscopy) (Laryngoscopy codes are for diagnostic or surgical services)
- 31622, 31645, 31646 (Bronchoscopy)
- 36000 - 36015 (Introduction of needle or catheter)
- 36400-36440 (Venipuncture and transfusion)
- Blood sample procurement through existing lines or requiring only venipuncture or arterial puncture.
- 62310-62311, 62318-62319 (Injection of diagnostic or therapeutic substance):

CPT codes 62310-62311 and 62318-62319 may be reported on the date of surgery if performed for postoperative pain relief rather than as the means for providing the regional block for the surgical procedure. If a narcotic or other analgesic is injected through the same catheter as the anesthetic, CPT codes 62311 and 62319 should not be billed. Modifier -59 will indicate that the injection was performed for postoperative pain relief but a procedure note should be included in the medical record.

Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesiologist bills for CPT code 01382 for "Anesthesia for diagnostic arthroscopic procedures of knee joint". The epidural catheter is left in place for postoperative pain management. The anesthesiologist may not also bill for CPT codes 62311 (injection of diagnostic or therapeutic substance) or 01996 (daily management of epidural) on the date of surgery. The CPT code 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. On the other hand, if the anesthesiologist performed general anesthesia and bills for CPT code 01382, and reasonably believes that postoperative pain is likely to be sufficient to warrant an epidural catheter, the CPT code 62319-59 may be reported indicating that this is a separate service from the anesthesia service. In this instance, the service is separately payable whether the catheter is placed before, during, or after the surgery. If the epidural catheter was placed on a different date from the surgery, then modifier -59 would not be necessary. The CPT code 01996 may not be reported on dates subsequent to reporting 62319. Evaluation and management codes are used to report daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with 62318-62319.

- 64400-64565 (Nerve blocks)
- 67500 (Retrobulbar injection)
- 81000-81015, 82013, 82205, 82270, 82273 (Performance and interpretation of laboratory tests)
- 90780-90788 (IV infusion - injections)
- 91000, 91055, 91105 (Esophageal, gastric intubation)

- 92511-92520, 92543 (Special otorhinolaryngologic services)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960 (Cardioversion)
- 93000-93010 (Electrocardiography)
- 93015-93018 (Cardiovascular stress tests)
- 93040-93042 (Electrocardiography)
- 93307-93308 (Transthoracic echocardiography when displayed for monitoring purposes.) However, when performed for diagnostic purposes with documentation of a formal report, this service will be considered a significant, separately identifiable, and separately payable service.
- 93312-93317 (Transesophageal echocardiography) However, when performed for diagnostic purposes with documentation of a formal report, this service will be considered a significant, separately identifiable, and separately payable service.
- 93318 (Transesophageal echocardiography for monitoring purposes)
- 93922-93981 (Extremity arterial venous studies) When performed diagnostically with a formal report, this will be considered a significant, separately identifiable, and if medically necessary, a payable service.
- 94640(Inhalation/IPPB treatments)
- 94656, 94660-94662 (Ventilation management/CPAP services) If performed as management for maintenance ventilation during a surgical procedure, this is part of the anesthesia service. This is separately payable

if performed as an ongoing service after transfer out of the operating room or post-anesthesia recovery to a hospital unit/ICU. Modifier -59 would be necessary to signify that this was a separate service.

- 94664 (Inhalations)
- 94680-94690 (Expired gas analysis)
- 94760-94770 (Oximetry)
- 99201-99499 (Evaluation and management)

(This is not a comprehensive list of all services included in anesthesia services.)

When a physician performs a procedure and, incidentally, provides the anesthesia, the anesthesia for the procedure is not reported. (The anesthesia for a procedure, if provided by the surgeon, is included in the global surgery package).

C. Radiologic Anesthesia Coding

In keeping with standard anesthesia billing guidelines for Medicare, only one anesthesia code may be reported for anesthesia services provided in conjunction with radiological procedures. Radiological Supervision and Interpretation (S & I) codes will usually be applicable to radiological procedures being performed.

The appropriate S & I code may be reported by the appropriate provider (radiologist, cardiologist, neurosurgeon, radiation oncologist, etc.). Accordingly, S & I codes are not included in anesthesia codes referable to these procedures; only the appropriate provider, however, may bill for S & I services.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter) can be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable. If the physician performing the radiologic service places a catheter as part of that service, and, through the same site, a catheter is left and used for monitoring purposes, it is inappropriate for either the anesthesiologist/certified registered nurse anesthetist or the physician performing the

radiologic procedure to bill for placement of the monitoring catheter (e.g. CPT codes 36500, 36555-36556, 36568-36569, 36580, 36584, 36597).

D. Monitored Anesthesia Care (MAC)

There has been a shift to providing more surgical and diagnostic services in an ambulatory, outpatient or office setting. Accompanying this, there has also been a change in the provision of anesthesia services from traditional general anesthetic to a combination of local or regional anesthetic with certain conscious altering drugs. This type of anesthesia is referred to as monitored anesthesia care if provided directly by a physician or anesthesiologist or by a medically-directed CRNA. In essence, MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and the recognition and treatment of any adverse changes. CMS recognizes this type of anesthesia service as a payable service if medically necessary and reasonable.

Because monitored anesthesia care (MAC) requires at least the same level of monitoring as that of general anesthesia, it is treated the same as general anesthesia except that the appropriate modifiers must be used for payment purposes. The guidelines as promulgated previously apply equally to MAC. It is particularly important to note that Medicare policy allows only one anesthesia CPT code to be reported, and the time units reported represent only time where the patient was continuously monitored by a physician or anesthesiologist (personally, or a CRNA.) Preoperative and postoperative assessments follow standard anesthesia billing guidelines.

Issues of medical necessity are addressed by National and Local Contractor Medical Review Policy.

E. Anesthesiologists and CRNAs

CMS recognizes the services of anesthesiologists as providers and physicians in a supervisory capacity. Anesthesiologists personally performing anesthesia services bill in a standard fashion, in accordance with CMS regulations as outlined in the Medicare Carriers' Manual Sections §4137 or online internet manual sections Pub.100-4, 12-§50, §4830 or online internet

manual sections Pub.100-4, 12-§40.1A, 40.1D, 50E, 50K, 140.2, §15018 or online internet manual sections Pub.100-4, 12-§50, 50K, 140.3.2. CMS also recognizes CRNAs and anesthesiologists' assistants practicing under the medical direction of anesthesiologists or practicing independently of anesthesiologists. Billing instructions and regulations regarding this arrangement are outlined in the Medicare Carriers' Manual as noted above and in Section §16003 or online internet manual sections Pub.100-4, 12-§140, 140.1, 140.2, 140.3, 140.3.1, 140.4.3, 140.4.4.

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CHAPTER III
SURGERY: INTEGUMENTARY SYSTEM
CPT CODES 10000-19999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter III
Surgery: Integumentary System
CPT Codes 10000 - 19999

A. Introduction

CPT coding of the integumentary system includes coding narrative for services performed by a number of specialties. While the coding system is oriented toward dermatological procedures, the dermatological aspects of the practice of plastic surgery are covered as are the dermatologic elements (particularly closure, tissue transfer, grafts, adjacent and distant flaps) of multiple surgical procedures, especially radical or mutilative surgical procedures. Integumentary procedures are also often performed in staged fashions due to the sophistication of services rendered.

Generally, integumentary procedures include incision, biopsy, removal, paring/curettement, shaving, destruction (multiple methodologies), excision, repair, adjacent tissue rearrangement, grafts, flaps, and specialized services such as burn management and Mohs' Micrographic Surgery.

When a column 1 code describes other column 2 codes, all of which were performed, the column 1 code should be used rather than listing the individual column 2 codes. Additionally, because of the technical advances and changes in technology, standard medical practice should be as accurately reflected in CPT coding as possible. The CPT code should reflect what transpires in a standard surgical setting. Necessary services performed in order to accomplish a more comprehensive service are included in the CPT code describing the more complex service.

B. Evaluation and Management

Evaluation and Management (E & M) of integumentary disorders may represent a separately identifiable service, serve as a prelude to a decision to perform a service, or be performed in follow-up of previously performed procedures. Policies referable to the appropriateness of reporting evaluation and management codes in conjunction with surgical procedures are well established in the standard CMS Global Surgery Policy. In essence, if the evaluation and management service provided is for the purpose of deciding that a major surgical procedure is to be performed, this service is a significant, separately identifiable service and may be reported separately, by attaching modifier -57 to the

appropriate level of evaluation and management service code. Surgical procedures have a "global period" following surgery (generally 0, 10 or 90 days); during this time E & M services provided in follow-up to the surgical procedure have been calculated into the relative value units for the surgery and are not to be separately reported. On the occasion when a separate condition is evaluated and a significant, separately identifiable service for a different problem is provided postoperatively, a separate E & M code may be reported and indicated with the modifier -24.

Surgical dressings, supplies, and local anesthetics used for a procedure are not to be separately reported as routine. There are some exceptions to this policy (e.g. surgical tray used for some office procedures). Wound closures using adhesive strips, topical skin adhesive, or tape alone do not represent a separately identifiable surgical procedure and are, therefore, included in the appropriate E & M service.

C. Anesthesia

Anesthesia for dermatologic procedures, when provided by the physician performing the procedure, is considered part of the procedure. This would include local infiltration, regional block, sedation, etc. performed by the physician doing the procedure. Local anesthesia or local anesthesia with sedation is often accomplished by the physician providing the primary services. General anesthesia or monitored anesthesia care may be required for more extensive dermatologic procedures (extensive debridement, flaps, grafts, etc.). In these cases, if anesthesia services are performed by another provider, the different physician may bill separately for his/her services. Billing for "anesthesia" services rendered by a nurse or other office personnel (unless the nurse is an independent certified nurse anesthetist, CRNA, etc.) is inappropriate as these services are “incident to” the physician’s services.

Use of injection codes for therapeutic injection or aspiration of lesions is inappropriate if the injection is administered for local anesthesia for a specific procedure. CPT codes such as 10160 (puncture aspiration), 20500-20501 (injection of sinus), 20550 (injection(s)of tendon sheath, ligament, etc.), 20600-20610 (arthrocentesis) are not to be reported separately if they are used to reflect local anesthetic techniques for another procedure.

In the postoperative state, patients treated with epidural or subarachnoid continuous drug administration will require daily hospital adjustment/management of the catheter, dosage, etc. (CPT code 01996). This service may be coded by the anesthesiologist for payment. The management of postoperative pain by the surgeon, including epidural or subarachnoid drug administration, is included in the global period associated with the operative procedure. If no surgery is performed but a catheter is placed for pain control (e.g. burn injury not requiring surgery), CPT code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is appropriately reported by the managing physician.

D. Incision and Drainage

Incision and drainage services, as related to the integumentary system, generally involve cutaneous or subcutaneous drainage of cysts, pustules, infections, hematomas, seromas or fluid collections. In cases where, in the course of an excision of a lesion, an area of involvement is identified which requires drainage, either as a part of the procedure or in order to gain access to the area of interest, coding/billing for incision and drainage of this fluid collection would be inappropriate if the excision or other procedure is performed in the same session.

Example: A patient who presents with a pilonidal cyst may require simple incision/drainage or may require an extensive excision. In the former case, the appropriate CPT coding is 10080 (or 10081 if complicated). If the pilonidal cyst is excised, while it is obvious that drainage from the cyst will occur in the course of its excision, the appropriate coding is CPT code 11770 (or 11771 or 11772, depending on the complexity), not CPT codes 10080 and 11770. If it is evident that an extensive cellulitis is present around the cyst preventing the complete procedure from being accomplished, it may be reasonable to bill for CPT code 10080, then, after perhaps a week of antibiotic therapy, complete the procedure using 11770-78 (Return to the operating room for a related procedure during the postoperative period.) The nature of the treatment should be driven by medical decision making rather than by coding conventions.

1. Procedure codes such as incision and drainage of hematomas (e.g. CPT Code 10140) are not to be reported if reported during

the same session or at the same site as an excision, repair, destruction, removal, etc.

2. Codes describing services necessary to address complications, such as CPT code 10180 (incision and drainage, complex, postoperative wound infection) should not be submitted for services rendered at the same surgical session that resulted in the complication. If performed in conjunction with the primary procedure, it would be included in the primary, column 1, procedure. For example, if a patient has undergone a thoracotomy and a necrotizing pneumonia with empyema develops, it may be necessary to perform a lobectomy through the previous incision. The reason for the surgery is to perform the lobectomy; therefore the lobectomy code should be reported. Since the drainage of the empyema is necessary to accomplish the lobectomy, it would be inappropriate to bill for CPT code 10180 (incision and drainage). On the other hand, if the patient would only require drainage of a thoracotomy wound infection (without lobectomy) and it is determined to be medically necessary to place a gastrostomy tube at the same time, the CPT code 10180 could be reported with the appropriate gastrostomy tube placement code.

E. Lesion Removal

For a given lesion, only one type of removal is reported, whether it is destruction (e.g. laser, freezing), debridement, paring, curettement, shaving or excision. CPT definition describes the nature of each of these forms of removal. CPT definition also defines the lesions (specifically full thickness excision) by lesion diameter. In the case where an initial attempt using a less invasive procedure is followed by a more invasive lesion removal, the more complex procedure used would be appropriately reported, but not both procedures. Additionally, multiple codes describing destruction of a lesion are not to be reported for a given lesion; if multiple distinct lesions are removed using different methods, an anatomic modifier or modifier -59 would be used to indicate a different site, a different method or a different lesion. The distinct location of the lesions should be reflected in the medical record.

A lesion biopsy represents a partial removal of a lesion and is frequently performed as a part of a lesion excision in order, for example, to procure a pathological specimen. Generally, a part of, or the entire lesion is submitted for biopsy. When a biopsy is performed as part of a lesion removal, it is part of the

overall procedure and is not to be considered as a separate procedure.

If a biopsy is performed on a separate date at a separate session, and subsequently a definitive procedure is performed, the biopsy code may be reported, followed by a separate removal code, indicating the different dates of service.

Tissues removed are often submitted for surgical pathological evaluation; in some cases, physicians qualified in dermatopathology may perform these evaluations. These codes generally include CPT codes 88300-88309 (surgical pathology). Additionally, when the physician is asked to review slides obtained from another physician's excision, and subsequently performs additional removal/biopsy, a separate code for review of outside slides is not reported, i.e. CPT code 88321, in addition to an evaluation and management service. The decision to perform surgery is generally based on an evaluation and management service which includes review of prior records including tissues, slides, etc.) The dermatopathology evaluation must be medically necessary and reasonable. When lesions of like nature (e.g. multiple seborrheic keratoses) are encountered, removal of multiple lesions is frequently accomplished at the same operative session. If it is determined to be medically necessary to separately submit the lesions for pathologic evaluation, documentation of the precise location of each separately submitted lesion must be present. If multiple lesion specimens are submitted as a collective group without documentation specifying locations sufficient to differentiate the source of each specimen, then the surgical pathology code should be submitted as one specimen (one unit of service) even if the specimens were subsequently separated.

Lesions or margins obtained during Mohs' Micrographic Surgery should not be coded under the surgical pathology codes. The definition of Mohs' Micrographic Surgery includes the services defined by the surgical pathology codes (CPT codes 88300-88309) and excision codes (CPT codes 11600-11646 and 17260-17286). These procedure codes are part of the Mohs' Micrographic Surgery CPT codes (17304-17310). Billing separately for one of the above pathology and/or one of the excision codes is inappropriate. It is recognized that a Mohs' surgeon may find it necessary to obtain a diagnostic biopsy in order to make the decision to perform surgery. When a diagnostic biopsy is necessary, it may be reported separately. Modifier -58 may be utilized to indicate

that the diagnostic biopsy and Mohs' Micrographic Surgery are staged or planned procedures.

Lesion removal, by whatever method (usually excisional), may require simple, intermediate, or complex closure and, in unusual circumstances, tissue transfer procedures. When the lesion removal requires only bandaging, strip closure or simple closure (see CPT definition of simple closure), this is included in the lesion excision and is not to be reported separately.

Accordingly, CPT codes 12001-12021 (simple repairs) are considered part of the lesion removal codes. Intermediate and complex closures, when medically necessary, may be coded separately. In the case of Mohs' Micrographic Surgery (CPT codes 17304-17310) all necessary repairs may be coded.

In the course of destruction, excision, incision, removal, repair, or closure, debridement of non-viable tissue surrounding a lesion, injury or incision is often necessary to accomplish the primary service. The debridement codes (CPT codes 11000-11042) are not to be reported separately, as this service is necessary as a part of the total procedure according to standard medical practice.

CPT codes describing intralesional chemotherapy (CPT Codes 96405, 96406) refer to injection of chemotherapeutic agents into one or multiple lesions. CPT codes 11900 and 11901 describe non-specific intralesional injection(s) into one or more lesions. While one or the other code may be appropriate for a given service, both lesion injection codes are not to be reported together (unless separate lesions are injected with different agents, in which case modifier -59 should be attached to the intralesional injection code). The CPT codes 11900, 11901 (injection, intralesional) are not to be used for local anesthetic injection in anticipation of chemotherapy or any other definitive service performed on a lesion or group of lesions. Local anesthesia is considered a part of the definitive procedure. These intralesional CPT injection codes (96405, 96406, 11900 and 11901) are included in the following list of CPT codes if the injection represents local anesthesia:

11200 - 11201 (Removal of skin tags)
11300 - 11313 (Shaving of lesions)
11400 - 11471 (Excision of lesions)
11600 - 11646 (Excision of lesions)

12001 - 12018	(Repair - simple)
12020 - 12021	(Treatment of wound dehiscence)
12031 - 12057	(Repair - intermediate)
13100 – 13160	(Repair - complex)
11719 - 11762	(Trimming, debridement and excision of nails)
11770 - 11772	(Excision of pilonidal cysts)
11765	(Wedge excision)

F. Repair and Tissue Transfer

When lesional excision is of such an extent that closure cannot be accomplished by simple, intermediate, or complex closure, other methodology must be employed. Frequently adjacent tissue transfer or tissue rearrangement is employed (Z-plasty, W-plasty, flaps, etc.). This family of codes, (CPT codes 14000-14350), involves excision with adjacent tissue transfer and correlates to excision codes. Excision CPT codes (11400-11646) and repair CPT codes (12001 – 13160) are not to be separately reported when CPT codes 14000-14350 are reported. On the other hand, skin grafting performed in conjunction with these codes may be separately reported if it is not included in the specific code definition. In the case of closure of traumatic wounds, these codes are appropriate only when the closure requires the surgeon to develop a specific adjacent tissue transfer; lacerations that coincidentally are approximated using a tissue transfer technique (e.g. Z-plasty, W-plasty) should be reported with the more simple closure code. Debridement necessary to accomplish these tissue transfer procedures is part of the column 1 procedure performed. Separate debridement CPT codes (11000-11042) or repair CPT codes (12001-13160) would be inappropriately reported with these CPT codes (14000-14350) for the same lesion/injury. Procurement of cultures or tissue samples as a part of a closure are included in the closure code and are not to be separately reported.

G. Grafts and Flaps

Free skin grafts are coded by type (split or full), location, and size. For a specific location, a primary code is defined and followed by a supplemental code for additional coverage area. As a result of this coding scheme, for a given area of involvement, the initial code is limited to one unit of service; the supplemental code may have multiple units of service depending on the area to be covered. Because, for a specific area, only one type of skin graft is typically applied, the primary free skin

graft CPT codes (15100, 15120, 15200, 15220, 15240, 15260) are mutually exclusive to one another. If multiple areas require different grafts, a modifier indicating different sites should be used (anatomic or modifier -59).

Generally, debridement of non-intact skin (CPT codes 11000-11042) in anticipation of a skin graft is necessary prior to application of the skin graft and is included in the skin graft (CPT codes 15050-15400). When skin is intact, however, and the graft is being performed after excisional preparation of intact skin, the CPT code 15000 (Excisional preparation) is separately reported. CPT code 15000 is not to be used to describe debridement of non-intact, necrotic or infected skin, nor is its use indicated with other lesion removal codes.

1. CPT codes 15350 (application of allograft) and 15400 (application of xenograft) are part of all other graft codes and are not to be separately reported with other grafts (CPT codes 15050 - 15261) for graft placement at the same site.

2. The CPT code 67911 describes the "Correction of lid retraction;" a parenthetical notation is added advising that, if autogenous graft materials are used, tissue graft codes 20920, 20922 or 20926 can be reported. Accordingly, all other procedures necessary to accomplish the service are included.

3. Flap grafts (CPT codes 15570-15576) include excision of lesions at the same site (CPT codes 11400-11646).

H. Breast (Incision, Excision, Introduction, Repair and Reconstruction)

Because of the unique nature of procedures developed to address breast disease, a section of CPT (19000-19499) is set aside for such services.

Fine needle aspiration biopsies, core biopsies, open incisional or excisional biopsies, and related procedures performed to procure tissue from a lesion for which an established diagnosis exists are not to be reported separately at the time of a lesion excision unless performed on a different lesion or on the contralateral breast. However, if a diagnosis is not established, and the decision to perform the excision or mastectomy is dependent on the results of the biopsy, then the biopsy is separately reported. Modifier -58 may be used

appropriately to indicate that the biopsy and the excision or mastectomy are staged or planned procedures.

Because excision of lesions occur in the course of performing a mastectomy, breast excisions are not separately reported from a mastectomy unless performed to establish the malignant diagnosis before proceeding to the mastectomy. Specifically CPT codes 19110-19126 (breast excision) are in general included in all mastectomy CPT codes 19140-19240 of the same side. However, if the excision is performed to obtain tissue to determine pathologic diagnosis of malignancy prior to proceeding to a mastectomy, the excision is separately reportable with the mastectomy. Modifier –58 should be utilized in this situation.

Use of other integumentary codes for incision and closure are included in the codes describing various breast excision or mastectomy codes. Because of the frequent need to excise lymph node or muscle tissue in conjunction with mastectomies, these procedures have been included in the CPT coding for mastectomy. It would be inappropriate to separately report ipsilateral lymph node excision in conjunction with the appropriate mastectomy codes. However, sentinel lymph node biopsy is separately reported when performed prior to a localized excision of breast or a mastectomy with or without lymphadenectomy. Open biopsy or excision of sentinel lymph node(s) should be reported as follows: axillary (CPT codes 38500 or 38525), deep cervical (CPT code 38520), internal mammary (CPT code 38530). In the circumstance where a breast lesion is identified and it is determined to be medically necessary to biopsy or excise the contralateral lymph nodes, use of the biopsy or lymph node dissection codes (using the appropriate anatomic modifier, -LT or -RT for left or right) would be acceptable. Additionally, breast reconstruction codes that include the insertion of a prosthetic implant are not to be reported with CPT codes that describe the insertion of a breast prosthesis only.

The CPT coding for breast procedures generally refers to unilateral procedures; when performed bilaterally, modifier -50 would be appropriate. This is identified parenthetically, where appropriate, in the CPT narrative.

I. Add-on Codes

There are a number of supplemental CPT codes known as “add-on” codes defined in the *CPT Manual*. The following is a listing of

add-on codes present in the integumentary section of the *CPT Manual*. Although, not all-inclusive, the add-on code must be used in combination with the primary CPT code or the add-on code cannot be reported.

Primary CPT code	***Add-on CPT code***
11000 (Debridement up to 10%)	*11001 (Each additional 10%)*
11200 (Removal of skin tags, up to and including 15 lesions)	*11201 (Each additional 10 lesions)*
11730 (Avulsion of nail plate)	*11732 (Each additional nail plate)*
15100 (Split Graft, 100 sq.cm. or less)	*15101 (Each additional 100 sq.cm.)*
15240 (Full Thickness Graft 20 sq.cm. or less)	*15241 (Each additional 20 sq.cm.)*

J. General Policy Statements

1. Repair/closure of a surgical incision, CPT codes 12001-12018, is not separately reported from other surgical procedures. The closure is an intricate part of the surgical procedure performed. As noted previously, simple closure of dermatologic excisions is included in the dermatologic procedure.

2. CPT codes 15851 - 15852 refer to suture removal and dressing change under anesthesia. These codes are not to be reported when a patient requires a general anesthesia for a related procedure (e.g. a return to the operating room for complications where an incision is reopened necessitating removal of sutures and redressing). Additionally, these codes, particularly CPT code 15852, are not to be reported with a primary procedure performed under general anesthesia.

3. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

4. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

5. The NCCI edits with column 1 CPT codes 11055-11057 (Paring or cutting of benign hyperkeratotic lesions) each with column 2 CPT codes 11720-11721 (Nail debridement by any method) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 11720 or 11721 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed for lesions anatomically separate from one another or if the two procedures are performed at separate patient encounters. CPT codes 11055-11057 must not be used to report removal of hyperkeratotic skin adjacent to nails needing debridement.

6. The NCCI edits with column 1 CPT codes 17000 and 17004 (Destruction of benign or premalignant lesions) each with column 2 CPT code 11100 (Biopsy of single skin lesion) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 11100 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed on separate lesions or at separate patient encounters. Refer to the *CPT Manual* instructions preceding CPT code 11100 for additional clarification about the codes 11100-11101.

7. The NCCI edit with column 1 CPT code 11719 ((Trimming of nondystrophic nails) and column 2 CPT code 11720 (Nail debridement by any method, one to five nails) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 11720 of this NCCI edit is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters.

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CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter IV
Surgery: Musculoskeletal System
CPT Codes 20000 - 29999

A. Introduction

The general guidelines regarding correct coding apply to the CPT codes in the range of 20000-29999. Specific issues unique to this section of CPT are clarified in the following guidelines.

B. Anesthesia

Anesthesia administered by a physician performing a procedure is included in the procedure. Accordingly, injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not to be separately reported. Specifically, the CPT codes 20526-20553 (therapeutic injection and injections of tendon sheath, ligament, muscle) are not to be used as an injection code to provide local anesthesia for a surgical, closed, manipulative or other procedure; this is not the intent of the CPT code. Many code pair edits are included in the National Correct Coding Initiative based on this policy. When separate anatomic areas are being treated, the appropriate anatomic modifier or modifier -59 should be used to indicate this situation.

C. Biopsy

In accordance with the sequential procedure policy, when a biopsy is performed in conjunction with any excision, destruction, removal, repair, or internal fixation procedure, the biopsy procedure is not to be separately coded assuming a diagnosis has already been established which makes the excision, destruction, removal, repair, or fixation procedure medically necessary. If the biopsy is performed at a different site and represents a significant, separately identifiable service, a biopsy service can be reported. For example, if a patient presents with an upper extremity fracture and, during an internal fixation procedure, it is determined to be medically reasonable to perform a bone biopsy of the iliac crest while under the same anesthetic, a separate service for a bone biopsy, with modifier -59, could be reported. If, however, through the same incision, a biopsy of the humerus was obtained, this service is not to be separately reported. In the circumstance where the decision to perform the more comprehensive procedure (excision, destruction, removal,

repair or fixation procedure) is dependent on the results of the biopsy procedure, the biopsy procedure may be separately reported.

Additionally, in accordance with the sequential procedure policy, when an arthroscopic procedure is followed by an open procedure at the same session, only the column 1 service is reported; generally, this would be the open procedure. If an arthroscopic service is performed at one site and an open procedure is performed at another, the arthroscopic service is reported with a modifier indicating that these services were performed at different anatomic sites (e.g. modifiers -RT or -LT, modifier -59, etc.)

D. Fractures

1. In general, the application of external immobilization devices (including casts) at the time of a procedure also includes removal services during (or after) the post-procedure period. CPT codes have been included for removal and modification of external fixation devices by a physician other than the physician who initially applied the device. These codes are not to be reported by the same entity (physician, practice, group, etc.) that performed the initial application service. When the initial service includes only an evaluation and management service and does not include a definitive procedure (e.g. surgical repair, reduction of a fracture or joint dislocation) the cast/strapping may be separately reported from the evaluation and management service. When the only service rendered at a visit is cast or strapping application, a separate evaluation and management service should not be reported unless separate evaluation/management services are performed that satisfy the evaluation and management guidelines. CPT codes describing modification or removal of casts (e.g. 29700-29750) are not to be reported when these modifications are performed at the same session as the primary (open or closed) procedure.

2. Different codes have been created for removal of internal fixation devices as a separate procedure and modification/removal of these devices in conjunction with other procedures. When a superficial or deep implant (buried wire, pin, rod) requires a surgical procedure to remove (e.g. CPT code 20670), and it is performed as a separate procedure, this service may be reported. On the other hand, when the service is necessary to accomplish

another procedure involving the same area, it is not to be reported separately.

3. In accordance with the general policy on more extensive procedures, when a fracture requires closed reduction followed by open reduction at the same patient encounter (e.g. inability to accomplish the closed reduction), only the open reduction service is reported.

4. When interdental wiring (e.g. CPT code 21497) is necessary in the treatment of facial (or other) fractures, as part of a facial reconstructive surgery, or arthroplasty, it is included as part of the service; accordingly, a separate service using the CPT code 21497 is not reported. If reported with other head and neck procedure codes, it should be coded with modifier -59, indicating a separate distinct service was performed. The medical record should reflect the nature of the separately identifiable service.

5. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion or accomplish fracture reduction as part of another related procedure, the corresponding manipulation code (e.g. CPT codes 22505, 23700, 27275, 27570, 27860) is not to be separately reported.

E. General Policy Statements

1. When a tissue transfer procedure (e.g. graft) is described in the principal procedure code, a separate service is not reported for performing the tissue transfer service necessary to complete the procedure.

2. In situations where monitoring of interstitial fluid pressure is routinely performed as part of the postoperative care (e.g. distal lower extremity procedures with risk of anterior compartment compression), a separate code for monitoring of interstitial fluid pressure (e.g. CPT code 20950) should not be reported.

3. When electrical stimulation is used to aid bone healing, the appropriate bone stimulation codes (CPT codes 20974-20975) should be reported; the codes for nerve stimulation (CPT codes 64550-64595) are inappropriate for this service. If a

neurostimulator is medically necessary for other indications (e.g. pain control), a separate service is reported, however, modifier -59 should be attached indicating that this service is distinct in that it represents treatment of different symptoms; accordingly the medical record should reflect the indication for the nerve stimulator. In addition, CPT codes 97014 and 97032 (physical medicine for electrical stimulation) are not to be reported in conjunction with the above listed codes by the surgeon.

4. Routinely, exploration of the surgical field is performed during a surgical session. Codes describing independent exploratory services are not to be reported when a more comprehensive procedure is being performed in the same area. Specifically, an exploration code such as CPT code 22830 (exploration of spinal fusion) is not reported with other procedures involving the spine unless performed at a different site/different incision from the other procedure (s). If, for example, a cervical spine procedure was being performed, and, at the same operative session, a lumbar fusion was explored through a separate incision, the CPT code 22830-59 could be reported assuming the requirement for medical necessity was satisfied.

5. Debridements (CPT codes 11040-11042, and 11720-11721) are included in the surgical procedures conducted on the musculoskeletal system when debridement of tissue is in the immediate surgical field of other than fractures and dislocations. If, however, tissue debridement is necessary for a more extensive area (e.g. concurrent soft tissue damage due to trauma), the debridement codes can be reported. In open fractures and/or dislocations, debridement of tissue due to the fracture should be separately reported using the CPT codes 11010-11012.

6. Grafts, such as CPT codes 20900-20924, are only to be separately reported if the major procedure code description does not include graft in its definition.

7. The CPT code 20926 is a general code for tissue grafting (e.g. paratenon, fat, dermis) to be used when the primary procedure does not include grafting and when another graft code does not more accurately describe the nature of the grafting procedure being performed. Accordingly, it should not be used with codes in which the graft is already listed as a part of the

procedure or with other grafting codes (see Chapter III for other graft codes).

8. CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29871-29889). Report G0289 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee).

9. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

10. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

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CHAPTER V
SURGERY: RESPIRATORY, CARDIOVASCULAR, HEMIC AND LYMPHATIC SYSTEMS
CPT CODES 30000-39999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter V
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems
CPT Codes 30000 - 39999

A. Introduction

The general guidelines regarding correct coding apply to the CPT codes in the range of 30000-39999. Specific issues unique to this section of the *CPT Manual* are clarified in the following guidelines.

B. Respiratory System

1. Because the upper airway is bordered by a mucocutaneous margin, several CPT codes may define services involving biopsy, destruction, excision, removal, revision, etc. of lesions of this margin, specifically the nasal and oral surfaces. When billing a CPT code for these services, only one CPT code which most accurately describes the service performed should be coded, generally either from the CPT section describing integumentary services (CPT codes 10040-19499) or respiratory services (CPT codes 30000-32999). When the narrative accompanying the CPT codes from the respiratory system section includes tissue transfer (grafts, flaps, etc.), individual tissue transfer/graft/flap codes (e.g. CPT codes 14000-15770) are not to be separately coded.

2. In keeping with the general guidelines previously promulgated, when a biopsy of an established lesion of the respiratory system is obtained as part of an excision, destruction, or other type of removal, either endoscopically or surgically, at the same session, a biopsy code is not to be reported by the surgeon in addition to the removal code. In the case of multiple similar or identical lesions, the biopsy code is not separately reported even if performed in a different area. As noted previously, in the circumstance where the decision to perform the more comprehensive procedure (excision, destruction, or other type of removal) is dependent on the results of the biopsy, the procedure may be separately reported. If, at the same session, a biopsy is necessary to establish the need for surgery, modifier -58 would be used to indicate this.

Example: If a patient presents with nasal obstruction, sinus obstruction and multiple nasal polyps, it may be reasonable to perform a biopsy prior to, or in conjunction with, polypectomy and ethmoidectomy; in this case a separate code (e.g. CPT code 31237 for nasal/sinus endoscopy) is not to be reported with the column 1 nasal/sinus endoscopy code (e.g. CPT code 31255) even though the latter code does not specifically list a biopsy in its CPT narrative because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic endoscopy of the respiratory system is performed, it is routine to evaluate the access regions as part of the medically necessary service; a separate service for this evaluation is not to be reported. For example, if an anterior ethmoidectomy is endoscopically performed, it is inappropriate to bill a diagnostic nasal endoscopy simply because the approach to the sinus was transnasal. As another example, fiberoptic bronchoscopy services routinely involve a limited inspection of the nasal cavity, the pharynx and the larynx; only the bronchoscopic code is reported, not with the nasal endoscopy, laryngoscopy, etc., for this service as this service is routine and incidental to the bronchoscopy.

If a diagnostic endoscopy is performed, and this results in a decision to perform a (non-endoscopic) surgical procedure, then this endoscopy could be separately reported, indicating that this represented a distinct diagnostic service. Modifier -58 may be used to denote that the diagnostic endoscopy and the non-endoscopic surgical procedure are staged or planned procedures. Diagnostic endoscopy of the respiratory system (e.g. sinus endoscopy, laryngoscopy, bronchoscopy, pleuroscopy, etc.) performed at the same encounter as a surgical endoscopy is included in the surgical endoscopy according to *CPT Manual* guidelines. However, when an open surgical procedure is performed and, at the same session, is accompanied by a "scout" endoscopy to evaluate the surgical field, the endoscopy code is not reported separately. This policy applies either if the endoscopic procedure is to confirm the anatomical nature of the patient's respiratory system or adequacy of the surgical procedure (e.g. tracheostomy, etc.). Additionally if an attempt to perform an endoscopic procedure fails and is converted to an open procedure, the endoscopic procedure is not separately reportable with the open procedure.

Example: If a patient presents with aspiration of a foreign body and a bronchoscopy is performed indicating a lobar foreign body obstruction, an attempt may be made to remove this bronchoscopically. It would be inappropriate to code and bill for CPT codes 31622 (bronchoscopy - diagnostic) and 31635 (surgical bronchoscopy with removal of foreign body); only the "surgical" endoscopy, CPT code 31635, would be appropriate. In this example, if the endoscopic effort is unsuccessful and a thoracotomy is planned, the diagnostic bronchoscopy could be separately coded in addition to the thoracotomy. Modifier -58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. If the surgeon decided to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, billing a service for this confirmatory bronchoscopy is inappropriate, although the initial diagnostic bronchoscopy could still be reported. Additionally, the failed bronchoscopic attempt to remove the foreign body should not be reported with an open procedure to remove the foreign body.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service is reported. If the medically necessary service was the sinusotomy and the endoscopy was performed to evaluate adequacy or visualize the sinus cavity for disease, then the primary procedure would be best represented by the appropriate sinusotomy CPT procedure code. On the other hand, as a sinusotomy is usually required to accomplish a medically necessary diagnostic (or surgical) sinus endoscopy, the sinus endoscopy would be the primary (medically necessary) service and should be reported. *CPT Manual* narrative indicates that a surgical sinus endoscopy always includes a sinusotomy and diagnostic endoscopy.

5. Control of bleeding during a procedure is an integral part of endoscopic procedures and is not separately reported (e.g. CPT code 30901 for control of nasal hemorrhage is not to be reported with CPT code 31235 for nasal/sinus endoscopy, etc.). If bleeding is a late complication and requires a significant, separately identifiable service after the patient has been released from the endoscopic procedure, a separate service may be reported with modifier -78 indicating that a related procedure was performed to treat a complication during the postoperative period.

6. When endoscopic procedures are performed, the most comprehensive code describing the service rendered is reported. If multiple procedures are performed and not adequately described by a single CPT procedure code, more than one code may be reported; however, the multiple procedure modifier -51 is attached to the appropriate secondary service CPT codes. Additionally, only medically necessary services are reported; incidental examination of other areas are not to be separately reported.

7. When laryngoscopy is required for placement of an endotracheal tube (e.g. CPT code 31500), a laryngoscopy code is not to be separately coded. Additionally, when a laryngoscopy is used to place an endotracheal tube for non-emergent reasons (e.g. general anesthesia, bronchoscopy, etc.) a separate service is not to be reported for the laryngoscopy. The CPT code 31500 refers only to endotracheal intubation as an emergency procedure and is not reported when an elective intubation is performed. When intubation is performed in the setting of a rapidly deteriorating patient who will require mechanical ventilation, a separate service may be reported with adequate documentation of the reasons for intubation.

8. When tracheostomy is performed as an essential part of laryngeal surgery, in accordance with the separate procedure policy, the CPT code 31600 is not separately reported. This would include laryngotomy, laryngectomy, laryngoplasty codes or other codes that routinely require placement of a tracheostomy.

9. If a laryngoscopy is required for the placement of a tracheostomy, the tracheostomy (CPT codes 31603-31614) is reported and not the laryngoscopy.

10. CPT code 92511 (nasopharyngoscopy with endoscopy) should not be reported as a distinct service when performed as a cursory inspection with other respiratory endoscopic procedures.

11. A surgical thoracoscopy is included in and not to be separately reported from an open thoracotomy when performed at the same session; the thoracotomy would represent the more extensive procedure successfully accomplished. If, however, the thoracoscopy was performed for purposes of an initial diagnosis and the decision to perform surgery is based on the results of the thoracoscopy, then it is separately reported. Modifier -58 may be used to indicate that the diagnostic thoracoscopy and the thoracotomy are staged or planned procedures.

C. Cardiovascular System

1. Procurement of a venous graft is integral to the performance of a coronary artery bypass using venous bypasses. CPT codes 37700-37735 (ligation of saphenous veins) are not to be separately reported in addition to CPT codes 33510-33523 (coronary artery bypass).

2. When a coronary artery bypass is performed, the more comprehensive code describing the procedure performed should be used. When venous grafting only is performed, only one code in the group of the coronary artery bypass CPT codes 33510-33516 (venous graft only) can be reported; no other bypass codes should be reported with these codes. One code in the group of CPT codes 33517-33523 (combined arterial-venous grafting) and one code in the group of CPT codes 33533-33536 (arterial grafting) can be reported together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, only one code in the group of CPT codes 33533-33536 (arterial grafting) is coded.

3. During venous or combined arterial venous coronary artery bypass grafting procedures (CPT codes 33510-33523), it is occasionally necessary to perform epi-aortic ultrasound. This procedure may be reported with CPT code 76986 (ultrasonic guidance, intraoperative) appending modifier -59. CPT code 76986 should not be reported for ultrasound guidance utilized to procure the vascular graft.

4. When an intervascular shunt procedure is performed as a part of another procedure at the same site requiring vascular revision, a service for a shunt procedure is not separately reported from CPT codes 36800-36861 (intervascular cannulization/shunt). By *CPT Manual* definition, this series of codes represents “separate procedures” (see separate procedure policy in Chapter I, Section J).

5. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy and/or bypass. When a thromboendarterectomy is undertaken at the site of the aneurysm and it is necessary for an aneurysm repair or graft insertion, a separate service is not reported for the thromboendarterectomy. Additionally, if only a bypass is placed, which may require an endarterectomy to place the bypass graft, only the code describing the bypass can be reported. If both an aneurysm repair (e.g. after rupture) and a bypass are performed

at separate non-contiguous sites, the aneurysm repair code and the bypass code should be reported with an anatomic modifier or modifier -59.

If a thromboendarterectomy is medically necessary, due to vascular occlusion on a different vessel at the same session, the appropriate code may be reported, but should include an anatomic modifier or modifier -59, indicating that this represents non-contiguous vessels. At a given site, only one type of bypass (venous, non-venous) code can be reported. If different vessels are bypassed by different methodology, separate codes may be reported. If the same vessel has multiple obstructions and requires different types of bypass in different areas, separate codes may be reported; however, it will be necessary to indicate that multiple procedures were performed by using an anatomic modifier or modifier -59.

6. When an open vascular procedure (e.g. thromboendarterectomy) is performed, the closure and repair are included in the description of the vascular procedure. Accordingly, the CPT codes 35201-35286 (repair of blood vessel) are not to be reported in addition to the primary vascular procedure.

7. When an unsuccessful percutaneous vascular procedure is followed by an open procedure at the same session/same physician (e.g. percutaneous transluminal angioplasty, thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the service for the successful procedure, which is usually the more extensive, open procedure is reported (see sequential procedure policy, Chapter I, Section M). In the case where a percutaneous procedure is performed at the site of one lesion, and an open procedure is performed at a separate lesion, the services for the percutaneous procedure should be reported with modifier -59 only if the lesions are in distinct anatomical vessels.

8. The HCPCS/CPT codes 36000, 36406, 36410, 90784, etc. represent very common procedures performed to gain venous access for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy, drug administration, among others. When intravenous access is routinely obtained in the course of performing other medical/diagnostic/surgical procedures, or is necessary to accomplish the procedure (e.g. infusion therapy, chemotherapy), it is inappropriate to bill separately for the venous access services. The work of gaining routine vascular

access is integral to and therefore included in the work value of the procedure. When the service is performed alone or a service does not routinely require vascular access, these codes may be separately reported. While this represents a general policy statement, specific policy statements are written for further clarification elsewhere. When transcatheter therapy services are performed, the placement of the needle and catheter are included in the primary service.

9. When a (non-coronary) percutaneous intravascular interventional procedure is performed at the same session/site as diagnostic angiography (arteriogram/venogram), only one selective catheter placement code for the involved site should be reported. If the angiogram and the percutaneous intravascular interventional procedure are not performed in immediate sequence and the catheters are left in place during the interim, a second selective catheter placement or access code should not be reported. Additionally, dye injections to position the catheter should not be reported as a second angiography procedure.

10. Diagnostic angiograms performed on the same date of service as a percutaneous intravascular interventional procedure should be reported with modifier -59. If a diagnostic angiogram was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifiers -52 and -59. If the prior diagnostic angiogram was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

11. When a median sternotomy is performed to accomplish cardiothoracic procedures, the repair of the sternal incision is part of the primary procedure. The CPT codes 21820-21825 (treatment of sternum fracture) are not separately reported nor should the removal of embedded wires be reported if a repeat procedure or return to the operating room (e.g. postoperative hemorrhage on the day of surgery) is necessary.

12. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples, billing for the sample collection separately is inappropriate.

13. Peripheral vascular bypass CPT codes describe bypass procedures using venous grafts (CPT codes 35501-35587) and using other types of bypass procedures (arterial reconstruction, composite). Because, at a given site of obstruction, only one type of bypass is performed, these groups of codes are mutually exclusive. When different sites are treated with different bypass procedures in the same operative session, the different bypass procedures may be separately reported, using an anatomic modifier or modifier -59.

14. Vascular obstruction may be caused by thrombosis, embolism and/or atherosclerosis as well as other conditions. Treatment may, therefore, include thrombectomy, embolectomy and/or endarterectomy; these procedures may be performed alone or in combination. CPT codes are available describing the separate services (CPT codes 34001 - 34203) and describing these services with thromboendarterectomy (CPT codes 35301 - 35381). Only the more comprehensive code describing the services performed for a given site can be reported; therefore, for a given site, a code from both of the above groups cannot be reported together. Additionally, in accordance with the sequential procedure policy, if a balloon thrombectomy fails, and requires a performance of an open thromboendarterectomy, only the more comprehensive service that was performed (generally the open procedure) is reported.

15. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the column 1 atherectomy procedure that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M).

16. CPT codes 35800-35860 are to be used when a return to the operating room is necessary for exploration for postoperative hemorrhage; accordingly, these codes are not to be coded for bleeding that occurs during the initial operative session. Generally, when these codes are used, they are to be reported with modifier -78 indicating that the service represents a return to the operating room for a related procedure during the postoperative period.

D. Hemic and Lymphatic Systems

When bone marrow aspiration is performed alone, the appropriate code to report is CPT code 38220. When a bone marrow biopsy is performed, the appropriate code is CPT code 38221 (bone marrow biopsy); this code cannot be reported with CPT code 20220 (bone biopsy). CPT codes 38220 and 38221 may only be reported together if the two procedures are performed at separate sites or at separate patient encounters. Separate sites include bone marrow aspiration and biopsy in different bones or two separate skin incisions over the same bone. When both a bone marrow biopsy (CPT code 38221) and bone marrow aspiration (CPT code 38220) are performed at the same site through the same skin incision, only the bone marrow biopsy (CPT 38221) should be reported.

E. General Policy Statements

1. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

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CHAPTER VI
SURGERY: DIGESTIVE SYSTEM
CPT CODES 40000 - 49999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter VI
Surgery: Digestive System
CPT Codes 40000 - 49999

A. Introduction

The general policy statements defined previously also apply to procedures described by the CPT range of codes, 40490-49999, that deal with the digestive system. The nature of services identified in this section requires specific clarification in relationship to these general policy statements.

B. Endoscopic Services

Endoscopic services are performed in many settings, i.e. office, outpatient, and ambulatory surgical centers (ASC). Procedures that are performed as an integral part of an endoscopic procedure are considered part of the endoscopic procedure. Services such as venous access (e.g. CPT code 36000) and/or injection (e.g. CPT codes 90780-90784), non-invasive oximetry (e.g. CPT codes 94760 and 94761), anesthesia provided by the surgeon, etc. are included in the endoscopic procedure code. These column 2 codes are not to be reported separately.

1. When a diagnostic endoscopy is performed in conjunction with endoscopic therapeutic services, the appropriate CPT code to use is the more comprehensive endoscopy code describing the service performed. If the same therapeutic endoscopy service is performed repeatedly (e.g. polyp removal) in the same area described by the CPT narrative, only one CPT code is reported with one unit of service. If different therapeutic services are performed and are not adequately described by a more comprehensive CPT code, the appropriate codes can be designated in accordance with the multiple GI endoscopy rules previously established by CMS.

2. When a diagnostic endoscopy is followed by a surgical endoscopy, the diagnostic endoscopy is considered part of the surgical endoscopy (per *CPT Manual* instruction) and is not to be separately reported.

3. Gastroenterologic tests included in CPT codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as

part of an upper endoscopy (CPT code 43235) and, therefore, CPT codes 91000 (esophageal intubation) and 91055 (gastric intubation) should not be separately reported when performed as part of an upper endoscopic procedure. Provocative testing (CPT code 91052) can be expedited during gastrointestinal endoscopy (procurement of gastric specimens); when performed at the same time as GI endoscopy, CPT code 91052 should be coded with modifier -52 indicating a reduced level of service was performed.

4. When a small intestinal endoscopy or enteroscopy is performed as a necessary part of a procedure, only the more comprehensive (column 1) code describing the service performed is to be reported. When services described by the range of CPT codes 44360-44386 (small intestinal endoscopies) are performed as part of another service (e.g. surgical repair or creation of enterostomy, etc.), these codes are not separately reported. As noted previously, when an endoscopic procedure is confirmatory or is performed to establish anatomical landmarks ("scout" endoscopy), the endoscopic procedure is not separately reported. In the case where the endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform a more extensive (open) procedure is made, the endoscopic procedure may be separately reported. Modifier -58 may be used to indicate that the diagnostic endoscopy and the more extensive, open procedure are staged or planned services.

5. When endoscopic esophageal dilation is performed, the appropriate endoscopic esophageal dilation code is to be reported. The CPT codes 43450-43458 (dilation of esophagus) are not used in addition (even if attempted unsuccessfully prior to endoscopic dilation); in such a case, modifier -22 could be used to indicate an unusual endoscopic dilation procedure.

6. When it is necessary to perform diagnostic endoscopy of the hepatic/biliary/pancreatic system using separate approaches (e.g. biliary T-tube endoscopy with ERCP, etc.) the appropriate CPT codes for both may be reported. However, the code should include modifier -51 indicating multiple procedures were performed at the same session.

7. When intubation of the GI tract is performed (e.g. percutaneous G-tube placement, etc.), it is not appropriate to bill a separate code for tube removal. Specifically, the CPT code 43247 (endoscopic removal of foreign body) is not to be

reported for routine removal of therapeutic devices previously placed.

8. When an endoscopic or open procedure is performed and a biopsy is also performed, followed by excision, destruction or removal of the biopsied lesion, the biopsy is not separately reported. Additionally, when bleeding results from an endoscopic or surgical service, the control of bleeding at the time of the service is included in the endoscopic procedure. Separate procedure codes for control of bleeding are not to be coded. In the case of endoscopy, if it is necessary to repeat the endoscopy at a later time during the same day to control bleeding, a procedure code for endoscopic control of bleeding may be reported with modifier -78, indicating that this service represents a return to the endoscopy suite or operating room for a related procedure during the postoperative period. In the case of open surgical services, the appropriate complication codes may be reported if a return to the operating room is necessary, but the complication code should not be reported if the complication described by the CPT code occurred during the same operative session.

9. Only the more extensive endoscopic procedure is reported for a session. For example if a sigmoidoscopy is completed and the physician performs a colonoscopy during the same session only the colonoscopy, is coded. It is, however, acceptable to bill for multiple services provided during an endoscopic procedure (with the exception of treating bleeding induced by the procedure); these services would be reimbursed under the multiple endoscopic payment rules for gastrointestinal endoscopy.

10. When a transabdominal colonoscopy (via colotomy)(CPT code 45355) and/or standard sigmoidoscopy or colonoscopy is performed as a necessary part of an open procedure (e.g. colectomy), the endoscopic procedure(s) is (are) not separately reported. On the other hand, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the procedure(s) may be reported separately. Modifier -58 may be used to indicate that the diagnostic endoscopy and the open procedure are staged or planned services.

C. Abdominal Procedures

When any open abdominal procedure is performed, an exploration of the surgical field is routinely performed to identify anatomic structures or any anomalies that may be present. Accordingly, an exploratory laparotomy (CPT code 49000) is not separately reported with any open abdominal procedure. If routine exploration of the abdomen during an open abdominal procedure identifies abnormalities requiring a more extensive surgical field that makes the procedure unusual, modifier -22 may be reported with supporting documentation in the medical record, indicating that an “unusual procedural service” was performed.

When, in the course of a hepatectomy, a cholecystectomy is necessary in order to successfully perform the hepatectomy, a separate procedure code is not reported for the cholecystectomy; component column 2 procedures necessary to perform a more comprehensive column 1 procedure are included in the column 1 code describing the more comprehensive service.

Appendectomies are commonly performed incidentally during many abdominal procedures. The appendectomy is only to be reported separately if it is medically necessary. If done incidental to another procedure, the appendectomy would be included in the major procedure performed.

When, in the course of an open abdominal procedure, a hernia repair is performed, a service is reported only if the hernia repair is medically necessary at a different incisional site. Incidental hernia repair in the course of an abdominal procedure that is not medically necessary should not be reported. The medical record should document the medical necessity of the service if it is reported.

When a recurrent hernia requires repair, the appropriate recurrent hernia repair code is reported. A code for incisional hernia repair is not to be reported in addition to the recurrent hernia repair unless a medically necessary incisional hernia repair is performed at a different site. In this case, modifier -59 should be attached to the incisional hernia repair code.

D. General Policy Statements

1. When a vagotomy is performed in conjunction with esophageal or gastric surgery, the appropriate CPT code describing the comprehensive column 1 coded service is reported. The range of CPT codes 64752-64760 includes services described by the vagotomy codes performed as separate procedures and are not reported in addition to esophageal or gastric surgical CPT codes (e.g. 43635-43641) which include vagotomy as part of the service.

2. When a closure of an enterostomy or enterovesical fistula requires the resection and anastomosis of a segment of bowel, the CPT codes 44626 and 44661, include the anastomosis or the enteric resection. Accordingly, additional enteric resection codes are not to be reported.

3. In accordance with the sequential procedure policy, only one code for hemorrhoidectomy is reported; the more extensive procedure necessary to successfully accomplish the hemorrhoidectomy would be appropriate. Additionally, if, in the course of a hemorrhoidectomy, an abscess is identified and drained, a separate procedure code is not reported for the incision and drainage, as this was performed in the course of the hemorrhoidectomy. If the incision and drainage of the abscess occurred at a different site than the hemorrhoidectomy, then this procedure could appropriately be reported with modifier -59.

4. A number of groups of codes describe surgical procedures of a progressively more comprehensive nature or with different approaches to accomplish similar services. In general, these groups of codes are not to be reported together (see mutually exclusive policy). While a number of these groups of codes exist in CPT, several specific examples include CPT codes 45110-45123 for proctectomies, CPT codes 44140-44160 for colectomies, CPT codes 43620-43639 for gastrectomies, and CPT codes 48140-48180 for pancreatectomies.

5. When it is necessary to create or revise an enterostomy, or remove or excise a section of bowel due to fistula formation, a separate enterostomy closure code or fistula closure code is not reported. In the case of creating or revising an enterostomy, the closure is mutually exclusive and in the case of fistula excision, the closure is included in the excision procedure.

6. Because the digestive tract is bordered by a mucocutaneous margin, several CPT codes may define services involving biopsy, destruction, excision, removal, etc. of lesions of this margin. When a lesion involving this margin is identified and it is medically necessary to remove, only one code which more accurately describes the service performed should be submitted, generally either from the CPT section describing integumentary services (10040-19499) or digestive services (40490-49999). For example, if a patient presents with a benign lip lesion, and it is removed with a wedge excision, it would be acceptable to bill the CPT code 40510 (excision of lip) or the appropriate code from CPT codes 11440-11446 (excision of lesions); billing a code from both sections would be inappropriate.

7. Laparoscopic procedures performed in place of an open procedure are subject to the standard surgical practice guidelines.

8. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

9. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

10. The NCCI edit with column 1 CPT code 45385 (Flexible colonoscopy with removal of tumor(s), polyp(s), or lesion(s) by snare technique) and column 2 CPT code 45380 (Flexible colonoscopy with single or multiple biopsies) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 45380 of this NCCI edit is only appropriate if the two

procedures are performed on separate lesions or at separate patient encounters.

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CHAPTER VII
SURGERY: URINARY, MALE GENITAL, FEMALE GENITAL, MATERNITY CARE AND DELIVERY SYSTEMS
CPT CODES 50000 -59999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter VII
Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems
CPT Codes 50000 - 59999

A. Introduction

The general policies previously promulgated regarding CPT defined services apply to the urinary tract. Because of the contiguous nature of the urinary tract, and the accessibility of the urinary tract to endoscopic intervention, several specific issues require emphasis.

B. Urinary System

1. Many procedures involving the female and male urinary system include the placement of a urethral catheter for postoperative drainage. Because this is integral to the service and represents the standard of medical practice, placement of a urinary catheter is not separately coded. In addition, catheterizations (e.g. CPT codes 51701, 51702, and 51703) are not separately reported when done at the time of or just prior to a surgical procedure.

2. Many lesions of the genitourinary tract which require biopsy, excision or destruction involve the mucocutaneous border and several CPT codes may generally describe the nature of the biopsy obtained. For a biopsy of a lesion or group of similar lesions, one unit of service for the CPT code that more accurately describes the service rendered is reported. As noted in the general policies, in Chapter I, when a biopsy is followed by an excision or destruction during the same session, only the more extensive service is reported. Additionally, separate codes (e.g. integumentary and genitourinary excision codes) are not to be reported unless the biopsy, excision, destruction, etc., service involves completely separate lesions; in these cases, modifier -59 will indicate that separate lesions were removed. The medical record should reflect accurately the precise location of the lesions removed, particularly if it is medically necessary to submit each lesion as a separate specimen for pathological evaluation.

3. Policies regarding injections and infusions (e.g. HCPCS/CPT codes 36000, 36410, 90780 and 90781) as part of more extensive procedures have previously been defined and apply to the genitourinary family of codes. When irrigation procedures or drainage procedures are necessary and are integral to successfully accomplish a genitourinary (or any other) procedure, only the more extensive service is reported.

4. Unless otherwise defined by *CPT Manual* instructions, the repair and closure of surgical procedures are included in the CPT code for the more extensive procedure and are not to be separately reported. In many genitourinary services, hernia repair is included in the *CPT Manual* descriptor for the service; accordingly, a hernia repair is not separately reported. If the hernia repair performed is at a different site, this can be separately reported with modifier -59 indicating that this service occurred at a different site (i.e., via a different incision).

5. In general, multiple methods of accomplishing a procedure (e.g. prostatectomy) are not performed at the same session (see general policy on mutually exclusive services); therefore, only one method of accomplishing a given procedure can be reported. In the event that an initial approach is unsuccessful, and an alternative approach is undertaken, the approach which successfully accomplishes the procedure becomes the medically necessary service and is reported; if appropriate, modifier -22 may be appended to the procedure code for the successful approach.

6. When an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reported. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be separately reported under the diagnostic or surgical endoscopy codes. When an endoscopic procedure is attempted unsuccessfully and converted to an open procedure, only the open procedure is reported (see general policy on sequential procedures). If the endoscopy is performed for diagnostic purposes and a subsequent therapeutic service can be performed at the same session, the procedure is coded at the highest level of specificity. If the *CPT Manual* narrative includes endoscopy, then the diagnostic endoscopy is not separately coded. If the narrative does not include endoscopy and a separate endoscopy is necessary as a

diagnostic procedure, this can be reported separately. Modifier -58 may be used to indicate that the diagnostic endoscopy and the subsequent therapeutic service are staged or planned procedures. The medical record must describe the intent and findings of the diagnostic endoscopy in these cases.

7. When multiple endoscopic procedures are performed at the same session, the more comprehensive code accurately describing the service performed is reported; if several procedures are performed at the same endoscopic session, modifier -51 is attached. (For example, if a renal endoscopy is performed through an established nephrostomy, a biopsy is performed, a lesion is fulgurated and a foreign body (calculus) is removed, the appropriate CPT coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.) This policy applies to endoscopic procedures in general and specifically to endoscopic procedures of the genitourinary system.

8. When bladder irrigation is performed as part of a more comprehensive procedure, or in order to accomplish access or visualization of the urinary system, the bladder irrigation (CPT code 51700) is not to be reported. This code is to be used for irrigation with therapeutic agents or for irrigation as an independent therapeutic service.

9. When electromyography (EMG) is performed as part of a biofeedback session, neither CPT code 51784 nor 51785 is to be reported unless a significant, separately identifiable diagnostic EMG service is provided. If either CPT code 51784 or CPT code 51785 is to be used for a diagnostic electromyogram, a separate report must be available in the medical record to indicate this service was performed for diagnostic purposes.

10. When endoscopic visualization of the urinary system involves several regions (e.g. kidney, renal pelvis, calyx, and ureter), the appropriate CPT code is defined by the approach (e.g. nephrostomy, pyelostomy, ureterostomy, etc.) as indicated in the CPT descriptor. When multiple endoscopic approaches are simultaneously necessary to accomplish a medically necessary service (e.g. renal endoscopy through a nephrostomy and cystourethroscopy performed at the same session), they may be separately coded with the multiple procedure modifier -51 on the less extensive codes. When multiple endoscopic approaches are necessary to accomplish the same procedure, the successful endoscopic approach should be reported.

11. When urethral catheterization or urethral dilation (e.g. CPT codes 51701-51703) is necessary to accomplish a more extensive procedure, the urethral catheterization/dilation is not to be separately reported.

12. Multiple ureteral anastomosis procedures are defined by CPT codes 50740-50810, and 50860. In general, they represent mutually exclusive procedures and are not to be reported together. If one anastomosis is performed on one ureter, and a different anastomosis is performed on a contralateral ureter, the appropriate modifier (e.g. -LT, -RT) is used with the appropriate CPT code to describe the service performed on the respective ureter.

13. CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive of CPT codes 50800-50830 (e.g. ureterostomy, ureterocolon conduit, urinary undiversion) unless performed at different locations in which case an anatomic modifier should be used.

14. The CPT codes 53502-53515 describe urethral repair codes for urethral wounds or injuries (urethrorrhaphy). When a urethroplasty is performed, codes for urethrorrhaphy should not be reported in addition since "suture to repair wound or injury" is included in the urethroplasty service.

C. Male Genital System

1. Transurethral drainage of a prostatic abscess (e.g. CPT code 52700) is included in male transurethral prostatic procedures and is not reported separately.

2. Urethral catheterization (e.g. CPT codes 51701, 51702, and 51703), when medically necessary to successfully accomplish a procedure, should not be separately reported.

3. The puncture aspiration of a hydrocele (e.g. CPT code 55000) is included in services involving the tunica vaginalis and proximate anatomy (scrotum, vas deferens) and in inguinal hernia repairs.

4. A number of codes describe surgical procedures of a progressively more comprehensive nature or with different approaches to accomplish similar services. In general, these groups of codes are not to be reported together (see mutually exclusive policy). While a number of these groups of codes exist in CPT, a specific example includes the series of codes

describing prostate procedures (CPT codes 55801-55845). In addition, all prostatectomy procedures (e.g. CPT codes 52601-52648 and 55801-55845) are also mutually exclusive of one another.

D. Female Genital System

1. When a pelvic examination is performed in conjunction with a gynecologic procedure, either as a necessary part of the procedure or as a confirmatory examination, the pelvic examination is not separately reported. A diagnostic pelvic examination may be performed for the purposes of deciding to perform a procedure; however, this examination is included in the evaluation and management service at the time the decision to perform the procedure is made.

2. All surgical laparoscopic, hysteroscopic or peritoneoscopic procedures include diagnostic procedures. Therefore, CPT code 49320 is included in 38120, 38570-38572, 43280, 43651-43653, 44200-44202, 44970, 47560-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, 60650; and 58555 is included in 58558-58563.

3. Lysis of adhesions (CPT code 58660) is not to be reported separately when done in conjunction with other surgical laparoscopic procedures.

4. Pelvic exam under anesthesia indicated by CPT code 57410, is included in all major and most minor gynecological procedures and is not to be reported separately. This procedure represents routine evaluation of the surgical field.

5. Dilation of vagina or cervix (CPT codes 57400 or 57800), when done in conjunction with vaginal approach procedures, is not to be reported separately unless the CPT code manual description states "without cervical dilation."

6. Administration of anesthesia, when necessary, is included in every surgical procedure code, when performed by the surgeon.

7. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a “scout” procedure to confirm the lesion or to assess the surgical field prior to a surgical procedure. A diagnostic colposcopy resulting in the decision to perform a non-colposcopic procedure may be reported with modifier -58. Diagnostic colposcopies (56820,57420,57452) are

not separately reported with other colposcopic procedures.

E. Maternity Care and Delivery

The majority of procedures in this section (CPT codes 59000-59899) include only what is described by the code in the CPT definition. Additional procedures performed on the same day would be reported separately. The few exceptions to this rule consist of:

- CPT codes 59050 and 59051(fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT codes 59400 (routine obstetric care, vaginal delivery), 59409 (vaginal delivery only), 59410 (vaginal delivery and postpartum care), 59510 (routine obstetric care, cesarean delivery), 59514 (cesarean delivery only), 59515 (cesarean delivery and postpartum care), 59610 (routine obstetric care, vaginal delivery, after previous cesarean delivery), 59612 (vaginal delivery only after previous cesarean delivery), 59614 (vaginal delivery and postpartum care after previous cesarean delivery), 59618 (routine obstetric care, cesarean delivery, after previous cesarean delivery), 59620 (cesarean delivery only after previous cesarean delivery), and 59622 (cesarean delivery and postpartum care after previous cesarean delivery). They are not to be separately reported.

- The total obstetrical packages (e.g. CPT codes 59400 and 59510) include antepartum care, the delivery, and postpartum care. They do not include among other services, ultrasound, amniocentesis, special screening tests for genetic conditions, visits for unrelated conditions (incidental to pregnancy) or additional and frequent visits due to high risk conditions.

F. General Policy Statements

1. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

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CHAPTER VIII
SURGERY: ENDOCRINE NERVOUS, EYE AND OCULAR ADNEXA, AUDITORY SYSTEMS
CPT CODES 60000 - 69999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter VIII
Surgery: Endocrine Nervous, Eye and Ocular Adnexa, Auditory Systems
CPT Codes 60000 - 69999

A. Introduction

The section of CPT codes 60000-69979 includes surgical procedures involving the endocrine and nervous systems, procedures involving eye, ocular adnexa, and ear. Because of the number of procedures involved, these sections are subdivided.

In keeping with the general policies introduced earlier, most issues of correct coding can be identified and addressed by reviewing the CPT code definition for the appropriate service.

As a general guideline, when a component service, which is described by a CPT code is necessary to accomplish a more comprehensive service, the component service is assumed to be included in the more comprehensive service; therefore only the more comprehensive service which was performed can be coded.

B. Endocrine and Nervous Systems

1. A burr hole is often necessary in anticipation for intracranial surgery (e.g. craniotomy, craniectomy), either to gain access to intracranial contents, to alleviate pressure in anticipation of further surgery or to place an intracranial pressure monitoring device as part of the surgery. As these services are integral to the performance of the subsequent services, codes representing these services are not to be separately reported if performed at the same session; if performed prior to the comprehensive procedure, modifier -58 can be used to indicate that the burr hole and the intracranial surgery are staged or planned services.

In addition, taps, punctures or burr holes accompanied by drainage procedures (e.g. hematoma, abscess, cyst, etc.) followed by other procedures, are not separately reported unless performed as staged procedures. Modifier -58 may be used to indicate staged or planned services. Many intracranial procedures include bone grafts by CPT definition and these grafts should not be reported separately.

2. Biopsies performed in the course of Central Nervous System (CNS) surgery should not be reported as separate procedures.

3. Craniotomies and craniectomies always include a general exploration of the accessible field; accordingly it is not appropriate to code an exploratory surgery (e.g. CPT codes 61304, 61305) when another procedure is performed at the same session.

4. When services are performed at the same session, but represent different types of services or are being performed at different sites (see example below), modifier -59 should be added. This modifier indicates that this service was a distinct, separate service and should not be included in the column 1 code.

Example: A patient with an open head injury and a contra-coup subdural hematoma requires a craniectomy for the open head injury and a burr hole drainage on the opposite side for the subdural hematoma. The performance of a burr hole at the time of the craniectomy would be considered part of the craniectomy. However, the contralateral burr hole would be considered a separate service not integral to the craniectomy. To correctly code the burr hole for the contralateral subdural hematoma and the column 1 coded service (the craniectomy), the burr hole should be coded with the appropriate modifier (-59, -RT, -LT, etc.). In this example the correct coding would be CPT codes 61304 with one unit of service and 61154-59 with one unit of service.

5. The use of general intravascular access devices (e.g. intravenous lines, etc.), cardiac monitoring, oximetry, laboratory sample procurement and other routine monitoring for patient safety has been addressed in the previous policy for general anesthesia or monitored anesthesia care (MAC). These policies also apply for procedures that do not require the presence of an anesthesiologist/certified registered nurse anesthetist. As an example, if a physician is performing a spinal puncture for intrathecal injection and administers an anxiolytic agent, but the procedure does not require the presence of an anesthesiologist/certified registered nurse anesthetist, the vascular access and any appropriate monitoring necessary is considered part of the spinal puncture procedure and is not to be reported separately.

6. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure itself. The submission of nerve block or facet block codes for local anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate when there is no independent medical necessity of the administration of local anesthetic except for the lumbar puncture. Separate codes are not to be reported. In comparison, if, in the course of a nerve or other anesthetic block procedure, cerebrospinal fluid is withdrawn, it is inappropriate to bill for a diagnostic lumbar puncture; only the nerve (or other) block should be reported; the CSF procurement is not for diagnostic purposes.

7. The appropriate code for the open treatment of median nerve compression at the wrist (carpal tunnel syndrome) is CPT code 64721; according to *CPT Manual* definition, this includes the open release of the transverse carpal ligament. Additionally, if an arthroscopic procedure (CPT code 29848) fails and must be followed by an open procedure (CPT code 64721), only the open, or successful, procedure can be reported, if necessary, with modifier -22.

8. Nerve repairs by suture or neurorrhaphies (CPT codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury to or anastomosis of nerves which are proximally associated (e.g. facial-spinal, facial-hypoglossal, etc.). When neurorrhaphy is performed in conjunction with a nerve graft (CPT codes 64885-64907), a neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., a separate service is not reported for the primary nerve suture.

9. In the same area of the cortex, neurostimulator electrodes can be implanted in only one fashion; accordingly, the CPT code 61850 (burr hole) is included in the CPT code 61860 (craniectomy). Codes describing craniotomy procedures (e.g. CPT codes 62100-62121) are generally bundled into craniectomy codes (e.g. CPT codes 61860-61875).

10. Because procedures necessary to accomplish a column 1 procedure are included in the column 1 procedure, CPT codes such as 62310-62311, 62318-62319 (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive back procedures. Additionally, at the same site, codes describing laminotomy procedures are included in laminectomy

codes. CPT codes 22100-22116 (partial excision of vertebral components) represent distinct procedures, and, accordingly, are not reported with laminotomy/laminectomy procedures unless the services are performed as described in the codes.

11. CPT codes describing the performance of a tracheostomy are not to be reported with the CPT code 61576 (transoral approach to skull base including tracheostomy) as this service is included in the descriptor for the code.

12. The Medicare Carrier Manual Section 15055 (online "Claims Processing Manual", Pub.100-4, 12-§20.4.5) limits the reporting of use of an operating microscope (CPT code 69990) to procedures described by CPT codes 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836,64840-64858, 64861-64870, 64885-64898 and 64905-64907. CPT code 69990 should not be reported with other procedures even if an operating microscope is utilized. CMS guidelines for payment of CPT code 69990 differ from *CPT Manual* instructions following CPT code 69990.

C. Ophthalmology

1. When a subconjunctival injection (e.g. CPT code 68200) with a local anesthetic is performed as part of a more extensive anesthetic procedure (e.g. peribulbar or retrobulbar block), a separate service for this procedure is not to be reported. This is a routine part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy, trabeculectomy, and anterior vitrectomy may be performed in conjunction with cataract removal. When an iridectomy is performed in order to accomplish the cataract extraction, it is an integral part of the procedure; it does not represent a separate service, and is not separately reported. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not to be separately reported unless it is medically necessary for a different diagnosis. While a trabeculectomy is not performed as a part of a cataract extraction, it may be performed to control glaucoma at the same time as a cataract extraction. If the procedure is medically necessary at the same time as a cataract extraction, it can be reported under a different diagnosis (e.g. glaucoma). The codes describing iridectomies, trabeculectomies, and anterior vitrectomies, when performed with a cataract

extraction under a separate diagnosis, must be reported with modifier -59. This indicates that the procedure was performed as a different service for a separate situation. The medical record should reflect the medical necessity of the service if separately reported. For example, if a patient presents with a cataract and has evidence of glaucoma, (i.e. elevated intraocular pressure preoperatively) and a trabeculectomy represents the appropriate treatment for the glaucoma, a separate service for the trabeculectomy would be separately reported. Performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not to be separately reported.

3. The various approaches to removing a cataract are mutually exclusive of one another when performed on the same eye.

4. Some retinal detachment repair procedures include some vitreous procedures (e.g. CPT code 67108 includes 67015, 67025, 67028, 67031, 67036, 67039, and 67040). Certain retinal detachment repairs are mutually exclusive to anterior procedures such as focal endolaser photocoagulation (e.g. CPT codes 67110 and 67112 are mutually exclusive to CPT code 67108).

5. CPT codes 68020-68200 (incision, drainage, excision of the conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362).

6. CPT code 67950 (canthoplasty) is included in repair procedures such as blepharoplasties (CPT codes 67917, 67924, 67961, 67966).

7. Correction of lid retraction (CPT code 67911) includes full thickness graft (e.g. CPT code 15260) as part of the total service performed.

8. In the circumstance that it is medically necessary and reasonable to inject sclerosing agents in the same session as surgery to correct glaucoma, the service is included in the glaucoma surgery. Accordingly, codes such as CPT codes 67500, 67515, and 68200 for injection of sclerosing agents (e.g. 5-FU, HCPCS/CPT code J9190) should not be reported with other pressure-reducing or glaucoma procedures.

D. Auditory System

1. When a mastoidectomy is included in the description of an auditory procedure (e.g. CPT codes 69530, 69802, 69910), separate codes describing mastoidectomy are not reported.

2. Myringotomies (e.g. CPT codes 69420 and 69421) are included in tympanoplasties and tympanostomies.

E. General Policy Statements

1. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

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CHAPTER IX
RADIOLOGY SERVICES
CPT CODES 70000 - 79999
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Chapter IX
Radiology Services
CPT Codes 70000 - 79999

A. Introduction

The *CPT Manual* includes codes related to diagnostic radiology (imaging), ultrasound, radiation oncology and nuclear medicine. The diagnostic imaging section includes non-invasive and invasive diagnostic and therapeutic (interventional) procedures, as well as computerized tomography and magnetic resonance imaging. Most correct coding issues are defined by CPT coding convention.

B. Non-interventional Diagnostic Imaging

Non-invasive/interventional diagnostic imaging includes standard radiographs, single or multiple views, contrast studies, computerized tomography and magnetic resonance imaging. The *CPT Manual* allows for various combinations of codes to address the number and type of radiographic views. For a given radiographic series, the procedure code that most accurately describes what was performed is appropriate. Because of the number of combinations of views necessary to obtain medically useful information, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code that describes the services performed rather than billing multiple codes to describe the service.

In the event that radiographs have to be repeated in the course of a radiographic encounter due to substandard quality, only one unit of service for the code can be reported. Additionally, if after reviewing initial films, the radiologist elects to obtain additional views in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests should be followed and the CPT code describing the total service is reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptor for many of these services refers to a “minimum” number of views. Accordingly, if more than the minimum number specified is necessary, and no other more specific CPT code is available, only that service should be billed. On the other hand, if additional films are necessary due to a change in the patient=s condition, separate billing would be appropriate.

CPT code descriptors which specify a minimum number of views should be reported when the minimum number of views or if more than the minimum number of views must be obtained in order to satisfactorily complete the radiographic study. For example, if three views of the shoulder are obtained, CPT code 73030, one unit of service, should be reported, not 73020 and 73030.

When limited comparative radiographic studies are performed (e.g. post-reduction radiographs, post-intubation, post-catheter placement, etc.), the CPT code for a comprehensive radiographic series should be reported with modifier -52, indicating that a reduced level of interpretive service was provided.

Studies may be performed without contrast, with contrast or both with and without contrast. There are separate codes available to describe all of these combinations of contrast usage. When studies require contrast, there is not generally an established number of radiographs to be obtained because of patient variation. Accordingly, all radiographs necessary to complete a study are included in the CPT code description. Unless specifically noted, fluoroscopy necessary to complete a procedure and obtain the necessary permanent radiographic record is included in the major procedure performed.

Preliminary "scout" radiographs obtained prior to contrast administration or delayed imaging radiographs are often performed; when a separate CPT code is available to include these radiographs, it should be used. If there is no separate CPT code including additional views, it is assumed that these are included in the basic procedure.

C. Interventional/Invasive Diagnostic Imaging

When contrast can be administered orally (upper GI) or rectally (barium enema), the administration is included as part of the procedure and no administration service is reported. When contrast material is parenterally administered, whether the timing of the injection has to correlate with the procedure or not (e.g. IVP, CT scans, gadolinium), the administration and the injection (e.g. HCPCS/CPT codes 36000, 36406, 36410 and 90782-90784) are included in the contrast studies.

When a contrast study is performed in which there is direct correlation of the timing of the study to the injection or

administration (e.g. angiography), and different providers perform separate parts of the procedure, each provider would bill the service he/she rendered. The procedural aspect of the service is coded from outside the CPT 70000 series and the radiographic supervision and interpretation (S & I) service is coded from the 70000 series of codes.

Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider as a percutaneous intravascular interventional procedure should be reported with modifier -59. If a diagnostic angiogram was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifiers -52 and -59. If the prior diagnostic angiogram was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

The individual CPT codes in the 70000 section identify which injection or administration code is appropriate for a given procedure. In the absence of a parenthetical CPT note, it is not appropriate to submit an administration component. When an intravenous line is placed (e.g. CPT code 36000) simply for access in the event of a problem with the procedure or for administration of contrast, it is considered part of the procedure. A separate code (e.g. CPT code 36005), is available for the injection procedure for contrast venography and includes the introduction of a needle or an intracatheter (e.g. CPT code 36000).

In the case of urologic procedures and other surgeries, insertion of a urethral catheter (e.g. CPT code 51701-51702) is part of the procedure and is not to be separately reported.

The CPT codes 90783 and 90784 are for intra-arterial and intravenous therapeutic or diagnostic injections. Injections for contrast procedures are included in the procedure. CPT codes 90783 and 90784 cannot be separately reported with radiographic, CT, MRI, or nuclear imaging codes to represent part of the injection procedure. CPT codes 90783 and 90784 are status “T” codes on the Medicare Physician Fee Schedule indicating that they

are not separately payable if any other service on the Medicare Physician Fee Schedule is payable on that date of service.

D. Evaluation and Management

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate evaluation and management service is not reported. As a rule, if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate evaluation and management service can be reported. The appropriate evaluation and management service code is chosen based on the type of service rendered which satisfies the Evaluation and Management guidelines developed by the AMA and CMS.

In radiation oncology, evaluation and management services would not be separately reported with the exception of an initial consultation at which time a decision is made whether to proceed with the treatment. Radiation oncology includes clinical treatment planning, simulation, medical radiation physics, dosimetry treatment devices, special services, and clinical treatment management procedures in teletherapy and brachytherapy.

The categories of procedures in this subsection are well-defined according to levels of intensity for clinical treatment planning, devices, delivery and management.

E. Nuclear Medicine

The general policies promulgated above apply to nuclear medicine as well as standard diagnostic imaging. Several issues specific to the practice of nuclear medicine require comment.

The injection of the radionuclide is included as part of the procedure; separate injection codes (e.g. 36000, 90783) should not be reported.

Single photon emission computed tomography (SPECT) studies represent an enhanced methodology over standard planar nuclear imaging. When a limited anatomic area is studied, there is no additional information procured by obtaining both planar and SPECT studies. While both represent medically acceptable imaging studies, when a SPECT study of a limited area is performed, a planar study is not to be separately reported. When vascular flow studies are obtained using planar technology in addition to SPECT studies, the appropriate CPT code for the vascular flow study should be reported, not the flow, planar and SPECT studies. In cases where planar images must be procured because of the extent of the scanned area (e.g. bone imaging), both planar and SPECT scans may be necessary and reported separately.

F. Radiation Oncology

1. Continuing medical physics consultation (CPT code 77336) is reported “per week of therapy”. It may be reported after every five radiation treatments. (It may also be reported if the total number of radiation treatments in a course of radiation therapy is less than five.) Since radiation planning procedures (CPT codes 77261-77334) are generally performed before radiation treatment commences, the NCCI contains edits preventing payment of CPT code 77336 with CPT codes 77261-77295, 77301-77328, and 77332-77334. Because radiation planning procedures may occasionally be repeated during a course of radiation treatment, the edits allow modifier -59 to be appended to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation occur on the same date of service.

G. General Policy Statements

1. Any abdominal radiology procedure that has a radiological supervision and interpretation code (e.g. CPT code 75625 for abdominal aortogram), would also include abdominal x-rays (e.g. CPT codes 74000-74022) as part of the total service.

2. Xeroradiography (e.g. CPT code 76150) is not to be reported with any mammography studies based on CPT coding instruction.

3. Guidance for placement of radiation fields by computerized tomography or ultrasound (CPT codes 76370 or 76950) for the same anatomical area are mutually exclusive of one another.

4. Ultrasound guidance services and diagnostic echography should be reported only when both procedures are performed. Ultrasound guidance services alone do not represent diagnostic echography.

5. CPT code 76970 (ultrasound study, follow-up) cannot be reported with any other echocardiographic or ultrasound guidance procedures because it represents a follow-up procedure on the same day.

6. CPT code 77790 (supervision, handling, loading of radiation source) is not to be reported with any of the remote afterloading brachytherapy codes (e.g. CPT codes 77781-77784) since these procedures inherently include the supervision of the radioelement.

7. Bone studies such as CPT codes 76020-76065 require a series of radiographs; billing separately for bone studies and individual radiographs obtained in the course of the bone study is inappropriate.

8. Radiologic supervision and interpretation codes for specific procedures include all the radiologic services necessary for that procedure. For example, do not additionally report fluoroscopy (e.g., CPT codes 76000, 76001, 76003, 76005) or ultrasound guidance (e.g., CPT codes 76942, 76986).

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CHAPTER X
PATHOLOGY LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter X
Pathology and Laboratory Services
CPT Codes 80000 - 89999

A. Introduction

Pathology and laboratory CPT coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens, or tissue specimens obtained by invasive/surgical procedures) in order to provide information to the treating physician. This information, coupled with information obtained from history and examination findings and other data, provides the physician with the background upon which medical decision making is established.

Generally, pathology and laboratory specimens are prepared and/or screened by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed personally by the pathologist. CPT coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist. On the occasion that a pathologist provides evaluation and management services (significant, separately identifiable, patient care services that satisfy the criteria set forth in the E & M guidelines developed by CMS, formerly HCFA, and the AMA), appropriate coding should be rendered from the evaluation and management section of the *CPT Manual*.

If, after a test is ordered and performed, additional related procedures are necessary to provide or confirm the result, these would be considered part of the ordered test. For example, if a patient with leukemia has a thrombocytopenia, and a manual platelet count (CPT code 85032) is performed in addition to the performance of an automated hemogram with automated platelet count (CPT code 85027), it would be inappropriate to report CPT codes 85032 and 85027 because the former provides a confirmatory test for the automated hemogram and platelet count (CPT code 85027). As another example, if a patient has an abnormal test result and repeat performance of the test is done to verify the result, the test is reported as one unit of service rather than two.

B. Organ or Disease Oriented Panels

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of a group of specified tests. If all tests of a CPT defined panel are performed, the provider may bill the panel code or the individual component test codes. The panel codes may be used when the tests are ordered as that panel or if the individual component tests of a panel are ordered separately. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service could be billed as a lipid panel (CPT code 80061).

C. Evocative/Suppression Testing

Evocative/suppression testing involves administration of agents to determine a patient's response to those agents (CPT codes 80400-80440 are to be used for reporting the laboratory components of the testing). When the test requires physician administration of the evocative/suppression agent as described by CPT codes 90780-90784 (therapeutic/diagnostic injections/infusions), these codes can be separately reported. However, when physician attendance is not required, and the agent is administered by ancillary personnel, these codes are not to be separately reported. In the inpatient setting, these codes are only reported if the physician performs the service personally. In the office setting, the service can be reported when performed by office personnel if the physician is directly supervising the service. While supplies necessary to perform the testing are included in the testing, the appropriate HCPCS J codes for the drugs can be separately reported for the diagnostic agents. Separate evaluation and management services are not to be reported, including prolonged services (in the case of prolonged infusions) unless a significant, separately identifiable service is provided and documented. If separate evaluation and management services are provided and reported, the injection procedure is included in this service and is not separately reported.

D. General Policy Statements

1. Multiple CPT codes are descriptive of services performed for bone and bone marrow evaluation. When a biopsy is performed for evaluation of bone matrix structure, the appropriate code to

bill is CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology evaluation.

When a bone marrow aspiration is performed alone, the appropriate coding is CPT code 38220. Appropriate coding for the interpretation is CPT code 85097 when the only service provided is the interpretation of the bone marrow smear. When both are performed by the same provider, both CPT codes may be reported. The pathological interpretations (CPT code 88300-88309) are not reported in addition to CPT code 85097 unless separate specimens are processed.

When it is medically necessary to evaluate both bone structure and bone marrow, and both services can be provided with one biopsy, only one code (CPT code 38221 or CPT code 20220) can be reported. If two separate biopsies are necessary, then both can be reported using modifier -59 on one of the codes. Pathological interpretation codes 88300-88309 may be separately reported for multiple separately submitted specimens. If only one specimen is submitted, only one code can be reported regardless of whether the report includes evaluation of both bone structure and bone marrow morphology or not.

2. The family of CPT codes 87040-87158 refers to microbial culture studies. The type of culture is coded to the highest level of specificity regarding source, type, etc. When a culture is processed by a commercial kit, report the code that describes the test to its highest level of specificity. A screening culture and culture for definitive identification are not performed on the same day on the same specimen and therefore are not reported together.

3. When cytopathology codes are reported, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a group of related codes describing a group of services that could be performed on a specimen with the same end result (e.g. 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) is to be reported. If multiple services (i.e., separate specimens) are reported, modifier -59 should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports. A cytopathology preparation from a fluid, washing, or brushing is to be reported using one code from

the range of CPT codes 88104-88112. It is inappropriate to additionally use CPT codes 88160-88162 because the smears are included in the codes referable to fluids (or washings or brushings) and 88160-88162 references “any other source” which would exclude fluids, washings, or brushings.

4. The CPT codes 80500 and 80502 are used to indicate that a pathologist has reviewed and interpreted, with a subsequent written report, a clinical pathology test. These codes additionally are not to be used with any other pathology service that includes a physician interpretation (e.g. surgical pathology). If an evaluation and management service (face-to-face contact with the patient) takes place by the pathologist, then the appropriate E & M code is reported, rather than the clinical pathology consultation codes, even if, as part of the evaluation and management service, review of the test result is performed. Reporting of these services (CPT codes 80500 and 80502) requires the written order for consultation by a treating physician.

5. The CPT codes 88321-88325 are to be used to review slides, tissues, or other material obtained and prepared at a different location and referred to a pathologist for a second opinion. (These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or material also examined and reported by another pathologist in the same provider group.) Medicare generally does not pay twice for an interpretation of a given technical service (e.g., EKGs, radiographs, etc.). When reporting CPT codes 88321-88325, providers should not report other pathology CPT codes such as 88312, 88313, 88342, 88180, etc., for interpretation of stains, slides or material previously interpreted by another pathologist. CPT codes 88312, 88313 and 88342 may be reported with CPT code 88323 if provider performs and interprets these stains de novo. These codes are not to be used for a face-to-face evaluation of a patient. In the event that a physician provides an evaluation and management service to a patient and, in the course of this service, specimens obtained elsewhere are reviewed as well, this is part of the evaluation and management service and is not to be reported separately. Only the evaluation and management service would be reported.

6. Multiple tests to identify the same analyte, marker, or infectious agent should not be reported separately. For example,

it would not be appropriate to report both direct probe and amplified probe technique tests for the same infectious agent.

7. Medicare does not pay for duplicate testing. CPT codes 88342 (immunocytochemistry, each antibody) and 88180 (flow cytometry) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The provider may report both CPT codes if both methods are required because the initial method is nondiagnostic or does not explain all the light microscopic findings. The provider can report both methods utilizing modifier -59 and document the need for both methods in the medical record.

If the abnormal cells in two or more specimens are morphologically similar and testing on one specimen by one method (88342 or 88180) establishes the diagnosis, the other method should not be reported on the same or similar specimen. Similar specimens would include, but are not limited to:

(1) blood and bone marrow;
(2) bone marrow aspiration and bone marrow biopsy;
(3) two separate lymph nodes; or
(4) lymph node and other tissue with lymphoid infiltrate.

8. Quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging) should not be reported as CPT code 88342 with CPT code 88358. Prior to January 1, 2004, it should be reported as CPT code 88342. Beginning January 1, 2004, it should be reported as CPT code 88361. CPT code 88361 should not be used to report any service other than quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging). Digital cellular imaging includes computer software analysis of stained microscopic slides. Beginning January 1, 2005, quantitative or semi-quantitative immunohistochemistry performed by manual techniques should be reported as CPT code 88360. Immunohistochemistry reported with qualitative grading such as 1^+ to 4^+ should be reported as 88342.

9. DNA ploidy and S-phase analysis of tumor by digital cellular imaging technique should not be reported as CPT code 88313 with CPT code 88358. Prior to January 1, 2004, it should be reported as CPT code 88313. Beginning January 1, 2004, it

should be reported as CPT code 88358. Prior to January 1, 2004, CPT code 88358 should be utilized to report DNA ploidy and S-phase analysis of tumor by non-digital cellular imaging techniques. CPT code 88358 should not be used to report any service other than DNA ploidy and S-phase analysis. One unit of service for CPT code 88358 includes both DNA ploidy and S-phase analysis.

10. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) is used to report direct measurement of the LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol in addition to total cholesterol (CPT code 82465) or lipid panel (CPT code 80061) may be reasonable and necessary if the triglyceride level is too high to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier -59.

11. Prior to January 1, 2005, qualitative, semi-quantitative, and quantitative (tissue) *in situ* hybridization should be reported as CPT code 88365 when performed by a physician. Beginning January 1, 2005, quantitative or semi-quantitative (tissue) *in situ* hybridization performed by computer-assisted technology should be reported as CPT code 88367 when performed by a physician. Beginning January 1, 2005, quantitative or semi-quantitative (tissue) *in situ* hybridization performed by manual methods should be reported as CPT code 88368 when performed by a physician. Do not report CPT code 88365 with CPT codes 88367 or 88368 for the same probe. Only one unit of service may be reported for CPT code 88365, 88367 or 88368 for each reportable probe marker. When *in situ* hybridization is performed on tissue or cytology specimens by a non-physician, it should be reported using appropriate CPT codes in the range 88271-88275. For each reportable probe marker, a provider should not report CPT codes both from the range 88365-88368 and the range 88271-88275. *In situ* hybridization reported as CPT codes 88365-88368 includes both physician and non-physician services to obtain a reportable probe marker result.

12. Beginning January 1, 2005, flow cytometry interpretation should be reported using CPT codes 88187-88189. Only one code should be reported for all flow cytometry performed on a specimen. Since Medicare does not pay for duplicate testing, do not report flow cytometry on multiple specimens on the same date

of service unless the morphology or other clinical factors suggest differing results on the different specimens. There is no CPT code for interpretation of one marker. The provider should not bill for interpretation of a single marker using another CPT code. Quantitative cell counts performed by flow cytometry (CPT codes 86064, 86359-86361, 86379, and 86587) should not be reported with the flow cytometry interpretation CPT codes 88187-88189 since there is no interpretative service for these quantitative cell counts.

13. CPT code 83912 is reported to describe a medically reasonable and necessary “interpretation and report” associated with molecular diagnostic testing described with CPT codes 83890-83906. CPT code 83912 should not be reported as an “interpretation and report” with CPT codes 87470-87801, 87901-87904.

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CHAPTER XI
MEDICINE
EVALUATION AND MANAGEMENT SERVICES
CPT CODES 90000 - 99999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter XI
Medicine
Evaluation and Management Services
CPT Codes 90000 - 99999

A. Introduction

The Medicine section of the *CPT Manual* includes codes for non-invasive or minimally invasive (primarily percutaneous access) services that would not be considered open surgical procedures or evaluation and management services. In keeping with the general principles of correct CPT coding, the services required to accomplish an evaluation or procedure as described by a medicine code descriptor are included in the code and cannot be separately reported even if other specific CPT codes exist to describe these supplemental services. These principles are described in depth in the general policies of Chapter I.

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

The CPT codes 90780-90799 describe services involving therapeutic or diagnostic injections and infusions. The CPT codes 96400-96549 describe administration of chemotherapeutic (primarily antineoplastic) agents. Issues referable to chemotherapy administration will be discussed in this section as well as Section L (Chemotherapy Administration) due to the frequent similarities in administration.

Because the placement of peripheral vascular access devices is integral to vascular (intravenous, intra-arterial) infusions and injections, the CPT codes for placement of these devices are not to be separately reported. Accordingly, routine insertion of an intravenous catheter (e.g. CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g. CPT codes 90780, 90781, 90784, 96408-96412) would be inappropriate. Insertion of central venous access is not routinely necessary to accomplish these services and therefore, could be separately reported. Because intra-arterial infusion usually involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes could be separately reported.

The administration of drugs other than antineoplastic agents, such as growth factors, saline, and diuretics, is reported with

CPT codes 90780-90784. When the sole purpose of fluid administration (e.g. saline, D_5W, etc.) is to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic. Therefore, the injection, infusion or chemotherapy administration codes are not to be separately reported. In the case of transfusion of blood or blood products, the insertion of a peripheral IV (e.g. CPT codes 36000, 36410) is routinely necessary and is not separately reported. Administration of fluid in the course of transfusions to maintain line patency or between units of blood products is, likewise, not to be separately reported. If fluid administration is medically necessary for therapeutic reasons (e.g. to correct dehydration, to prevent nephrotoxicity, etc.) in the course of a transfusion or chemotherapy, this could be separately reported with modifier -59 as this is being administered as medically necessary for a different diagnosis.

CPT codes 90782-90788 are status “T” on the Medicare Physician Fee Schedule (MPFS). Therefore, these codes are not separately payable if any other service on the physician fee schedule is payable on that date of service. In compliance with the MPFS, all NCCI edits with column two CPT codes of 90782-90788 do not allow use of NCCI-associated modifiers.

Administration of immunizations not excluded by law are reported with CPT codes 90471 and 90472 and are payable on the MPFS. Thus, separate payment for injections (90782-90788) on the same date of service is prohibited. However, since administration of immunizations for influenza, pneumococcus, and hepatitis B reported as HCPCS Level II codes of G0008-G0010 are payable on a different fee schedule, a separate injection reported as 90782-90788 is additionally payable with G0008-G0010.

Effective January 1, 2004, physician work relative value units equal to that of CPT code 99211 (office visit, established patient, Level 1) were added to drug administration CPT codes 90780-90788, 96400, 96408-96425, 96520, and 96530. Thus, CPT code 99211 cannot be billed with any of these drug administration codes. Other evaluation and management CPT codes may be billed on the same date of service as the drug administration service utilizing modifier -25 to indicate that a significant and separately identifiable evaluation and management service was provided.

C. Psychiatric Services

CPT codes for psychiatric services include general and special diagnostic services as well as a variety of therapeutic services. By *CPT Manual* definition, therapeutic services (e.g. HCPCS/CPT codes 90804-90829) include psychotherapy and continuing medical diagnostic evaluation; therefore, CPT codes 90801 and 90802 are not reported with these services.

Interactive services (diagnostic or therapeutic) are distinct forms of services for patients who have "lost, or have not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment...". Accordingly, non-interactive services would not be possible at the same session as interactive services and are not to be reported together with interactive services.

Drug management is included in some therapeutic services (e.g. HCPCS/CPT codes 90801-90829, 90845,90847-90853,90865-90870) and therefore CPT code 90862 (pharmacologic management) is not to be reported with these codes.

When medical services, other than psychiatric services, are provided in addition to psychiatric services, separate evaluation and management codes cannot be reported. The psychiatric service includes the evaluation and management services provided according to CMS policy.

D. Biofeedback

Biofeedback services involve the use of electromyographic techniques to detect and record muscle activity. The CPT codes 95860-95872 (EMG) should not be reported with biofeedback services based on the use of electromyography during a biofeedback session. If an EMG is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate EMG codes (e.g. CPT codes 95860-95872) may be reported. Modifier -59 should be added to indicate that the service performed was a separately identifiable diagnostic service. Reporting only an objective electromyographic response to biofeedback is not sufficient to bill the codes referable to diagnostic EMG.

E. Gastroenterology

Gastroenterological tests included in CPT codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as part of upper endoscopy (e.g. CPT code 43235); therefore, CPT codes 91000 (esophageal intubation) and 91055 (gastric intubation) are not separately reported when performed as part of an upper endoscopy. Provocative testing (CPT code 91052) can be expedited during GI endoscopy (procurement of gastric specimens). When performed at the same time as GI endoscopy, CPT code 91052 is reported with modifier -52 indicating that a reduced level of service was performed.

F. Ophthalmology

General ophthalmological services (e.g. CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management codes are reported, these general ophthalmological service codes (e.g. CPT codes 92002-92014) are not to be reported; the same services would be represented by both series of codes.

Special ophthalmologic services represent specific services not described as part of a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services.

For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are necessary to accomplish the procedure and are included in the procedure. Accordingly, HCPCS/CPT codes 36000 (introduction of a needle or catheter), 36410 (venipuncture), 90780 (IV infusion), and 90784 (IV injection)as well as selective vascular catheterization codes are not to be separately reported with services requiring intravenous injection (e.g. CPT codes 92230, 92235, 92240, 92287, for angioscopy and angiography).

G. Otorhinolaryngologic Services

CPT coding for otorhinolaryngologic services involves a number of tests that can be performed qualitatively by confrontation during physical examination or quantitatively with electrical recording equipment. CPT definition specifies which is the case for each code. CPT codes 92552-92557, and 92561-92589 can be performed qualitatively or quantitatively but according to CPT definition

these can be reported only if calibrated electronic equipment is used. Confrontational estimation of these tests by the physician is part of the evaluation and management service.

H. Cardiovascular Services

Cardiovascular medicine services include non-invasive and invasive diagnostic testing (including intracardiac testing) as well as therapeutic services (e.g. electrophysiological procedures). Several unique issues arise due to the spectrum of cardiovascular codes included in this section.

1. When cardiopulmonary resuscitation is performed without other evaluation and management services (e.g. a physician responds to a "code blue" and directs cardiopulmonary resuscitation with the patient's attending physician then resuming the care of the patient after the patient has been revived), only the CPT code 92950 for CPR should be reported. Levels of critical care services and prolonged management services are determined by time; when CPT code 92950 is reported, the time required to perform CPR is not included in critical care or other timed evaluation and management services.

2. In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately reported. A number of therapeutic and diagnostic cardiovascular procedures (e.g. CPT codes 92950-92998, 93501-93545, 93600-93624, 93640-93652) routinely utilize intravenous or intra-arterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques; accordingly, separate codes for routine access, monitoring, injection or infusion services are not to be reported. Fluoroscopic guidance procedures are integral to invasive intravascular procedures and are included in those services. In unique circumstances, where these services are performed, not as an integral part of the procedure, the appropriate code can be separately reported with modifier -59. When supervision and interpretation codes are identified in the *CPT Manual* for a given procedure, these can be separately reported.

3. Cardiac output measurement (e.g. CPT codes 93561-93562) is routinely performed during cardiac catheterization procedures per CPT definition and, therefore, CPT codes 93561-93562 are not to be reported with cardiac catheterization codes.

4. CPT codes 93797 and 93798 describe comprehensive services provided by a physician for cardiac rehabilitation. As this includes all services referable to cardiac rehabilitation, it would be inappropriate to bill a separate evaluation and management service code unless an unrelated, separately identifiable, service is performed and documented in the medical record.

5. When a physician who is in attendance for a cardiac stress test obtains a history, and performs a limited examination referable specifically to the cardiac stress test, a separate evaluation and management service is not reported unless a significant, separately identifiable service is performed unrelated to the performance of the cardiac stress test and in accordance with the evaluation and management guidelines. The evaluation and management service would be reported with modifier -25 in this instance.

6. Routine monitoring of EKG rhythm and review of daily hemodynamics, including cardiac outputs, is a part of critical care evaluation and management. Separate billing for review of EKG rhythm strips and cardiac output measurements (e.g. CPT codes 93040-93042, 93561, 93562) and critical care services is inappropriate. An exception to this may include a sudden change in patient status associated with a change in cardiac rhythm requiring a return to the ICU or telephonic transmission to review a rhythm strip. If reported separately, time included for this service is not included in the critical care time calculated for the critical care service.

7. Percutaneous coronary artery interventions include stent placement, atherectomy, and balloon angioplasty. For reimbursement purposes, Medicare recognizes three coronary arteries: right coronary artery (modifier –RC), left circumflex coronary artery (modifier –LC) and left anterior descending coronary artery (modifier –LD). For a given coronary artery and its branches, the provider should report only one intervention, the most complex, regardless of the number of stent placements, atherectomies, or balloon angioplasties performed in that coronary artery and its branches. From a coding perspective, stent placement is considered more complex than an atherectomy which is considered more complex than a balloon angioplasty. These interventions should be reported with the appropriate modifier (-RC, -LC, -LD) indicating in which coronary artery (including its branches) the procedure(s) was (were) performed.

Since Medicare recognizes three coronary arteries (including their branches) for reimbursement purposes, it is possible that a provider will report up to three percutaneous interventions if an intervention is performed in each of the three coronary arteries or their branches. The first reported procedure must utilize a primary code (CPT codes 92980, 92982, 92995) corresponding to the most complex procedure performed. The procedure(s) performed in the other one or two coronary arteries (including their branches) are reported with the CPT add-on codes (CPT codes 92981, 92984, 92996). Modifier -59 should not be utilized to report percutaneous coronary artery stent placement, atherectomy, or balloon angioplasty.

I. Pulmonary Services

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories. As a result of these code combinations, several issues are addressed in this policy section.

1. Alternate methods of reporting data obtained during a spirometry or other pulmonary function session cannot be separately reported. Specifically, the flow volume loop is an alternative method of calculating a standard spirometric parameter. The CPT code 94375 is included in standard spirometry (rest and exercise) studies.

2. When a physician who is in attendance for a pulmonary function study, obtains a limited history, and performs a limited examination referable specifically to the pulmonary function testing, separately coding for an evaluation and management service is not appropriate. If a significant, separately identifiable service is performed unrelated to the technical performance of the pulmonary function test, an evaluation and management service may be reported.

3. When multiple spirometric determinations are necessary (e.g. CPT code 94070) to complete the service described in the CPT code, only one unit of service is reported.

4. Pulmonary stress testing (e.g. CPT code 94620) is a comprehensive stress test with a number of component tests separately defined in the *CPT Manual*. It is inappropriate to separately code venous access, EKG monitoring, spirometric parameters performed before, during and after exercise, oximetry,

O_2 consumption, CO_2 production, rebreathing cardiac output calculations, etc., when performed as part of a progressive pulmonary exercise test. It is also inappropriate to bill for a cardiac stress test and the component codes used to perform a routine pulmonary stress test, when a comprehensive pulmonary stress test was performed. If using a standard exercise protocol, serial electrocardiograms are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, both a cardiac and pulmonary stress test could be reported. Modifier -59 should be reported with the secondary procedure. In addition, if both tests are reported, both tests must satisfy the requirement for medical necessity.

J. Allergy Testing and Immunotherapy

The *CPT Manual* divides allergy and clinical immunology into testing and immunotherapy. Immunotherapy is divided into codes that include preparation of the antigen when it is administered at the same session and when it is prepared but delivered for immunotherapy by a different physician. Several specific issues are identified regarding allergy testing and immunotherapy.

1. If percutaneous or intracutaneous (intradermal)single test (CPT codes 95004 or 95024) and "sequential and incremental" tests (CPT codes 95010, 95015, or 95027) are performed on the same date of service, both the "sequential and incremental" test and single test codes may be reported if the tests are for different allergens or different dilutions of the same allergen. The unit of service to report is the number of separate tests. Do not report both a single test and a “sequential and incremental” test for the same dilution of an allergen. For example, if the single test for an antigen is positive and the provider proceeds to “sequential and incremental” tests with three additional *different* dilutions of the same antigen, the provider may report one unit of service for the single test code and three units of service for the “sequential and incremental” test code.

2. When photo patch tests (e.g. CPT code 95052) are performed (same antigen/same session) with patch or application tests, only the photo patch testing should be reported. Additionally, if photo testing is performed including application or patch testing, the code for photo patch testing (CPT code 95052) is to be reported, not CPT code 95044 (patch or application tests) and CPT code 95056 (photo tests).

3. Evaluation and management codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is administered. Obtaining informed consent, is included in the immunotherapy. If E & M services are reported, medical documentation of the separately identifiable service should be in the medical record.

4. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. These codes should, therefore, not be reported together. Additionally, the testing becomes an integral part to rapid desensitization kits (CPT code 95180) and would therefore not be reported separately.

K. Neurology and Neuromuscular Procedures

The *CPT Manual* defines codes for neuromuscular diagnostic/therapeutic services not requiring surgical procedures. Sleep testing, nerve and muscle testing and electroencephalographic procedures are included. The *CPT Manual* guidelines regarding sleep testing are very precise and should be reviewed carefully before billing for these services.

1. Sleep testing differs from polysomnography in that the latter requires the presence of sleep staging. Sleep staging includes a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. Accordingly, at the same session, a "sleep study" and "polysomnography" are not reported together.

2. Polysomnography requires at least one central and usually several other EEG electrodes. EEG procurement for polysomnography (sleep staging) differs greatly from that required for diagnostic EEG testing (i.e. speed of paper, number of channels, etc.). Accordingly, EEG testing is not to be reported with polysomnography unless performed separately; the EEG tests, if rendered with a separate report, are to be reported with modifier -59, indicating that this represents a different session from the sleep study.

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) represent different services than those provided during sleep testing; accordingly these codes are only to be reported when a separately identifiable service is performed and documented. Additionally, billing standard EEG services would only be appropriate if a significant, separately

identifiable service is provided. These codes are to be reported with modifier -59 to indicate that a different service is clearly documented.

4. When nerve testing (EMG, nerve conduction velocity, etc.) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the series of CPT codes 95851-95937 are not to be separately reported; these codes reflect significant, separately identifiable diagnostic services requiring a formal report in the medical record. Additionally, electrical stimulation used to identify or locate nerves as part of a procedure involving treatment of a cranial or peripheral nerve (e.g. nerve block, nerve destruction, neuroplasty, transection, excision, repair, etc.) is part of the primary procedure.

5. Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing since they are also included in the global package.

6. The NCCI edit with column 1 CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column 2 CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 95900 of this NCCI edit is only appropriate if the two procedures are performed on different nerves or in separate patient encounters.

L. Chemotherapy Administration

1. Chemotherapy administration codes include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Prior to January 1, 2004, Medicare payment rules limited the reporting of CPT code 96408 (intravenous push administration of chemotherapy) to one unit of service per day. Effective January 1, 2004, CPT code 96408 can be reported as one unit of service for each drug administered by the intravenous push route. For a given chemotherapeutic agent, only one intravenous (or intra-arterial) route (push or infusion)

is payable at the same patient encounter. It is recognized that combination chemotherapy is frequently provided by different routes at the same session. Modifier –59 can be appropriately used when two different modes of chemotherapy administration are used for different chemotherapeutic agents. Modifier –59 is used in this situation to indicate that two separate procedures are utilized to administer different chemotherapeutic agent(s), not to indicate that two separate agents are administered. (See MCM Section §15400 or online internet manual Pub.100-4,12-§20.9.1.1, 30.5)

2. When infusion of saline, an antiemetic, or any other non-chemotherapy drug is required under CPT codes 90780-90781 and administered at the same time as the chemotherapeutic agents, the former infusions are not separately payable; however, the drugs are payable. If the hydration and/or infusion of antiemetics or any other non-chemotherapy drugs are administered on the same day but sequentially to rather than at the same time as the administration of the chemotherapeutic agents, these infusions are payable with CPT codes 90780-90781 using modifier -59 to indicate that the infusions were administered at different time intervals.

3. In circumstances where a physician has no face-to-face contact with the patient, a physician may report and be paid for “incident to” services in addition to the chemotherapy administration if these services are furnished by one of the physician’s employees, under direct supervision in the office by one of the physician’s employees, and the medical records reflect that the physician has actively participated in and managed the patient’s course of treatment. The “incident to” services in this situation are reported with the evaluation and management code 99211.

4. Flushing of a vascular access port prior to the administration of chemotherapeutic agents is integral to the chemotherapy administration and therefore is not separately reportable.

5. The NCCI edits with column 1 CPT codes 96408 (Intravenous chemotherapy administration by push technique) and 96410 (Intravenous chemotherapy administration by infusion technique, up to one hour) each with column 2 CPT code 90780 (Therapeutic or diagnostic intravenous infusion up to one hour) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 90780 of these NCCI edits is only appropriate if the 90780 is for hydration, antiemetic, or other non-

chemotherapy drug administered before, after, or at different patient encounters than the chemotherapy. Modifier -59 should not be used for “keep open” infusion for the chemotherapy.

M. Physical Medicine and Rehabilitation

With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. (The only exception involves a “supervised modality” defined by CPT codes 97010-97028 which may be reported for the same fifteen minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI edits pair a “timed” CPT code with another “timed” CPT code or a non-timed CPT code. These edits may be bypassed with modifier -59 if the two procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter. NCCI does not include all edits pairing two physical medicine and rehabilitation services (excepting “supervised modality” services) even though they should never be reported for the same fifteen minute time period.

NCCI contains edits with column one codes of the physical medicine and rehabilitation therapy services and column two codes of the physical therapy and occupational therapy re-evaluation CPT codes of 97002 and 97004 respectively. The re-evaluation services should not be routinely reported during a planned course of physical or occupational therapy. However, if the patient’s status should change and a re-evaluation is warranted, it may be reported with modifier -59 appended to CPT code 97002 or 97004 as appropriate.

The NCCI edit with column 1 CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column 2 CPT code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column 2 CPT code 97530 of this NCCI edit is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.

N. Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is subject to Global Surgery Rules. Per Medicare Anesthesia Rules a provider performing OMT cannot separately report anesthesia services such as nerve blocks or epidural injections for OMT. In addition, per Medicare Global Surgery Rules, postoperative pain management after OMT (e.g., nerve block, epidural injection) is not separately reportable. Epidural or nerve block injections performed on the same date of service as OMT and unrelated to the OMT may be reported with OMT using modifier -59.

O. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. Physical therapy services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical therapy services are performed in a different region than CMT and the provider is eligible to report physical therapy codes under the Medicare program, the provider may report CMT and the above physical therapy codes using modifier -59.

P. Miscellaneous Services

1. When CPT code 99175 is reported, observation time provided exclusively to monitor the patient for a response to an emetogenic agent is not to be included in other timed codes (e.g. critical care, office visits, prolonged services, etc.).

2. If hypothermia (e.g. CPT code 99185) is accomplished by regional infusion techniques, separate services for chemotherapy administration should not be reported unless chemotherapeutic agents are also administered at the same session.

3. Therapeutic phlebotomy services (e.g. CPT code 99195) are not to be reported with transfusion service codes (e.g. CPT codes 86890, 86891), plasmapheresis codes, or exchange transfusion codes. Services necessary to perform the phlebotomy (e.g. HCPCS/CPT codes 36000, 36410, 90780, 90781) are included in the procedure.

Q. Evaluation and Management

CPT codes for evaluation and management services are principally included in the group of CPT codes, 99201-99499. The codes are

divided to describe the place of service (e.g. office, hospital, home, nursing facility, emergency department, critical care, etc.) the type of service (e.g. new or initial encounter, follow-up or subsequent encounter, consultation, etc.), and various miscellaneous services (e.g. prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be reported per day.

The prolonged physician service with direct face-to-face patient contact, (CPT codes 99354 and 99355) represents an exception and may be used in conjunction with another evaluation and management code. Other services that are described by codes based on the duration of the encounter, such as critical care services, must be reported alone and not with the prolonged service codes.

Evaluation and management services, in general, are cognitive services and significant procedural services are not included in the evaluation and management services. Certain procedural services that arise directly from the evaluation and management service are included as part of the evaluation and management service. Cleansing of traumatic lesions, closure of lacerations with adhesive strips, dressings, counseling and educational services, among other services are included in evaluation and management services.

Digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an evaluation and management code. CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

> "As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

Because of the intensive nature of caring for critically ill patients, certain services beyond patient history, examination and medical decision making are included in the overall evaluation and management associated with critical care. By CPT definition, services including the interpretation of cardiac output measurements (CPT codes 93561 and 93562), chest X-rays (CPT codes 71010 and 71020), blood gases, and data stored in computers (EKGs, blood pressures, hematologic data), gastric intubation (CPT code 91105), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94656, 94657, 94660, 94662), and vascular access procedures (HCPCS/CPT codes 36000, 36410, 36600) are included in critical care services. Certain sections of CPT codes have incorporated codes describing specialty-specific services which primarily involve evaluation and management. When codes for these services are reported, a separate evaluation and management service described by the series of CPT codes 99201-99499 are not to be reported on the same date. Examples of these codes include general and special ophthalmologic services, general and special diagnostic and therapeutic psychiatric services, among others. Procedural services involve some degree of physician involvement or supervision which is integral to the service; separate evaluation and management services are not reported unless a significant, separately identifiable service is provided. Examples of such procedures include allergy testing and immunotherapy, osteopathic manipulative treatment, physical therapy services, neurologic and vascular testing procedures.

R. General Policy Statements

1. CPT codes 92230 and 92235 (fluorescein angioscopy and angiography) include injection procedures for angiography.

2. Coronary artery angioplasty, atherectomy, or stenting procedures include insertion of a needle and/or catheter, infusion, fluoroscopy and EKG strips (e.g. CPT codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 90780-90784, 76000-76001, 93040-93042). All are components of performing a coronary artery angioplasty, atherectomy, or stenting.

3. Cardiac catheterization procedures may require procurement of EKG tracings during the procedure to assess chest pain during catheterization and angioplasty; when performed in this fashion, these EKG tracings are not separately reported.

EKGs procured prior to, or after, the procedure may be separately reported with modifier -59.

4. CPT codes 93501, 93505-93545 (cardiac catheterization) include CPT codes 71034, 76000, and 76001 (fluoroscopy).

5. Placement of an occlusive device such as an angioseal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported as HCPCS code G0269. Provider should not report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

6. Renal artery angiography at the time of cardiac catheterization should be reported as HCPCS code G0275 if selective catheterization of the renal artery is not performed. HCPCS code G0275 should not be reported with CPT code 36245 for selective renal artery catheterization or CPT codes 75722 or 75724 for renal angiography. If it is medically necessary to perform selective renal artery catheterization and renal angiography, HCPCS code G0275 should not be additionally reported.

7. Cardiovascular stress tests include insertion of needle and/or catheter, infusion (pharmacologic stress tests) and EKG strips (e.g. CPT codes 36000, 36410, 90780-90784, 93000-93010, 93040-93042).

8. Ventilation management and continuous positive airway pressure ventilation (CPAP) initiation and management services are mutually exclusive of evaluation and management services with the exception of critical care services. Critical care services (CPT codes 99291-99292) include ventilation management (CPT codes 94656-94657) and CPAP management (CPT codes 94660, 94662).

9. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

10. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.

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CHAPTER XII
SUPPLEMENTAL SERVICES
HCPCS LEVEL II CODES A0000 - V9999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter XII
Supplemental Services
HCPCS Level II Codes A0000 - V9999

A. Introduction

The HCPCS Level II codes are alpha-numeric codes that have been developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe non-physician services and supplies such as drugs, durable medical equipment, ambulance, manipulations, etc. The general correct coding policies previously outlined in Chapter I apply to these codes as well as CPT codes. The correct coding edits and policy statements that follow address only those HCPCS Level II codes that are to be reported to the Medicare Part B carriers.

B. General Policy Statements

1. HCPCS code M0064 is not to be reported separately from CPT codes 90801-90857 (psychiatric services). This code describes a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.

2. HCPCS code Q0091, for screening pap smears includes the services necessary to procure and transport the specimen to the laboratory. If an evaluation and management service is performed at the same visit solely for the purpose of performing a screening pap smear, then the evaluation and management service is not reported separately. If a significant, separately identifiable evaluation and management service is performed to evaluate other medical problems, then both the screening pap smear and the evaluation and management service are reported. By appending the modifier -25 to the evaluation and management code, the provider is indicating that a significant, separately identifiable service was rendered.

3. HCPCS code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E & M) services under certain circumstances. If a Medicare covered E & M service requires breast and pelvic examination, HCPCS code G0101 should not be

additionally reported. However, if the Medicare covered E & M service and the screening services, G0101, are unrelated to one another, both HCPCS code G0101 and the E & M service may be reported appending modifier -25 to the E & M service CPT code. Use of modifier -25 indicates that the E & M service is significant and separately identifiable from the screening service, G0101.

4. HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an evaluation and management code (CPT codes 99201-99499). CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

> "As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

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CHAPTER XIII
Category III Codes
CPT Codes 0001T – 0099T
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter XIII
Category III Codes
CPT Codes 0001T – 0099T

A. Introduction

The *CPT Manual* contains Category III codes, XXXXT, that represent emerging technologies, services, and procedures. Each Category III code is referenced in another section of the *CPT Manual* that contains related procedures. The NCCI contains edits for many of these codes. The coding policies used to establish these edits are the same as those used for other procedures in the related section of the *CPT Manual*. For example, if the XXXXT code describes a laboratory procedure, the coding policies that apply are those found in Chapter I (General Correct Coding Policies) and Chapter X (Pathology and Laboratory Services (CPT Codes 80000-89999)) of the *"National Correct Coding Policy Manual for Medicare Part B Carriers".*