National Correct Coding Initiative Policy Manual for Medicare Services Revision Date: 1/1/2016

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INTRODUCTION
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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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 Physician Fee Schedule, it was important to assure that uniform payment policies and procedures were followed by all carriers (A/B MACs processing practitioner service claims) so that the same service would be paid similarly in all carrier (A/B MAC processing practitioner service claims) jurisdictions. Accurate coding and reporting of services by physicians is a critical aspect of assuring proper payment.

Purpose

The Centers for Medicare & 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 of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

NCCI includes three types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUE), and Add-on Code Edits.

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.

Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under

most circumstances reportable by the same provider for the same beneficiary on the same date of service.

Additional general information concerning NCCI PTP edits and MUEs is discussed in Chapter I.

Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment.

NCCI PTP edits are utilized by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) 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 (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006 all therapy claims at most sites of service paid by A/B MACs processing facility claims (Fiscal Intermediaries) were also subject to NCCI PTP edits in the OCE. These include, but are not limited to, therapy services reported by skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and outpatient rehabilitation agencies (OPTs - outpatient physical therapy and speech pathology services). NCCI PTP edits utilized for practitioner claims are also utilized for Ambulatory Surgical Center claims.

Prior to January 1, 2012 NCCI PTP edits incorporated into OCE appeared in OCE one calendar quarter after they appear in NCCI. Effective January 1, 2012, NCCI PTP edits in OCE appear synchronously with NCCI PTP edits for practitioners. Hospitals like physicians and other providers must code correctly even in the absence of NCCI or OCE edits. For example, new category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in NCCI on January 1. Prior to January 1, 2012, the new edits for these codes did not appear in OCE until the following April 1. Hospitals were required to code correctly during the three month delay.

On January 1, 2007, CMS incorporated Medically Unlikely Edits (MUEs) into the NCCI program. These edits are applicable to claims submitted to Carriers (A/B MACs processing practitioner service claims), A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Fiscal Intermediaries (FIs) A/B MACs processing outpatient hospital service claims).

Pursuant to Section 6507 of the Affordable Care Act, CMS provided instructions to States for implementation of NCCI methodologies in State Medicaid programs by October 1, 2010. CMS publishes on its website separate edit files and manuals for the CMS State Medicaid NCCI program methodology. In order to avoid confusion between the use of the term NCCI for the NCCI program methodology and NCCI procedure to procedure (PTP) edits, the CMS Medicaid NCCI program uses the term NCCI PTP to identify NCCI column one/column two edits. Although the Medicaid NCCI methodology edit files were originally created as a subset of the Medicare NCCI and MUE edits, the Medicaid NCCI methodology edit files will also contain edits for HCPCS/CPT codes not utilized by the Medicare program.

In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

CPT codes representing services denied based on NCCI PTP 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.

Since the NCCI is a CMS program, its policies and edits represent CMS national policy. However, NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

NCCI PTP edits are adopted after due consideration of Medicare policies including the principles described in the *National Correct Coding Initiative Policy Manual for Medicare Services,* HCPCS and *CPT Manual* code descriptors, *CPT Manual* coding guidelines, coding guidelines of national societies, standards of medical and surgical practice, current coding practice, and provider billing patterns. Since the NCCI is developed by CMS for the Medicare program, the most important consideration is CMS policy.

Prior to initial implementation of the NCCI in 1996, the proposed edits were evaluated by Medicare Part B Carrier Medical Directors, representatives of the American Medical Association's CPT Advisory Committee, and representatives of other national medical and surgical societies.

The NCCI undergoes continuous refinement with revised edit tables published quarterly. There is a process to address annual changes (additions, deletions, and modifications) of HCPCS/CPT codes and *CPT Manual* coding guidelines. Other sources of refinement are initiatives by the CMS central office and comments from the CMS regional offices, AMA, national medical, surgical, and other healthcare societies/organizations, Medicare contractor medical directors, providers, consultants, other third party payors, and other interested parties. Prior to implementing new edits, CMS generally provides a review and comment period to representative national organizations that may be impacted by the edits. However, there are situations when CMS thinks that it is prudent to implement edits prior to completion of the review and comment period. CMS Central Office evaluates the input from all sources and decides which edits are modified, deleted, or added each quarter.

Policy Manual Background

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

The *National Correct Coding Initiative Policy Manual for Medicare Services* and the edits were developed for the purpose of encouraging

consistent and correct coding and reducing 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. If a provider determines that he/she has been coding incorrectly, the provider should contact his/her Carrier, Fiscal Intermediary, or MAC about potential payment adjustments.

The *National Correct Coding Initiative Policy Manual for Medicare Services* 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, additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes occur based on changes in technology, standard medical practice, and input from the AMA, specialty societies, other national healthcare organizations, Medicare contractor medical directors and staff, providers, consultants, etc.

The *National Correct Coding Initiative Policy Manual for Medicare Services* 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, and Chapter XIII which addresses Category III CPT codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

The *National Correct Coding Initiative Policy Manual for Medicare Services* 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' HCPCS Level II code descriptors for complete descriptors of the codes.

Edit Development and Review Process

The NCCI undergoes constant refinement publishing four versions annually. Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries implement the versions effective January 1, April 1, July 1, and October 1 of each year. 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, other national healthcare organizations, Medicare contractor medical directors and staff, 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 and other national healthcare organizations before implementing many types of changes in NCCI. Although national medical/surgical societies and other national healthcare organizations 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 or other national healthcare organizations, it does so after due consideration of those comments and other information available to CMS.

NCCI PTP, MUE, or Add-on Code edits may be revised for a variety of reasons. Edit revisions may be effective in the next version of the relevant edit file or may be retroactive. If an edit revision is retroactive, Medicare Administrative Contractors (MACs) may reopen claims that are brought to their attention when such claims would have payment changes due to that retroactive change. In accordance with CMS policy, a reopening with a new adverse determination affords the physician new appeal rights. In limited circumstances, CMS may at times issue directions for a mass adjustment when it determines that such an action meets the needs of the program and can occur within its current operational constraints.

Sources of Information about NCCI and MUE

The CMS website contains:

1) *National Correct Coding Initiative Policy Manual for Medicare Services* (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html);
2) NCCI PTP edits utilized for practitioner claims (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html);
3) NCCI PTP edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE) (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html);
4) NCCI Frequently Asked Questions (FAQ) (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html);
5) MUE Overview (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html);

6) MUE Frequently Asked Questions (FAQ) (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html);
7) HCPCS/CPT codes with published MUE values in the Practitioner/DME Supplier MUE table (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html);
8) HCPCS/CPT codes with published MUE values in the Hospital Outpatient Services MUE table (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html);
9) HCPCS/CPT codes with published MUE values in the Durable Medical Equipment (DME) Supplier Services MUE table (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html);
10) Current quarterly version update changes for NCCI PTP edits and published MUEs (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html);
11) Add-on code edits utilized for practitioner claims (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html);
12) Current quarterly updates to add-on code edits (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html);
13) Medicare Learning Network Publication: “Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program” (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf) and
14) Medicare Learning Network Publication: “How to Use the National Correct Coding Initiative (NCCI) Tools” (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)

Sources of information about NCCI published by entities other than CMS or its NCCI contractor should not be relied upon for guidance about the NCCI or MUE in legal matters regarding the Medicare program.

Correspondence to CMS about NCCI and its Contents

The NCCI is maintained for CMS by Correct Coding Solutions, LLC. If the user of this manual has concerns regarding the content of the edits or this manual, an inquiry may be submitted in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax number: (317) 571-1745

CMS makes all decisions about the contents of NCCI and this manual. Correspondence from Correct Coding Solutions, LLC reflects CMS' policies on coding and NCCI.

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CHAPTER I
GENERAL CORRECT CODING POLICIES
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

Applicable FARS\DFARS Restrictions Apply to Government Use.

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LIST OF ACRONYMS

AA	Anesthesia Assistant
A/B MAC	A/B Medicare Administrative Contractor
ABN	Advanced Beneficiary Notice
AMA	American Medical Association
ASC	Ambulatory Surgical/Surgery Center
CBC	Complete Blood Count
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMT	Chiropractic Manipulative Treatment
CMV	Cytomegalovirus
CNS	Central Nervous System
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CT	Computed Tomography
CTA	Computed Tomographic Angiography
DME	Durable Medical Equipment
D.O.	Doctor of Osteopathy
DOJ	Department of Justice
ECG	Electrocardiogram
E/M or E&M	Evaluation & Management Services
EEG	Electroencephalogram
EMG	Electromyogram
FNA	Fine Needle Aspiration
HCPCS	Healthcare Common Procedure Coding System
HLA	Human Leukocyte Antigen
IPPB	Intermittent Positive Pressure Breathing
IVP	Intravenous Pyelogram
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
LT	Left Side
MAC	Monitored Anesthesia Care
MAI	MUE Adjudication Indicator
M.D.	Medical Doctor
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
PET	Positron Emission Tomography
PSC	Program Safeguard Contractor
PTP	Procedure-To-Procedure
RAC	Recovery Audit Contractor
RC	Right Coronary Artery

LIST OF ACRONYMS (Continued)

RT	Right Side
RS&I	Radiological Supervision and Interpretation
SPECT	Single Photon Emission Computed Tomography
SSA	Social Security Act
UOS	Unit(s) of Service
VAD	Ventricular Assist Device
WBC	White Blood Cell
ZPIC	Zoned Program Integrity Contractor

Chapter I

General Correct Coding Policies

A. Introduction

Healthcare providers utilize HCPCS/CPT codes to report medical services performed on patients to Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries (FIs). HCPCS (Healthcare Common Procedure Coding System) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA's) *CPT Manual* which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare & Medicaid Services (CMS) and are updated throughout the year as necessary. Changes in CPT codes are approved by the AMA CPT Editorial Panel which meets three times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific defining a single service (e.g., CPT code 93000 (electrocardiogram)) while other codes define procedures consisting of many services (e.g., CPT code 58263 (vaginal hysterectomy with removal of tube(s) and ovary(s) and repair of enterocele)). Because many procedures can be performed by different approaches, different methods, or in combination with other procedures, there are often multiple HCPCS/CPT codes defining similar or related procedures.

CPT and HCPCS Level II code descriptors usually do not define all services included in a procedure. There are often services inherent in a procedure or group of procedures. For example, anesthesia services include certain preparation and monitoring services.

The CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together. Prior to April 1, 2012, NCCI PTP edits were placed into either the "Column One/Column Two Correct Coding Edit Table" or the "Mutually Exclusive Edit Table". However, on April 1, 2012, the edits in the "Mutually Exclusive Edit Table" were moved to the "Column One/Column Two Correct Coding Edit Table" so that all the NCCI PTP edits are currently contained in this single table. Combining the two tables simplifies researching NCCI PTP edits and online use of NCCI tables.

Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment. (NCCI-associated modifiers and their appropriate use are discussed elsewhere in this chapter.)

When the NCCI was first established and during its early years, the "Column One/Column Two Correct Coding Edit Table" was termed the "Comprehensive/Component Edit Table". This latter terminology was a misnomer. Although the column two code is often a component of a more comprehensive column one code, this relationship is not true for many edits. In the latter type of edit the code pair edit simply represents two codes that should not be reported together. For example, a provider should not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

In this chapter, Sections B–Q address various issues relating to NCCI PTP edits.

Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is one that allows the vast majority of appropriately coded claims to pass the MUE. More information concerning MUEs is discussed in Section V of this chapter.

In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS

Internet-only Manual, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

Physicians must report services correctly. This manual discusses general coding principles in Chapter I and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. There are certain types of improper coding that physicians must avoid.

Procedures should be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code. Some examples follow:

- A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician should report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician should not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less;) plus CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)).

- A physician should not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician should report CPT code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code 46600(Anoscopy; diagnostic,...) plus CPT code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be utilized with an endoscopic procedure code.

- A physician should not unbundle a bilateral procedure code into two unilateral procedure codes. For example if a physician performs bilateral mammography, the physician

should report CPT code 77056 (Mammography; bilateral). The physician should not report CPT code 77055 (Mammography; unilateral) with two units of service or 77055LT plus 77055RT.

- A physician should not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician should not report CPT code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. For example if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider should report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician should not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must avoid upcoding. A HCPCS/CPT code may be reported only if all services described by that code have been performed. For example, if a physician performs a superficial axillary lymphadenectomy (CPT code 38740), the physician should not report CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. For example, some therapy codes are reported in fifteen minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A physician should not report a "per session" code using fifteen minute increments. CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.

In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

This chapter addresses general coding principles, issues, and policies. Many of these principles, issues, and policies are addressed further in subsequent chapters dealing with specific groups of HCPCS/CPT codes. In this chapter examples are often utilized to clarify principles, issues, or policies. The examples do not represent the only codes to which the principles, issues, or policies apply.

B. Coding Based on Standards of Medical/Surgical Practice

Most HCPCS/CPT code defined procedures include services that are integral to them. Some of these integral services have specific CPT codes for reporting the service when not performed as an integral part of another procedure. (For example, CPT code 36000 (introduction of needle or intracatheter into a vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein.) Other integral services do not have specific CPT codes. (For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.) Services integral to HCPCS/CPT code defined procedures are included in those procedures based on the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

Many NCCI PTP edits are based on the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. When integral component services have their own HCPCS/CPT codes, NCCI PTP edits place the comprehensive service in column one and the component service in column two. Since a component service integral to a comprehensive service is not separately reportable, the column two code is not separately reportable with the column one code.

Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration

- Insertion of urinary catheter
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia Services)
- Local, topical or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS unit
- Institution of Patient Controlled Anesthesia
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where CMS policy permits separate payment

Although other chapters in this Manual further address issues related to the standards of medical/surgical practice for the procedures covered by that chapter, it is not possible because of space limitations to discuss all NCCI PTP edits based on the principle of the standards of medical/surgical practice. However, there are several general principles that can be applied to the edits as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.

2. The component service is usually necessary to complete the comprehensive service.

3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Specific examples of services that are not separately reportable because they are components of more comprehensive services follow:

Medical:

1. Since interpretation of cardiac rhythm is an integral component of the interpretation of an electrocardiogram, a rhythm strip is not separately reportable.

2. Since determination of ankle/brachial indices requires both upper and lower extremity doppler studies, an upper extremity doppler study is not separately reportable.

3. Since a cardiac stress test includes multiple electrocardiograms, an electrocardiogram is not separately reportable.

Surgical:

1. Since a myringotomy requires access to the tympanic membrane through the external auditory canal, removal of impacted cerumen from the external auditory canal is not separately reportable.

2. A “scout” bronchoscopy to assess the surgical field, anatomic landmarks, extent of disease, etc., is not separately reportable with an open pulmonary procedure such as a pulmonary lobectomy. By contrast, an initial diagnostic bronchoscopy is separately reportable. If the diagnostic bronchoscopy is performed at the same patient encounter as the open pulmonary procedure and does not duplicate an earlier diagnostic bronchoscopy by the same or another physician, the diagnostic bronchoscopy may be reported with modifier 58 appended to the open pulmonary procedure code to indicate a staged procedure. A cursory examination of the upper airway during a bronchoscopy with the bronchoscope should not be reported separately as a laryngoscopy. However, separate endoscopies of anatomically distinct areas with different endoscopes may be reported separately (e.g., thoracoscopy and mediastinoscopy).

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Since a colectomy requires exposure of the colon, the laparotomy and adhesiolysis to expose the colon are not separately reportable.

C. Medical/Surgical Package

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work.

The component elements of the pre-procedure and post-procedure work for each procedure are included component services of that procedure as a standard of medical/surgical practice. Some general guidelines follow:

1. Many invasive procedures require vascular and/or airway access. The work associated with obtaining the required access is included in the pre-procedure or intra-procedure work. The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work.

Airway access is necessary for general anesthesia and is not separately reportable. There is no CPT code for elective endotracheal intubation. CPT code 31500 describes an emergency endotracheal intubation and should not be reported for elective endotracheal intubation. Visualization of the airway is a component part of an endotracheal intubation, and CPT codes describing procedures that visualize the airway (e.g., nasal endoscopy, laryngoscopy, bronchoscopy) should not be reported with an endotracheal intubation. These CPT codes describe diagnostic and therapeutic endoscopies, and it is a misuse of these codes to report visualization of the airway for endotracheal intubation.

Intravenous access (e.g., CPT codes 36000, 36400, 36410) is not separately reportable when performed with many types of procedures (e.g., surgical procedures, anesthesia procedures, radiological procedures requiring intravenous contrast, nuclear medicine procedures requiring intravenous radiopharmaceutical). After vascular access is achieved, the access must be maintained by a slow infusion (e.g., saline) or injection of heparin or saline into a “lock”. Since these services are necessary for maintenance of the vascular access, they are not separately reportable with the vascular access CPT codes or procedures

requiring vascular access as a standard of medical/surgical practice. CPT codes 37211-37214 (Transcatheter therapy with infusion for thrombolysis) should not be reported for use of an anticoagulant to maintain vascular access.

The global surgical package includes the administration of fluids and drugs during the operative procedure. CPT codes 96360-96376 should not be reported separately. Under OPPS, the administration of fluids and drugs during or for an operative procedure are included services and are not separately reportable (e.g., CPT codes 96360-96376).

When a procedure requires more invasive vascular access services (e.g., central venous access, pulmonary artery access), the more invasive vascular service is separately reportable if it is not typical of the procedure and the work of the more invasive vascular service has not been included in the valuation of the procedure.

Insertion of a central venous access device (e.g., central venous catheter, pulmonary artery catheter) requires passage of a catheter through central venous vessels and, in the case of a pulmonary artery catheter, through the right atrium and ventricle. These services often require the use of fluoroscopic guidance. Separate reporting of CPT codes for right heart catheterization, selective venous catheterization, or pulmonary artery catheterization is not appropriate when reporting a CPT code for insertion of a central venous access device. Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 76001, 77002) should not be reported separately.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia services by the same physician performing a surgical or medical procedure. The physician performing a surgical or medical procedure should not report CPT codes 96360-96376 for the administration of anesthetic agents during the procedure. If it is medically reasonable and necessary that a separate provider (anesthesia practitioner) perform anesthesia services (e.g., monitored anesthesia care) for a surgical or medical procedure, a separate anesthesia service may be reported by the second provider.

Under OPPS, anesthesia for a surgical procedure is an included service and is not separately reportable. For example, a provider should not report CPT codes 96360-96376 for anesthesia services.

When anesthesia services are not separately reportable, physicians and facilities should not unbundle components of anesthesia and report them in lieu of an anesthesia code.

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Many procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable. Examples of these services include cardiac monitoring, pulse oximetry, and ventilation management (e.g., 93000-93010, 93040-93042, 94760, 94761, 94770).

5. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

If a single lesion is biopsied multiple times, only one biopsy code may be reported with a single unit of service. If multiple lesions are non-endoscopically biopsied, a biopsy code may be

reported for each lesion appending a modifier indicating that each biopsy was performed on a separate lesion. For endoscopic biopsies, multiple biopsies of a single or multiple lesions are reported with one unit of service of the biopsy code. If it is medically reasonable and necessary to submit multiple biopsies of the same or different lesions for separate pathologic examination, the medical record must identify the precise location and separate nature of each biopsy.

6. Exposure and exploration of the surgical field is integral to an operative procedure and is not separately reportable. For example, an exploratory laparotomy (CPT code 49000) is not separately reportable with an intra-abdominal procedure. If exploration of the surgical field results in additional procedures other than the primary procedure, the additional procedures may generally be reported separately. However, a procedure designated by the CPT code descriptor as a "separate procedure" is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

7. If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement, incision and drainage) is not separately reportable. For example, debridement of skin *and subcutaneous tissue at the site of an abdominal incision made to perform an intra-abdominal procedure* is not separately reportable. *(See Chapter IV, Section H (General Policy Statements), paragraph #10 for guidance on reporting debridement with open fractures and dislocations.)*

8. If removal, destruction, or other form of elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure may be reported. For example, if an area of pilonidal disease contains an abscess, incision and drainage of the abscess during the procedure to excise the area of pilonidal disease is not separately reportable.

9. An excision and removal (-ectomy) includes the incision and opening (-otomy) of the organ. A HCPCS/CPT code for an –otomy procedure should not be reported with an –ectomy code for the same organ.

10. Multiple approaches to the same procedure are mutually exclusive of one another and should not be reported separately. For example, both a vaginal hysterectomy and abdominal hysterectomy should not be reported separately.

11. If a procedure utilizing one approach fails and is converted to a procedure utilizing a different approach, only the completed procedure may be reported. For example, if a laparoscopic hysterectomy is converted to an open hysterectomy, only the open hysterectomy procedure code may be reported.

12. If a laparoscopic procedure fails and is converted to an open procedure, the physician should not report a diagnostic laparoscopy in lieu of the failed laparoscopic procedure. For example, if a laparoscopic cholecystectomy is converted to an open cholecystectomy, the physician should not report the failed laparoscopic cholecystectomy nor a diagnostic laparoscopy.

13. If a diagnostic endoscopy is the basis for and precedes an open procedure, the diagnostic endoscopy may be reported with modifier 58 appended to the open procedure code. However, the medical record must document the medical reasonableness and necessity for the diagnostic endoscopy. A scout endoscopy to assess anatomic landmarks and extent of disease is not separately reportable with an open procedure. When an endoscopic procedure fails and is converted to another surgical procedure, only the completed surgical procedure may be reported. The endoscopic procedure is not separately reportable with the completed surgical procedure.

14. Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operating room during the procedure or (2) if it occurs postoperatively and does not require return to the operating room. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.

D. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an

E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 date 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. The AMA *CPT Manual* and CMS define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of two alphanumeric characters.

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicare restrictions are fulfilled. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU

Modifiers 76 (“repeat procedure or service by same physician”) and 77 (“repeat procedure by another physician”) are not NCCI-associated modifiers. Use of either of these modifiers does not bypass an NCCI PTP edit.

Each NCCI PTP 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 may 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.

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 subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have *NCCI PTP* 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 pairs 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 PTP edit indicates

that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations. 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.

The appropriate use of most of these modifiers is straight-forward. However, further explanation is provided about modifiers 25, 58, and 59. Although modifier 22 is not a modifier that bypasses an NCCI PTP edit, its use is occasionally relevant to an NCCI PTP edit and is discussed below.

a) **Modifier 22**: Modifier 22 is defined by the *CPT Manual* as "Increased Procedural Services". This modifier should not be reported routinely but only when the service(s) performed is (are) substantially more extensive than the usual service(s) included in the procedure described by the HCPCS/CPT code reported.

Occasionally a provider may perform two procedures that should not be reported together based on an NCCI PTP edit. If the edit allows use of NCCI-associated modifiers to bypass it and the clinical circumstances justify use of one of these modifiers, both services may be reported with the NCCI-associated modifier. However, if the NCCI PTP edit does not allow use of NCCI-associated modifiers to bypass it and the procedure qualifies as an unusual procedural service, the physician may report the column one HCPCS/CPT code of the NCCI PTP edit with modifier 22. The Carrier (A/B MAC processing practitioner service claims) may then evaluate the unusual procedural service to determine whether additional payment is justified.

For example, CMS limits payment for CPT code 69990(microsurgical techniques, requiring use of operating microscope...) to procedures listed in the *Internet-only Manual* (*IOM*) (*Claims Processing Manual,* Publication 100-04, 12-§20.4.5). If a physician reports CPT code 69990 with two other CPT codes and one of the codes is not on this list, an NCCI PTP edit with the code not on the list will prevent payment for CPT code 69990. Claims processing systems do not determine which procedure is linked with CPT code 69990. In situations such as this, the physician may submit his claim to the local carrier (A/B MAC processing practitioner service claims) for readjudication appending modifier 22 to the CPT code. Although the carrier (A/B MAC processing practitioner service claims) cannot override an NCCI PTP edit that does not allow use of NCCI-associated modifiers,

the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

b) **Modifier 25**: The *CPT Manual* defines modifier 25 as a "significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service". Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.

c) **Modifier 58**: Modifier 58 is defined by the *CPT Manual* as a "staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period". It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI-associated modifiers.

If a diagnostic endoscopic procedure results in the decision to perform an open procedure, both procedures may be reported with modifier 58 appended to the HCPCS/CPT code for the open procedure. However, if the endoscopic procedure preceding an open procedure is a "scout" procedure to assess anatomic landmarks and/or extent of disease, it is not separately reportable.

Diagnostic endoscopy is never separately reportable with another endoscopic procedure of the same organ(s) when performed at the same patient encounter. Similarly, diagnostic laparoscopy is

never separately reportable with a surgical laparoscopic procedure of the same body cavity when performed at the same patient encounter.

If a planned laparoscopic procedure fails and is converted to an open procedure, only the open procedure may be reported. The failed laparoscopic procedure is not separately reportable. The NCCI contains many, but not all, edits bundling laparoscopic procedures into open procedures. Since the number of possible code combinations bundling a laparoscopic procedure into an open procedure is much greater than the number of such edits in NCCI, the principle stated in this paragraph is applicable regardless of whether the selected code pair combination is included in the NCCI tables. A provider should not select laparoscopic and open HCPCS/CPT codes to report because the combination is not included in the NCCI tables.

d) **Modifier 59:** Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. The *CPT Manual* defines modifier 59 as follows:

> **Modifier 59: "Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, 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 individual. 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. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with

a non-E/M service performed on the same date, see modifier 25."

NCCI PTP edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. Carrier (A/B MAC processing practitioner service claims) processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

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

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe "different procedure or surgery". The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service.

There are several exceptions to this general principle about misuse of modifier 59 that apply to some code pair edits for procedures performed at the same patient encounter.

(1) When a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a

service that would have otherwise been required during the therapeutic intervention. If the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure, it should not be reported separately.

(2) When a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a)it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

(3) There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two *separate and distinct* timed services are provided in *separate and distinct* time *blocks*, modifier 59 may be used to identify the services. *The separate and distinct time blocks for the two services may be sequential to one another or split. When the two services are split, the time block for one service may be followed by a time block for the second service followed by another time block for the first service. All Medicare rules for reporting timed services are applicable. For example, the total time is calculated for all related timed services performed. The number of reportable units of service is based on the total time, and these units of service are allocated between the HCPCS/CPT codes for the individual services performed. The physician is not permitted to perform multiple services, each for the minimal reportable time, and report each of these as separate units of service. (e.g., A physician or therapist performs eight minutes of neuromuscular reeducation (CPT code 97112) and eight minutes of therapeutic exercises (CPT code 97110). Since the physician or therapist performed 16 minutes of related timed services, only one unit of service may be reported for one, not each, of these codes.)*

Use of modifier 59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not

adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. It does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site.

If the same procedure is performed at different anatomic sites, it does not necessarily imply that a HCPCS/CPT code may be reported with more than one unit of service (UOS) for the procedure. Determining whether additional UOS may be reported depends in part upon the HCPCS/CPT code descriptor including the definition of the code's unit of service, when present.

Example #1: The column one/column two code edit with column one CPT code 38221 (bone marrow biopsy) and column two CPT code 38220(bone marrow, aspiration only) includes 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 CMS does not allow separate payment for CPT code 38220 with CPT code 38221 when bone marrow aspiration and biopsy are performed through the same skin incision at a single patient encounter, CMS does allow separate payment for HCPCS level II code G0364 (bone marrow aspiration performed with bone marrow biopsy through same incision on the same date of service) with CPT code 38221 under these circumstances.

Example #2: The procedure to procedure edit with column one CPT code 11055 (paring or cutting of benign hyperkeratotic lesion ...) and column two CPT code 11720 (debridement of nail(s) by any method; 1 to 5) may be bypassed with modifier 59 only if the paring/cutting of a benign hyperkeratotic lesion is performed on a different digit (e.g., toe) than one that has nail debridement. Modifier 59 should not be used to bypass the edit if the two procedures are performed on the same digit.

e) **Modifiers XE, XS, XP, XU:** These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, physicians may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service.

XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"

XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"

XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

F. Standard Preparation/Monitoring Services for Anesthesia

With few exceptions anesthesia HCPCS/CPT codes do not specify the mode of anesthesia for a particular procedure. Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service HCPCS/CPT codes when performed in association with the anesthesia service. However, if the provider of the anesthesia service performs one or more of these services prior to and unrelated to the anticipated anesthesia service or after the patient is released from the anesthesia practitioner's postoperative care, the service may be separately reportable with modifier 59.

G. Anesthesia Service Included in the Surgical Procedure

Under the CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for 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 procedure.

For example, separate payment is not allowed for the physician's performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. However, Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

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 procedure include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), intravenous infusion/injection (CPT codes 96360-96368, 96374-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042). However, if these services are not related to the delivery of an anesthetic agent, or are not an inherent component of the procedure or global service, they may be reported separately.

The physician performing a surgical or medical procedure should not report an epidural/subarachnoid injection (CPT codes 62310-62319) or nerve block (CPT codes 64400-64530) for anesthesia for that procedure.

H. HCPCS/CPT Procedure Code Definition

The HCPCS/CPT code descriptors of two codes are often the basis of an NCCI PTP edit. If two HCPCS/CPT codes describe redundant services, they should not be reported separately. Several general principles follow:

1. A family of CPT codes may include a CPT code followed by one or more indented CPT codes. The first CPT code descriptor includes a semicolon. The portion of the descriptor of the first code in the family preceding the semicolon is a common part of the descriptor for each subsequent code of the family. For example:

CPT code 70120 Radiologic examination, mastoids; less than 3 views per side
CPT code 70130 complete, minimum of 3 views per side

The portion of the descriptor preceding the semicolon ("Radiologic examination, mastoids") is common to both CPT codes 70120 and 70130. The difference between the two codes is the portion of the descriptors following the semicolon. Often as in this case, two codes from a family may not be reported separately. A physician cannot report CPT codes 70120 and 70130 for a procedure performed on ipsilateral mastoids at the same patient encounter. It is important to recognize, however, that there are numerous circumstances when it may be appropriate to report more than one code from a family of codes. For example, CPT codes 70120 and 70130 may be reported separately if the two procedures are performed on contralateral mastoids or at two separate patient encounters on the same date of service.

2. If a HCPCS/CPT code is reported, it includes all components of the procedure defined by the descriptor. For example, CPT code 58291 includes a vaginal hysterectomy with "removal of tube(s) and/or ovary(s)". A physician cannot report a salpingo-oophorectomy (CPT code 58720) separately with CPT code 58291.

3. CPT code descriptors often define correct coding relationships where two codes may not be reported separately with one another at the same anatomic site and/or same patient encounter. A few examples follow:

a) A "partial" procedure is not separately reportable with a "complete" procedure.

b) A "partial" procedure is not separately reportable with a "total" procedure.

c) A "unilateral" procedure is not separately reportable with a "bilateral" procedure.

d) A "single" procedure is not separately reportable with a "multiple" procedure.

e) A "with" procedure is not separately reportable with a "without" procedure.

f) An "initial" procedure is not separately reportable with a "subsequent" procedure.

I. *CPT Manual* and CMS Coding Manual Instructions

CMS often publishes coding instructions in its rules, manuals, and notices. Physicians must utilize these instructions when reporting services rendered to Medicare patients.

The *CPT Manual* also includes coding instructions which may be found in the "Introduction", individual chapters, and appendices. In individual chapters the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow *CPT Manual* instructions unless CMS has provided different coding or reporting instructions.

The American Medical Association publishes *CPT Assistant* which contains coding guidelines. CMS does not review nor approve the information in this publication. In the development of NCCI PTP edits, CMS occasionally disagrees with the information in this publication. If a physician utilizes information from *CPT Assistant* to report services rendered to Medicare patients, it is possible that Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries may utilize different criteria to process claims.

J. CPT "Separate Procedure" Definition

If a CPT code descriptor includes the term "separate procedure", the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service.

K. Family of Codes

The *CPT Manual* often contains a group of codes that describe related procedures that may be performed in various combinations. Some codes describe limited component services, and other codes

describe various combinations of component services. Physicians must utilize several principles in selecting the correct code to report:

1. A HCPCS/CPT code may be reported if and only if all services described by the code are performed.

2. The HCPCS/CPT code describing the services performed should be reported. A physician should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed. There are limited exceptions to this rule which are specifically identified in this Manual.

3. HCPCS/CPT code(s) corresponding to component service(s) of other more comprehensive HCPCS/CPT code(s) should not be reported separately with the more comprehensive HCPCS/CPT code(s) that include the component service(s).

4. If the HCPCS/CPT codes do not correctly describe the procedure(s) performed, the physician should report a “not otherwise specified” CPT code rather than a HCPCS/CPT code that most closely describes the procedure(s) performed.

L. More Extensive Procedure

The *CPT Manual* often describes groups of similar codes differing in the complexity of the service. Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable. Several examples of this principle follow:

1. If two procedures only differ in that one is described as a “simple” procedure and the other as a “complex” procedure, the “simple” procedure is included in the “complex” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

2. If two procedures only differ in that one is described as a “simple” procedure and the other as a “complicated” procedure, the “simple” procedure is included in the “complicated” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

3. If two procedures only differ in that one is described as a “limited” procedure and the other as a “complete” procedure, the “limited” procedure is included in the “complete” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

4. If two procedures only differ in that one is described as an “intermediate” procedure and the other as a “comprehensive” procedure, the “intermediate” procedure is included in the “comprehensive” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

5. If two procedures only differ in that one is described as a “superficial” procedure and the other as a “deep” procedure, the “superficial” procedure is included in the “deep” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

6. If two procedures only differ in that one is described as an “incomplete” procedure and the other as a “complete” procedure, the “incomplete” procedure is included in the “complete” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

7. If two procedures only differ in that one is described as an “external” procedure and the other as an “internal” procedure, the “external” procedure is included in the “internal” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

M. Sequential Procedure

Some surgical procedures may be performed by different surgical approaches. If an initial surgical approach to a procedure fails and a second surgical approach is utilized at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. If there are different HCPCS/CPT codes for the two different surgical approaches, the two procedures are considered “sequential”, and only the HCPCS/CPT code corresponding to the second surgical approach may be reported. For example, a physician may begin a cholecystectomy procedure utilizing a laparoscopic approach and

have to convert the procedure to an open abdominal approach. Only the CPT code for the open cholecystectomy may be reported. The CPT code for the failed laparoscopic cholecystectomy is not separately reportable.

N. Laboratory Panel

The *CPT Manual* defines organ and disease specific panels of laboratory tests. If a laboratory performs all tests included in one of these panels, the laboratory may report the CPT code for the panel or the CPT codes for the individual tests. If the laboratory repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended.

O. Misuse of Column Two Code with Column One Code *(Misuse of Code Edit Rationale)*

CMS manuals and instructions often describe groups of HCPCS/CPT codes that should not be reported together for the Medicare program. Edits based on these instructions are often included as misuse of column two code with column one code.

A HCPCS/CPT code descriptor does not include exhaustive information about the code. Physicians who are not familiar with a HCPCS/CPT code may incorrectly report the code in a context different than intended. The NCCI has identified HCPCS/CPT codes that are incorrectly reported with other HCPCS/CPT codes as a result of the misuse of the column two code with the column one code. If these edits allow use of NCCI-associated modifiers (modifier indicator of "1"), there are limited circumstances when the column two code may be reported on the same date of service as the column one code. Two examples follow:

1. Three or more HCPCS/CPT codes may be reported on the same date of service. Although the column two code is misused if reported as a service associated with the column one code, the column two code may be appropriately reported with a third HCPCS/CPT code reported on the same date of service. For example, CMS limits separate payment for use of the operating microscope for microsurgical techniques (CPT code 69990) to a group of procedures listed in the online *Claims Processing Manual* (Chapter 12, Section 20.4.5 (Allowable Adjustments)). The NCCI has edits with column one codes of surgical procedures not listed in this section of the manual and column two CPT code of 69990. Some of these edits allow use of NCCI-associated modifiers

because the two services listed in the edit may be performed at the same patient encounter as a third procedure for which CPT code 69990 is separately reportable.

2. There may be limited circumstances when the column two code is separately reportable with the column one code. For example, the NCCI has an edit with column one CPT code of 80061 (lipid profile) and column two CPT code of 83721 (LDL cholesterol by direct measurement). If the triglyceride level is less than 400 mg/dl, the LDL is a calculated value utilizing the results from the lipid profile for the calculation, and CPT code 83721 is not separately reportable. However, if the triglyceride level is greater than 400 mg/dl, the LDL may be measured directly and may be separately reportable with CPT code 83721 utilizing an NCCI-associated modifier to bypass the edit.

Misuse of code as an edit rationale may be applied to procedure to procedure edits where the column two code is not separately reportable with the column one code based on the nature of the column one coded procedure. This edit rationale may also be applied to code pairs where use of the column two code with the column one code is deemed to be a coding error.

P. Mutually Exclusive Procedures

Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an “initial” service or a “subsequent” service. With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same patient encounter.

Q. Gender-Specific Procedures

The descriptor of some HCPCS/CPT codes includes a gender-specific restriction on the use of the code. HCPCS/CPT codes specific for one gender should not be reported with HCPCS/CPT codes for the opposite gender. For example, CPT code 53210 describes a total urethrectomy including cystostomy in a female, and CPT code 53215 describes the same procedure in a male. Since the patient cannot have both the male and female procedures performed, the two CPT codes cannot be reported together.

R. Add-on Codes

Some codes in the *CPT Manual* are identified 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 most add-on codes. For other add-on codes, the primary procedure code(s) is (are) not specified. When the *CPT Manual* identifies specific primary codes, the add-on code should not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code.

Add-on codes permit the reporting of significant supplemental services commonly performed in addition to the primary procedure. By contrast, 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 reportable with an add-on code. Similarly, complications inherent in an invasive procedure occurring during the procedure are not separately reportable. For example, control of bleeding during an invasive procedure is considered part of the procedure and is not separately reportable.

In general, NCCI procedure to procedure edits do 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 should 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 HCPCS/CPT codes 69990 (microsurgical techniques requiring use of operating microscope) and 95940/95941/G0453 (intraoperative neurophysiology testing).

HCPCS/CPT codes that are not designated as add-on codes should not be misused as an add-on code to report a supplemental service. A HCPCS/CPT code may be reported if and only if all services described by the CPT code are performed. A HCPCS/CPT code should not be reported with another service because a portion of the service described by the HCPCS/CPT code was performed with the other procedure. For example: If an ejection fraction is estimated from an echocardiogram study, it would be inappropriate to additionally report CPT code 78472 (cardiac blood pool imaging with ejection fraction) with the echocardiography (CPT code 93307). Although the procedure described by CPT code 78472 includes an ejection fraction, it is

measured by gated equilibrium with a radionuclide which is not utilized in echocardiography.

S. Excluded Service

The NCCI does not address issues related to HCPCS/CPT codes describing services that are excluded from Medicare coverage or are not otherwise recognized for payment under the Medicare program.

T. Unlisted Procedure Codes

The *CPT Manual* includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes and are located at the end of each section or subsection of the manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service should be reported utilizing an unlisted procedure code. A physician should not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI generally does not include edits with these codes.

U. Modified, Deleted, and Added Code Pairs/Edits – Information moved to Introduction chapter, Section (Purpose), Page Intro-5 of this Manual

V. Medically Unlikely Edits (MUEs)

To lower the Medicare Fee-For-Service Paid Claims Error Rate, CMS has established units of service edits referred to as Medically Unlikely Edit(s) MUEs).

An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE.

All practitioner claims submitted to Carriers (A/B MACs processing practitioner service claims), outpatient facility

services claims (Type of Bill 13X, 14X, 85X) submitted to Fiscal Intermediaries (A/B MACs processing facility claims), and supplier claims submitted to Durable Medical Equipment (DME) MACs are tested against MUEs.

Prior to April 1, 2013, each line of a claim was adjudicated separately against the MUE value for the HCPCS/CPT code reported on that claim line. If the units of service on that claim line exceeded the MUE value, the entire claim line was denied.

In the April 1, 2013 version of MUE, CMS began introducing date of service (DOS) MUEs. Over time CMS will convert many, but not all, MUEs to DOS MUEs. Since April 1, 2013, MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the units of service (UOS) on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS MUE, all UOS on each claim line for the same date of service for the same HCPCS/CPT code are summed, and the sum is compared to the MUE value. If the summed UOS exceed the MUE value, all UOS for the HCPCS/CPT code for that date of service are denied. Denials due to claim line MUEs or DOS MUEs may be appealed to the local claims processing contractor. DOS MUEs are utilized for HCPCS/CPT codes where it would be extremely unlikely that more UOS than the MUE value would ever be performed on the same date of service for the same patient.

The MUE files on the CMS NCCI website display an “MUE Adjudication Indicator” (MAI) for each HCPCS/CPT code. An MAI of “1” indicates that the edit is a claim line MUE. An MAI of “2” or “3” indicates that the edit is a DOS MUE.

If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, appropriate use of CPT modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.

MUEs for HCPCS codes with an MAI of “2” are absolute date of service edits. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be

considered impossible because it was contrary to statute, regulation or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the HIPAA mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for CPT 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of “2” denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy.

MUEs for HCPCS codes with an MAI of “3” are “per day edits based on clinical benchmarks”. MUEs assigned an MAI of “3” are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If contractors have evidence (e.g., medical review) that UOS in excess of the MUE value were actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

(1) Anatomic considerations may limit units of service based on anatomic structures. For example, the MUE value for an appendectomy is “1” since there is only one appendix.

(2) CPT code descriptors/CPT coding instructions in the *CPT Manual* may limit units of service. For example, a procedure described as the “initial 30 minutes” would have an MUE value of “1” because of the use of the term “initial”.

(3) Edits based on established CMS policies may limit units of service. For example, the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB) may limit

reporting of bilateral procedures to a single unit of service reported with a bilateral modifier.

(4) The nature of an analyte may limit units of service and is in general determined by one of three considerations:

a) The nature of the specimen may limit the units of service as for a test requiring a 24-hour urine specimen.

b) The nature of the test may limit the units of service as for a test that requires 24 hours to perform.

c) The physiology, pathophysiology, or clinical application of the analyte is such that a maximum unit of service for a single date of service can be determined. For example, the MUE for RBC folic acid level is one since the test would only be necessary once on a single date of service.

(5) The nature of a procedure/service may limit units of service and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).

(6) The nature of equipment may limit units of service and is in general determined by the number of items of equipment that would be utilized (e.g., cochlear implant or wheelchair).

(7) Clinical judgment considerations and determinations are based on input from numerous physicians and certified coders.

(8) Prescribing information is based on FDA labeling as well as off-label information published in CMS approved drug compendia.

(9) Submitted claims data (100%) from a six month period is utilized to ascertain the distribution pattern of UOS typically billed for a given HCPCS/CPT code.

UOS denied based on an MUE may be appealed. Because a denial of services due to an MUE is a coding denial, not a medical necessity denial, the presence of an Advanced Beneficiary Notice of Noncoverage (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, contractors should review the records to determine if the provider actually

furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of "1". CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider/ supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

HCPCS J code and drug related C and Q code MUEs are based on prescribing information and 100% claims data for a six month period of time. Utilizing the prescribing information the highest total daily dose for each drug was determined. This dose and its corresponding units of service were evaluated against paid and submitted claims data. Some of the guiding principles utilized in developing these edits are as follows:

(1) If the prescribing information defined a maximum daily dose, this value was used to determine the MUE value. For some drugs there is an absolute maximum daily dose. For others there is a maximum "recommended" or "usual" dose. In the latter two cases, the daily dose calculation was evaluated against claims data.

(2) If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110-150 kg was evaluated against the claims data. If the maximum daily dose calculation is based on ideal body weight, a dose based on a weight range of 90-110 kg was evaluated against claims data. If the maximum daily dose calculation is based on body surface area (BSA), a dose based on a BSA range of 2.4-3.0 square meters was evaluated against claims data.

(3) For "as needed" (PRN) drugs and drugs where maximum daily dose is based on patient response, prescribing information and claims data were utilized to establish MUE values.

(4) Published off label usage of a drug was considered for the maximum daily dose calculation.

(5) The MUE values for some drug codes are set to 0. The rationale for such values include but are not limited to: discontinued manufacture of drug, non-FDA approved compounded drug, practitioner MUE values for oral anti-neoplastic, oral anti-emetic, and oral immune suppressive drugs which should be billed to the DME MACs, outpatient hospital MUE values for inhalation drugs which should be billed to the DME MACs, and Practitioner/ASC MUE values for HCPCS C codes describing medications that would not be related to a procedure performed in an ASC.

Non-drug related HCPCS/CPT codes may be assigned an MUE of 0 for a variety of reasons including, but not limited to: outpatient hospital MUE value for surgical procedure only performed as an inpatient procedure, noncovered service, bundled service, or packaged service.

The MUE files on the CMS NCCI website displays an "Edit Rationale" for each HCPCS/CPT code. Although an MUE may be based on several rationales, only one is displayed on the website. One of the listed rationales is "Data." This rationale indicates that 100% claims data from a six month period of time was the major factor in determining the MUE value. If a physician appeals an MUE denial for a HCPCS/CPT code where the MUE is based on "Data," the reviewer will usually confirm that (1) the correct code is reported; (2) the correct UOS is utilized; (3) the number of reported UOS were performed; and (4) all UOS were medically reasonable and necessary.

The first MUEs were implemented January 1, 2007. Additional MUEs are added on a quarterly basis on the same schedule as NCCI updates. Prior to implementation proposed MUEs are sent to numerous national healthcare organizations for a sixty day review and comment period.

Many surgical procedures may be performed bilaterally. Instructions in the CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 require that bilateral surgical procedures be reported using modifier 50 with one unit of service. If a bilateral surgical procedure is performed at different sites bilaterally (e.g., transforaminal epidural

injections (CPT codes 64480, 64484)), one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

Some A/B MACs allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the “from date” and “to date” on the claim line. Contractors are instructed to divide the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line.

Suppliers billing services to the DME MACs typically report some HCPCS codes for supply items for a period exceeding a single day. The DME MACs have billing rules for these codes. For some codes the DME MACs require that the “from date” and “to date” be reported. The MUEs for these codes are based on the maximum number of units of service that may be reported for a single date of service. For other codes the DME MACs permit multiple days’ supply items to be reported on a single claim line where the “from date” and “to date” are the same. The DME MACs have rules allowing supply items for a maximum number of days to be reported at one time for each of these types of codes. The MUE values for these codes are based on the maximum number of days that may be reported at one time. As with all MUEs, the MUE value does not represent a utilization guideline. Suppliers should not assume that they may report units of service up to the MUE value on each date of service. Suppliers may only report supply items that are medically reasonable and necessary.

Most MUE values are set so that a provider or supplier would only very occasionally have a claim line denied. If a provider encounters a code with frequent denials due to the MUE or frequent use of a CPT modifier to bypass the MUE, the provider or supplier should consider the following: (1) Is the HCPCS/CPT code being used correctly? (2) Is the unit of service being counted correctly? (3) Are all reported services medically reasonable and necessary? and (4) Why does the provider’s or supplier’s practice differ from national patterns? A provider or supplier may choose to discuss these questions with the local Medicare contractor or a national healthcare organization whose members frequently perform the procedure.

Most MUE values are published on the CMS MUE webpage (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html). However, some MUE values are not published and are confidential. These values should not be published in oral or written form by any party that acquires one or more of them.

MUEs are not utilization edits. Although the MUE value for some codes may represent the commonly reported units of service (e.g., MUE of "1" for appendectomy), the usual units of service for many HCPCS/CPT codes is less than the MUE value. Claims reporting units of service less than the MUE value may be subject to review by claims processing contractors, Program Safeguard Contractors (PSCs), Zoned Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs), and Department of Justice (DOJ).

Since MUEs are coding edits rather than medical necessity edits, claims processing contractors may have units of service edits that are more restrictive than MUEs. In such cases, the more restrictive claims processing contractor edit would be applied to the claim. Similarly, if the MUE is more restrictive than a claims processing contractor edit, the more restrictive MUE would apply.

A provider, supplier, healthcare organization, or other interested party may request reconsideration of an MUE value for a HCPCS/CPT code. A written request proposing an alternative MUE with rationale may be sent to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax: 317-571-1745

W. Add-on Code Edit Tables

Add-on codes are discussed in Chapter I, Section R (Add-on Codes). CMS publishes a list of add-on codes and their primary codes annually prior to January 1. The list is updated quarterly based on the AMA's "CPT Errata" documents or implementation of new HCPCS/CPT add-on codes. CMS identifies add-on codes and their primary codes based on *CPT Manual* instructions, CMS interpretation of HCPCS/CPT codes, and CMS coding instructions.

The NCCI program includes three Add-on Code Edit Tables, one table for each of three "Types" of add-on codes. Each table lists the add-on code with its primary codes. An add-on code,

with one exception, is eligible for payment if and only if one of its primary codes is also eligible for payment.

The “Type I Add-on Code Edit Table” lists add-on codes for which the *CPT Manual* or HCPCS tables define all acceptable primary codes. Claims processing contractors should not allow other primary codes with Type I add-on codes. CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) is included as a Type I add-on code since its only primary code is CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes). For Medicare purposes, CPT code 99292 may be eligible for payment to a physician without CPT code 99291 if another physician of the same specialty and physician group reports and is paid for CPT code 99291.

The “Type II Add-on Code Edit Table” lists add-on codes for which the *CPT Manual* and HCPCS tables do not define any primary codes. Claims processing contractors should develop their own lists of acceptable primary codes.

The “Type III Add-on Code Edit Table” lists add-on codes for which the *CPT Manual* or HCPCS tables define some, but not all, acceptable primary codes. Claims processing contractors should allow the listed primary codes for these add-on codes but may develop their own lists of additional acceptable primary codes.

Although the add-on code and primary code are normally reported for the same date of service, there are unusual circumstances where the two services may be reported for different dates of service (e.g., CPT codes 99291 and 99292).

The first Add-On Code edit tables were implemented April 1, 2013. For subsequent years, new Add-On Code edit tables will be published to be effective for January 1 of the new year based on changes in the new year’s *CPT Manual*. CMS also issues quarterly updates to the Add-On Code edit tables if required due to publication of new HCPCS/CPT codes or changes in add-on codes or their primary codes. The changes in the quarterly update files (April 1, July 1, or October 1) are retroactive to the implementation date of that year’s annual Add-On Code edit files unless the files specify a different effective date for a change. Since the first Add-On Code edit files were implemented on

April 1, 2013, changes in the July 1 and October 1 quarterly updates for 2013 were retroactive to April 1, 2013 unless the files specified a different effective date for a change.

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

Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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Anesthesia Services
CPT Codes 00000 - 09999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 00000-01999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

Anesthesia care is provided by an anesthesia practitioner who may be a physician, a certified registered nurse anesthetist (CRNA) with or without medical direction, or an anesthesia assistant (AA) with medical direction. The anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care.

Preoperative evaluation includes a sufficient history and physical examination so that the risk of adverse reactions can be minimized, alternative approaches to anesthesia planned, and all questions regarding the anesthesia procedure by the patient or family answered. Types of anesthesia include local, regional, epidural, general, moderate conscious sedation, or monitored anesthesia care (MAC). The anesthesia practitioner assumes responsibility for anesthesia and related care rendered in the post-anesthesia recovery period until the patient is released to the surgeon or another physician.

Anesthesiologists may personally perform anesthesia services or may supervise anesthesia services performed by a CRNA or AA. CRNAs may perform anesthesia services independently or under the supervision of an anesthesiologist or operating practitioner. An AA always performs anesthesia services under the direction of an anesthesiologist. Anesthesiologists personally performing anesthesia services and non-medically directed CRNAs bill in a standard fashion in accordance with CMS regulations as outlined in the *Internet-only Manuals* (*IOM*), *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Sections 50 and 140. CRNAs and AAs practicing under the medical direction of anesthesiologists follow instructions and regulations regarding this arrangement as outlined in the above sections of the *Internet–Only Manual.*

B. Standard Anesthesia Coding

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

1. CPT codes 00100-01860 specify “Anesthesia for” followed by a description of a surgical intervention. CPT codes 01916-01933 describe anesthesia for diagnostic or interventional radiology procedures. Several CPT codes (01951-01999, excluding 01996) describe anesthesia services for burn excision/debridement, obstetrical, and other procedures. CPT codes 99143-99150 describe moderate (conscious) sedation services.

Anesthesia services include, but are not limited to, preoperative evaluation of the patient, administration of anesthetic, other medications, blood, and fluids, monitoring of physiological parameters, and other supportive services.

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.

2. A unique characteristic of anesthesia coding is the reporting of time units. Payment for anesthesia services increases with time. In addition to reporting a base unit value

for an anesthesia service, the anesthesia practitioner reports anesthesia time. Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient (i.e., when the patient may be placed safely under postoperative care). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

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 anesthesia practitioner. 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 included in the anesthesia time 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 anesthesia practitioner to continuously monitor the patient during the interval time and not perform any other service, the interval time may be included in the anesthesia time.

3. It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service and is included in the base unit value of the anesthesia code. The evaluation and examination are not reported in the anesthesia time. If surgery is canceled, subsequent to the preoperative evaluation, payment may be allowed to the anesthesiologist for an evaluation and management service and the appropriate E&M code may be reported. (A non-medically directed

CRNA may also report an E&M code under these circumstances if permitted by state law.)

Similarly, routine postoperative evaluation is included in the base unit for the anesthesia service. If this evaluation occurs after the anesthesia practitioner has safely placed the patient under postoperative care, neither additional anesthesia time units nor evaluation and management codes should be reported for this evaluation. Postoperative evaluation and management services related to the surgery are not separately reportable by the anesthesia practitioner except when an anesthesiologist provides significant, separately identifiable ongoing critical care services.

Anesthesia practitioners other than anesthesiologists and CRNAs cannot report evaluation and management codes except as described above when a surgical case is canceled.

If permitted by state law, anesthesia practitioners may separately report significant, separately identifiable postoperative management services after the anesthesia service time ends. These services include, but are not limited to, postoperative pain management and ventilator management unrelated to the anesthesia procedure.

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 should not be reported in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or non-medically directed CRNA may be able to report 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 anesthesia practitioner 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 anesthesia practitioner.

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. Certain procedural services such as insertion of a Swan-Ganz catheter, insertion of a central venous pressure line, emergency intubation (outside of the operating suite), etc., are separately payable to anesthesiologists as well as non-medically directed CRNAs if these procedures are furnished within the parameters of state licensing laws.

4. Under certain circumstances an anesthesia practitioner may separately report an epidural or peripheral nerve block injection (bolus, intermittent bolus, or continuous infusion) for postoperative pain management when the surgeon requests assistance with postoperative pain management. An epidural injection (CPT code 623XX) for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia and the adequacy of the intraoperative anesthesia is not dependent on the epidural injection. A peripheral nerve block injection (CPT codes 64XXX)for postoperative pain management may be reported separately with an anesthesia 0XXXX code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection. An epidural or peripheral nerve block injection (code numbers as identified above) administered preoperatively or intraoperatively is not separately reportable for postoperative pain management if the mode of anesthesia for the procedure is monitored anesthesia care (MAC), moderate conscious sedation, regional anesthesia by peripheral nerve block, or other type of anesthesia not identified above. If an epidural or peripheral nerve block injection (code numbers as identified above) for postoperative pain management is reported separately on the same date of service as an anesthesia 0XXXX code, modifier 59 may be appended to the epidural or peripheral nerve block injection code (code numbers as identified above) to indicate that it was administered for postoperative pain management. An epidural or peripheral nerve block injection (code numbers as identified above) for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above may be administered preoperatively, intraoperatively, or postoperatively.

5. If an epidural or subarachnoid injection (bolus, intermittent bolus, or continuous) is utilized for intraoperative anesthesia and postoperative pain management, CPT code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is not separately reportable on the day of insertion of the epidural or subarachnoid catheter. CPT code 01996 may only be reported for management for days subsequent to the date of insertion of the epidural or subarachnoid catheter.

6. Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure such as preparation, monitoring, intra-operative care, and post-operative care until the patient is released by the anesthesia practitioner to the care of another physician. Examples of integral services include, but are not limited to, the following:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of external devices including, but not limited to, those for cardiac monitoring, oximetry, capnography, temperature monitoring, EEG, CNS evoked responses (e.g., BSER), Doppler flow.
- Placement of peripheral intravenous lines for fluid and medication administration.
- Placement of airway (e.g., endotracheal tube, orotracheal tube).
- Laryngoscopy (direct or endoscopic) for placement of airway (e.g., endotracheal tube).
- Placement of naso-gastric or oro-gastric tube.
- Intra-operative interpretation of monitored functions (e.g., blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (e.g., arterial blood gases such as pH, pO_2, pCO_2, bicarbonate, CBC, blood chemistries, lactate) 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 diagnostic report must be present in the medical record.)

- Insertion of urinary bladder catheter.
- Blood sample procurement through existing lines or requiring venipuncture or arterial puncture.

The NCCI contains many edits bundling standard preparation, monitoring, and procedural services into anesthesia CPT codes. Although some of these services may never be reported on the same date of service as an anesthesia service, many of these services could be provided at a separate patient encounter unrelated to the anesthesia service on the same date of service. Providers may utilize modifier 59 to bypass the edits under these circumstances.

CPT codes describing services that are integral to an anesthesia service include, but are not limited to, the following:

- 31505, 31515, 31527 (Laryngoscopy) (Laryngoscopy codes describe diagnostic or surgical services.)
- 31622, 31645, 31646 (Bronchoscopy)
- 36000, 36010-36015 (Introduction of needle or catheter)
- 36400-36440 (Venipuncture and transfusion)
- 62310-62311, 62318-62319 (Epidural or subarachnoid injections of diagnostic or therapeutic substance - bolus, intermittent bolus, or continuous infusion)

  CPT codes 62310-62311 and 62318-62319 (Epidural or subarachnoid injections of diagnostic or therapeutic substance - bolus, intermittent bolus, or continuous infusion) may be reported on the date of surgery if performed for postoperative pain management rather than as the means for providing the regional block for the surgical procedure. If a narcotic or other analgesic is injected postoperatively through the same catheter as the anesthetic agent, CPT codes 62310-62319 should not be reported for postoperative pain management. An epidural injection for postoperative pain management may be separately reportable with an anesthesia 0XXXX code only if the patient receives a general anesthetic

and the adequacy of the intraoperative anesthesia is not dependent on the epidural injection. If an epidural injection is not utilized for operative anesthesia but is utilized for postoperative pain management, modifier 59 may be reported to indicate that the epidural injection was performed for postoperative pain management rather than intraoperative pain management.

Pain management performed by an anesthesia practitioner after the postoperative anesthesia care period terminates may be separately reportable. However, postoperative pain management by the physician performing a surgical procedure is not separately reportable by that physician. Postoperative pain management is included in the global surgical package.

Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesia practitioner reports CPT code 01382 (Anesthesia for diagnostic arthroscopic procedures of knee joint). The epidural catheter is left in place for postoperative pain management. The anesthesia practitioner should not also report CPT codes 62311 or 62319 (epidural/subarachnoid injection of diagnostic or therapeutic substance), or 01996 (daily management of epidural) on the date of surgery. 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 anesthesia practitioner performed general anesthesia reported as CPT code 01382 and at the request of the operating physician inserted an epidural catheter for treatment of anticipated postoperative pain, the anesthesia practitioner may report CPT code 62319-59 indicating that this is a separate service from the anesthesia service. In this instance, the service is separately reportable whether the catheter is placed before, during, or after the surgery. Since treatment of postoperative pain is included in the global surgical package, the operating physician may request the assistance of the anesthesia practitioner if the degree of postoperative pain is expected to exceed the skills and experience of the operating physician to manage it. If the epidural catheter was placed on a different date than the surgery, modifier 59 would not be necessary. Effective

January 1, 2004, daily hospital management of continuous epidural or subarachnoid drug administration performed on the day(s) subsequent to the placement of an epidural or subarachnoid catheter (CPT codes 62318-62319) may be reported as CPT code 01996.

- 64400-64530 (Peripheral nerve blocks – bolus injection or continuous infusion)

  CPT codes 64400-64530 (Peripheral nerve blocks – bolus injection or continuous infusion) may be reported on the date of surgery if performed for postoperative pain management only if the operative anesthesia is general anesthesia, subarachnoid injection, or epidural injection and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block. Peripheral nerve block codes should not be reported separately on the same date of service as a surgical procedure if used as the primary anesthetic technique or as a supplement to the primary anesthetic technique. Modifier 59 may be utilized to indicate that a peripheral nerve block injection was performed for postoperative pain management, rather than intraoperative anesthesia, and a procedure note should be included in the medical record.

- 67500 (Retrobulbar injection)
- 81000-81015, 82013, 80345, 82270, 82271(Performance and interpretation of laboratory tests) (CPT code 82205 was deleted January 1, 2015 and replaced by CPT code 80345.)
- 43753, 43754, 43755 (Esophageal, gastric intubation)
- 92511-92520, *92537, 92538*(Special otorhinolaryngologic services)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960, 92961 (Cardioversion)
- 93000-93010 (Electrocardiography)
- 93040-93042 (Electrocardiography)
- 93303-93308 (Transthoracic echocardiography when utilized for monitoring purposes) However, when

performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service.

- 93312-93317 (Transesophageal echocardiography when utilized for monitoring purposes) However, when performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service.
- 93318 (Transesophageal echocardiography for monitoring purposes)
- *93355 (Transesophageal echocardiography for guidance for transcatheter intracardiac or great vessel(s) structural intervention(s))*
- 93561-93562 (Indicator dilution studies)
- 93701 (Thoracic electrical bioimpedance)
- 93922-93981 (Extremity or visceral arterial or venous vascular studies) However, when performed diagnostically with a formal report, this service may be considered a significant, separately identifiable, and if medically necessary, a separately reportable service.
- 94640(Inhalation/IPPB treatments)
- 94002-94004, 94660-94662 (Ventilation management/CPAP services) If these services are performed during a surgical procedure, they are included in the anesthesia service. These services may be separately reportable if performed by the anesthesia practitioner after post-operative care has been transferred to another physician by the anesthesia practitioner. Modifier 59 may be reported to indicate that these services are separately reportable. For example, if an anesthesia practitioner who provided anesthesia for a procedure initiates ventilation management in a post-operative recovery area prior to transfer of care to another physician, CPT codes 94002-94003 should not be reported for this service since it is included in the anesthesia procedure package. However, if the anesthesia practitioner transfers care to another physician and is called back to initiate ventilation because of a change

in the patient’s status, the initiation of ventilation may be separately reportable.

- 94664 (Inhalations)
- 94680-94690, 94770 (Expired gas analysis)
- 94760-94762 (Oximetry)
- 96360-96376 (Drug administration)
- 99201-99499 (Evaluation and management)

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

7. Per Medicare Global Surgery rules the physician performing an operative procedure is responsible for treating postoperative pain. Treatment of postoperative pain by the operating physician is not separately reportable. However, the operating physician may request that an anesthesia practitioner assist in the treatment of postoperative pain management if it is medically reasonable and necessary. The actual or anticipated postoperative pain must be severe enough to require treatment by techniques beyond the experience of the operating physician. For example, the operating physician may request that the anesthesia practitioner administer an epidural or peripheral nerve block to treat actual or anticipated postoperative pain. The epidural or peripheral nerve block may be administered preoperatively, intraoperatively, or postoperatively. An epidural or peripheral nerve block that provides intraoperative pain management even if it also provides postoperative pain management is included in the 0XXXX anesthesia code and is not separately reportable. (See Chapter II (B) (paragraph 4) for guidelines regarding reporting anesthesia and postoperative pain management separately by an anesthesia practitioner on the same date of service.)

If the operating physician requests that the anesthesia practitioner perform pain management services after the postoperative anesthesia care period terminates, the anesthesia practitioner may report it separately using modifier 59. Since postoperative pain management by the operating physician is included in the global surgical package, the operating physician may request the assistance of an anesthesia practitioner if it requires techniques beyond the experience of the operating physician.

8. Several nerve block CPT codes (e.g., 64416 (brachial plexus), 64446 (sciatic nerve), 64448 (femoral nerve), 64449 (lumbar plexus)) describe “continuous infusion by catheter (including catheter placement)”. Two epidural/subarachnoid injection CPT codes 62318-62319 describe continuous infusion or intermittent bolus injection including placement of catheter. If an anesthesia practitioner places a catheter for continuous infusion epidural/subarachnoid or nerve block for intraoperative pain management, the service is included in the 0XXXX anesthesia procedure and is not separately reportable on the same date of service as the anesthesia 0XXXX code even if it is also utilized for postoperative pain management.

Per CMS Global Surgery rules postoperative pain management is a component of the global surgical package and is the responsibility of the physician performing the global surgical procedure. If the physician performing the global surgical procedure does not have the skills and experience to manage the postoperative pain and requests that an anesthesia practitioner assume the postoperative pain management, the anesthesia practitioner may report the additional services performed once this responsibility is transferred to the anesthesia practitioner. Pain management services subsequent to the date of insertion of the catheter for continuous infusion may be reported with CPT code 01996 for epidural/subarachnoid infusions and with evaluation and management codes for nerve block continuous infusions.

C. Radiologic Anesthesia Coding

Medicare’s anesthesia billing guidelines allow only one anesthesia code to be reported for anesthesia services provided in conjunction with radiological procedures. Radiological Supervision and Interpretation (RS&I) codes may be applicable to radiological procedures being performed.

The appropriate RS&I code may be reported by the appropriate provider (e.g., radiologist, cardiologist, neurosurgeon, radiation oncologist). The RS&I codes are not included in anesthesia codes for these procedures.

Since Medicare anesthesia rules, with one exception, do not permit the physician performing a surgical or diagnostic procedure to separately report anesthesia for the procedure, the RS&I code(s) should not be reported by the same physician

reporting the anesthesia service. Medicare rules allow physicians performing a surgical or diagnostic procedure to separately report medically reasonable and necessary moderate conscious sedation with a procedure unless the procedure is listed in Appendix G of the *CPT Manual.*

If a physician performing a radiologic procedure inserts a catheter as part of that procedure, and through the same site a catheter is utilized for monitoring purposes, it is inappropriate for either the anesthesia practitioner or the physician performing the radiologic procedure to separately report placement of the monitoring catheter (e.g., CPT codes 36500, 36555-36556, 36568-36569, 36580, 36584, 36597).

D. Monitored Anesthesia Care (MAC)

Monitored Anesthesia Care (MAC) may be performed by an anesthesia practitioner who administers sedatives, analgesics, hypnotics, or other anesthetic agents so that the patient remains responsive and breathes on his own. MAC provides anxiety relief, amnesia, pain relief, and comfort. 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 reasonable and necessary.

Monitored anesthesia care includes the intraoperative monitoring by an anesthesia practitioner of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse reaction to the surgical procedure. It also includes the performance of a pre-anesthesia evaluation and examination, prescription of the anesthesia care, administration of necessary oral or parenteral medications, and provision of indicated postoperative anesthesia care.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)) may be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable.

Issues of medical necessity are addressed by national CMS policy and local contractor coverage policies.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. Physicians should not report drug administration CPT codes 96360-96376 for anesthetic agents or other drugs administered between the patient’s arrival at the operative center and discharge from the post-anesthesia care unit.

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

6. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) should not be reported by the physician/anesthesia practitioner performing an anesthesia procedure since it is included in the global package for the primary service code. The physician/anesthesia practitioner performing an anesthesia procedure should not report other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95907-95913, 95925-95937) since they are also included in the global package for the primary service code. However, when performed by a different physician during the procedure, intra-anesthesia neurophysiology testing may be separately reportable by the second physician.

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CHAPTER III
SURGERY: INTEGUMENTARY SYSTEM
CPT CODES 10000-19999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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Chapter III
Surgery: Integumentary System
CPT Codes 10000 - 19999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 10000-19999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same

day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

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 date 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.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Local anesthesia including local infiltration, regional blocks, mild sedation, and all other anesthesia services except moderate conscious sedation reportable as CPT codes 99143-99145 are not separately reportable by a physician performing a medical or surgical procedure.

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.

It is a misuse of therapeutic injection or aspiration CPT codes to report administration of local anesthesia for a procedure. For example, it is a misuse of CPT codes 10160 (puncture aspiration), 20500-20501 (injection of sinus tract), 20526-20553 (injection of carpal tunnel, tendon sheath, ligament, trigger points, etc.), 20600-20611 (arthrocentesis) to report administration of local anesthetic for another procedure.

CPT codes 64450 (injection, anesthetic agent; other peripheral nerve or branch) and 64455 (injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton’s neuroma)) should not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately.

In the postoperative period, patients treated with epidural or subarachnoid continuous drug administration may require daily hospital adjustment/management of the catheter, dosage, etc., (CPT code 01996). This service may be reported by the anesthesia practitioner. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global period services associated with the operative procedure. If the only surgery performed is placement of an epidural or subarachnoid catheter for continuous drug administration, CPT code 01996 may be reported on subsequent days 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, abscesses, seromas or fluid collections.

If it is necessary to incise and/or drain a lesion as part of another procedure or in order to gain access to an area for another procedure, the incision and/or drainage is not separately reportable if performed at the same patient encounter.

For example, a physician excising pilonidal cysts and/or sinuses (CPT codes 11770-11772) may incise and drain one or more of the cysts. It is inappropriate to report CPT codes 10080 or 10081 separately for the incision and drainage of the pilonidal cyst(s).

HCPCS/CPT codes for incision and drainage should not be reported separately with other procedures such as excision, repair, destruction, removal, etc., when performed at the same anatomic site at the same patient encounter.

HCPCS/CPT codes describing complications of a procedure may or may not be separately reportable at the same patient encounter as the procedure causing the complication. (See Chapter I, Section C, paragraph 13)

CPT code 10180 (incision and drainage, complex, postoperative wound infection) would never be reportable for the same patient encounter as the procedure causing the postoperative infection. It may be separately reportable with a subsequent procedure depending upon the circumstances. If it is performed to gain access to an anatomic region for another procedure, CPT code 10180 is not separately reportable. However, if the procedure described by CPT code 10180 is performed at an anatomic site unrelated to another procedure, it may be reported separately with the procedure.

E. Lesion Removal

1. HCPCS/CPT codes define different types of removal codes such as destruction (e.g., laser, freezing), debridement, paring/cutting, shaving, or excision. Only one removal HCPCS/CPT code may be reported for a lesion. If multiple lesions are included in a single removal procedure (e.g., single excision of skin containing three nevi), only one removal HCPCS/CPT code may be reported for the procedure. If a removal procedure is begun by one method but is converted to another method to complete the procedure, only the HCPCS/CPT code describing the completed procedure may be reported. If multiple lesions are removed separately, it may be appropriate depending upon the code descriptors for the procedures to report multiple HCPCS/CPT codes utilizing anatomic modifiers or modifier 59 to indicate different

sites or lesions. The medical record must document the appropriateness of reporting multiple HCPCS/CPT codes with these modifiers.

2. The HCPCS/CPT codes for lesion removal include the procurement of tissue from the same lesion by biopsy at the same patient encounter. CPT codes 11100-11101 (biopsy of skin, subcutaneous tissue and/or mucous membrane) should not be reported separately. CPT codes 11100-11101 may be separately reportable with lesion removal HCPCS/CPT codes if the biopsy is performed on a different lesion than the removal procedure.

3. The procedure to procedure edit with column one CPT code 11055 (paring or cutting of benign hyperkeratotic lesion ...) and column two CPT code 11720 (debridement of nail(s) by any method; 1 to 5) may be bypassed with modifier 59 only if the paring/cutting of a benign hyperkeratotic lesion is performed on a different digit (e.g., toe) than one that has nail debridement. Modifier 59 should not be used to bypass the edit if the two procedures are performed on the same digit.

4. Removed tissue is often submitted for surgical pathology evaluation generally reported with CPT codes 88300-88309. If multiple lesions are submitted for pathological examination as a single specimen, only one CPT code may be reported for examination of all the lesions even if each lesion is processed separately. However, if it is medically reasonable and necessary to submit multiple lesions separately identifying the precise location of each lesion, a separate surgical pathology CPT code may be reported for each lesion.

5. If a physician reviews pathology slides from previously removed lesion(s) in association with an evaluation and management (E&M) service to determine whether additional surgery is required, the review of the pathology slides is included in the E&M service. The physician should not report CPT codes 88321-88325 (surgical pathology consultation) in addition to the E&M code.

6. Lesion removal may require closure (simple, intermediate, or complex), adjacent tissue transfer, or grafts. If the lesion removal requires dressings, strip closure, or simple closure, these services are not separately reportable. Thus, CPT codes 12001-12021 (simple repairs) are integral to the lesion removal codes. Intermediate or complex repairs, adjacent tissue transfer, and grafts may be separately reportable if medically reasonable and necessary. However, excision of benign

lesions with excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440) includes simple, intermediate, or complex repairs which should not be reported separately. *If more than one lesion is removed and one of those lesions is larger than 0.5 cm, an intermediate or complex repair may be reported, if performed, for a lesion larger than 0.5 cm. Removal of one lesion smaller than 0.5 cm does not preclude also reporting an intermediate or complex repair for a larger lesion.*

7. If lesion removal, incision, or repair requires debridement of non-viable tissue surrounding a lesion, incision, or injury in order to complete the procedure, the debridement is not separately reportable.

F. Mohs Micrographic Surgery

Mohs micrographic surgery (CPT codes 17311-17315) is performed to remove complex or ill-defined cutaneous malignancy. A single physician performs both the surgery and pathologic examination of the specimen(s). The Mohs micrographic surgery CPT codes include skin biopsy and excision services (CPT codes 11100-11101, 11600-11646, and 17260-17286) and pathology services (88300-88309, 88329-88332). Reporting these latter codes in addition to the Mohs micrographic surgery CPT codes is inappropriate. However, if a suspected skin cancer is biopsied for pathologic diagnosis prior to proceeding to Mohs micrographic surgery, the biopsy (e.g., CPT codes 11100-11101) and frozen section pathology (CPT code 88331) may be reported separately utilizing modifier 59 or 58 to distinguish the diagnostic biopsy from the definitive Mohs surgery. Although the *CPT Manual* indicates that modifier 59 should be utilized, it is also acceptable to utilize modifier 58 to indicate that the diagnostic skin biopsy and Mohs micrographic surgery were staged or planned procedures. Repairs, grafts, and flaps are separately reportable with the Mohs micrographic surgery CPT codes.

G. Intralesional Injections

CPT codes 11900-11901 describe intralesional injections of non-chemotherapeutic agents. CPT codes 96405-96406 describe intralesional injections of chemotherapeutic agents. Two intralesional injection codes should not be reported together unless separate lesions are injected with different agents in which case modifier 59 may be utilized. It is a misuse of CPT codes 11900, 11901, 96405, or 96406 to report injection of local anesthetic prior to another procedure on the lesion(s). Some of the procedures with which CPT codes 11900, 11901, 96405, and

96406 are not separately reportable if the intralesional injection is a local anesthetic include:

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)
11765	(Wedge excision)
11770 – 11772	(Excision of pilonidal cysts)

This list in not an exhaustive listing of the procedures since the administration of local anesthesia by the physician performing a procedure is not separately reportable for any procedure.

H. Repair and Tissue Transfer

The *CPT Manual* classifies repairs (closure) (CPT codes 12001-13160) as simple, intermediate, or complex. If closure cannot be completed by one of these procedures, adjacent tissue transfer or rearrangement (CPT codes 14000-14350) may be utilized. Adjacent tissue transfer or rearrangement procedures include excision (CPT codes 11400-11646) and repair (12001-13160). Thus, CPT codes 11400-11646 and 12001-13160 should not be reported separately with CPT codes 14000-14350 for the same lesion or injury. Additionally debridement necessary to perform a tissue transfer procedure is included in the procedure. It is inappropriate to report debridement (e.g., CPT codes 11000*-11001, 11004-11006,* 11042-11047, 97597, 97598*, 97602*) with adjacent tissue transfer (e.g., CPT codes 14000-14350) for the same lesion/injury.

Skin grafting in conjunction with a repair or adjacent tissue transfer is separately reportable if the grafting is *not* included in the code descriptor of the adjacent tissue transfer code.

Adjacent tissue transfer codes should not be reported with the closure of a traumatic wound if the laceration is coincidentally approximated using a tissue transfer type closure (e.g., Z-plasty, W-plasty). The closure should be reported with repair codes. However, if the surgeon develops a specific tissue

transfer to close a traumatic wound, a tissue transfer code may be reported.

Procurement of cultures or tissue samples during a closure is included in the repair or adjacent tissue transfer codes and are not separately reportable.

I. Grafts and Flaps

CPT codes describing skin grafts and skin substitutes are classified by size, location of recipient area defect, and type of graft or skin substitute. For most combinations of location and type of graft/skin substitute, there are two or three CPT codes including a primary code and one or two add-on codes. The primary code describes one size of graft/skin substitute and should not be reported with more than one unit of service. Larger size grafts or skin substitutes are reported with add-on codes.

1. The primary graft/skin substitute codes (e.g., 15100, 15120, 15200, 15220) are mutually exclusive since only one type of graft/skin substitute can be utilized at an anatomic site. If multiple sites require different types of grafts/skin substitutes, the different graft/skin substitute CPT codes should be reported with anatomic modifiers or modifier 59 to indicate the different sites.

2. Simple debridement of a skin wound (CPT codes 11000, 11042-11045, 97597, 97598) prior to a graft/skin substitute is included in the skin graft/skin substitute procedure (CPT codes 15050-*15278*) and should not be reported separately. If the recipient site requires excision of open wounds, burn eschar, or scar or incisional release of scar contracture, CPT codes 15002-15005 may be separately reportable for certain types of skin grafts/skin substitutes.

3. A *CPT Manual* instruction following CPT code 67911 (Correction of lid retraction) states that autogenous graft CPT codes (20920, 20922, or 20926) may be reported separately. All other services necessary to complete the procedure are included.

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

1. Since a mastectomy (CPT codes 19300-19307) describes removal of breast tissue including all lesions within the breast tissue, breast excision codes (19110-19126) generally are not

separately reportable unless performed at a site unrelated to the mastectomy. However, if the breast excision procedure precedes the mastectomy for the purpose of obtaining tissue for pathologic examination which determines the need for the mastectomy, the breast excision and mastectomy codes are separately reportable. (Modifier 58 may be utilized to indicate that the procedures were staged.) If a diagnosis was established preoperatively, an excision procedure for the purpose of obtaining additional pathologic material is not separately reportable.

Similarly, diagnostic biopsies (e.g., fine needle aspiration, core, incisional) to procure tissue for diagnostic purposes to determine whether an excision or mastectomy is necessary at the same patient encounter may be reported with modifier 58 appended to the excision or mastectomy code. However, biopsies (e.g., fine needle aspiration, core, incisional) are not separately reportable if a preoperative diagnosis exists.

2. The breast procedure codes include incision and closure. Some codes describe mastectomy procedures with lymphadenectomy and/or removal of muscle tissue. The latter procedures are not separately reportable. Except for sentinel lymph node biopsies, ipsilateral lymph node excisions are not separately reportable. Contralateral lymph node excisions may be separately reportable with appropriate modifiers (i.e., LT, RT).

3. Sentinel lymph node biopsy is separately reportable when performed prior to a localized excision of breast or a mastectomy without lymphadenectomy. However, sentinel lymph node biopsy is not separately reportable with a mastectomy procedure that includes lymphadenectomy in the anatomic area of the sentinel lymph node biopsy. Open biopsy or excision of sentinel lymph node(s) should be reported as follows: axillary (CPT codes 38500 or 38525), deep cervical (CPT code 38510), internal mammary (CPT code 38530). CPT code 38740(axillary lymphadenectomy; superficial) should not be reported for a sentinel lymph node biopsy. Sentinel lymph node biopsy of superficial axillary lymph node(s) is correctly reported as CPT code 38500 (biopsy or excision of lymph node(s), superficial) which includes the removal of one or more discretely identified superficial lymph nodes. By contrast a superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue.)

4. Breast reconstruction codes that include the insertion of a prosthetic implant should not be reported with codes that separately describe the insertion of a breast prosthesis.

5. CPT codes for breast procedures generally describe unilateral procedures.

6. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281,19282), the physician should not separately report a post procedure mammography code (e.g., 77051, 77052, 77055-77057, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.

7. CPT code 15734 (muscle, myocutaneous, or fasciocutaneous flap, trunk) should not be reported with breast reconstruction CPT codes 19357-19364 and 19367-19369 or breast prosthesis CPT codes 19340 and 19342 since a flap, if performed, is included in the reconstruction or prosthesis procedure.

8. Breast reconstruction procedures (CPT codes 19357-19369) include adjacent tissue transfer or rearrangement procedures (e.g., CPT codes 14000, 14001) if performed. An adjacent tissue transfer or rearrangement procedure may be reported on the same day as a breast reconstruction procedure if the adjacent tissue transfer or rearrangement is performed at a different site unrelated to the breast reconstruction procedure.

K. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The unit of service for fine needle aspiration (CPT codes 10021 and 10022) is the separately identifiable lesion. If a physician performs multiple “passes” into the same lesion to

obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for separate aspiration(s) of a distinct separately identifiable lesion.

4. If a Mohs surgeon removes a tumor specimen and divides it into multiple pieces of tissue, creates a block from each piece of tissue, and stains one or more blocks from that specimen with an initial single antibody immunohistochemistry stain, the Mohs surgeon should report only one (1) unit of service (UOS) of CPT code 88342 (Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure). Only one (1) UOS of CPT code 88342 may be reported per specimen. If the Mohs surgeon additionally stains one or more blocks from that specimen with an additional different single antibody immunohistochemistry (immunocytochemistry) stain, CPT code 88341 (Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)) may be reported with one (1) UOS per different antibody stain procedure. The UOS for these codes is ***not*** *each block derived from a single specimen.*

5. The CMS *Internet-Only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

6. CPT code 15852 describes a dressing change, other than for burns, under anesthesia (other than local). The unit of service (UOS) for this code is each encounter for a dressing change. The UOS is not each separate dressing.

L. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but

applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

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CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 20000-29999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules

are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for

which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

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 date 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.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For example, CPT codes 20526-20553 (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) should not be reported for the administration of local anesthesia to perform another procedure. The NCCI contains many edits based on this principle. If a procedure and a separate and distinct injection service unrelated to anesthesia for the former procedure are reported, the injection service may be reported with an NCCI-associated modifier if appropriate.

CPT codes 64450 (injection, anesthetic agent; other peripheral nerve or branch) and 64455 (injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)) should not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately.

D. Biopsy

A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

E. Arthroscopy

1. Surgical arthroscopy includes diagnostic arthroscopy which is not separately reportable. If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient encounter, only the surgical arthroscopy may be reported.

2. If an arthroscopy is performed as a “scout” procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic arthroscopy lead to the decision to perform an open procedure, the diagnostic arthroscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic arthroscopy and non-arthroscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic arthroscopy.

3. If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code should be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.

4. With the exception of the knee joint, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter. For knee joint arthroscopic debridement see the following paragraph.

5. 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 (29866-29889). With two exceptions HCPCS code 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) may be reported with other knee arthroscopy codes. Since CPT codes 29880 and 29881 (Surgical knee arthroscopy with meniscectomy including debridement/shaving of articular cartilage of same or separate compartment(s)) include debridement/shaving

of articular cartilage of any compartment, HCPCS code G0289 may be reported with CPT codes 29880 or 29881 only if reported for removal of a loose body or foreign body from a different compartment of the same knee. HCPCS code G0289 should not be reported for removal of a loose body or foreign body or debridement/shaving of articular cartilage from the same compartment as another knee arthroscopic procedure. *This paragraph was relocated here from Section H (General Policy Statements), paragraph 11 in 2014.*

6. Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 (limited synovectomy, "separate procedure") or 29876 (major synovectomy of two or three compartments). A synovectomy to "clean up" a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 should never be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 should never be reported for a major synovectomy with CPT code 29880 (knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments.

F. Fractures, Dislocations, and Casting/Splinting/Strapping

1. The application of external immobilization devices (casts, splints, strapping) at the time of a procedure includes the subsequent removal of the device when performed by the same entity (e.g., physician, practice, group, employees, etc.). Providers should not report removal or repair CPT codes 29700-29750 for those services. These removal or repair CPT codes may only be reported if the initial application of the cast, splint, or strapping was performed by a different entity.

2. Casting/splinting/strapping should not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed. Additionally casting/splinting/strapping CPT codes should not be reported for application of a dressing after a therapeutic procedure. Several examples follow: (1) If a provider injects an anesthetic agent into a peripheral nerve or branch (CPT code 64450), the provider

should not report CPT codes such as 29515, 29540, or 29580 for that anatomic area; (2) A provider should not report a casting/splinting/strapping CPT code for the same site as an injection or aspiration (e.g., CPT codes 20526-20615); (3) Debridement CPT codes (e.g., 11042-11044, 97597) and grafting CPT codes (e.g., 15040-15776) should not be reported with a casting/splinting/strapping CPT code (e.g., 29445, 29580, 29581) for the same anatomic area.

3. If an ankle fracture or dislocation repair is stabilized with a strapping, the ankle fracture or dislocation repair CPT code should not be reported with a strapping code such as CPT code 29581 (application of multi-layer venous wound compression system, below knee) even if the strapping simultaneously treats another problem such as edema or a venous stasis ulcer. Fracture and dislocation CPT codes include the initial casting, strapping, or splinting.

4. CPT codes for closed, percutaneous, or open treatment of fractures or dislocations include the application of casts, splints, or strapping. CPT codes for casting/splinting/strapping should not be reported separately.

5. If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and also assumes the follow-up care, the physician cannot report the casting/splinting/strapping CPT codes since these services are included in the fracture and/or dislocation CPT codes.

6. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report an evaluation and management (E&M) service, a casting/splinting/strapping CPT code, and a cast/splint/strap supply code (Q4001-Q4051).

For OPPS if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.

7. An evaluation and management (E&M) service may be reported with a casting/splinting/strapping CPT code if the

E&M service is significant and separately identifiable.

8. There are CPT codes (20670 and 20680) for removal of internal fixation devices (e.g., pin, rod). These codes are not separately reportable if the removal is performed as a necessary integral component of another procedure. For example, if revision of an open fracture repair for nonunion or malunion of bone requires removal of a previously inserted pin, CPT code 20670 or 20680 is not separately reportable.

Similarly, if a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure.

9. CPT code 20670 or 20680 (removal of implant) should not be reported for the removal of wire sutures during cardiac reoperation procedures or sternal procedures (e.g., debridement, resection, closure of median sternotomy separation).

10. If a closed reduction procedure fails and is converted to an open reduction procedure at the same patient encounter, only the more extensive open reduction procedure is reportable. Similarly, if a closed fracture treatment procedure fails and is converted to an open fracture treatment procedure at the same patient encounter, only the more extensive open fracture treatment procedure is reportable.

11. If interdental wiring (e.g., CPT code 21497) is necessary for the treatment of a facial or other fracture, arthroplasty, facial reconstructive surgery, or other facial/head procedure, the interdental wiring is not separately reportable. However, if interdental wiring is performed unrelated to another facial/head procedure, the interdental wiring may be separately reportable with modifier 59.

12. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is not separately reportable.

13. When a fracture or dislocation is repaired, only one fracture/dislocation repair code may be reported. Closed repair codes, percutaneous repair codes, and open repair codes for the

same anatomic site are mutually exclusive of one another, and only one of these codes may be reported for the repair of a fracture or dislocation at an anatomic site.

14. If a single cast, strapping, or splint treats multiple closed fractures without manipulation, only one closed fracture treatment without manipulation CPT code may be reported.

Additionally, if a single cast, strapping, or splint treats multiple fractures without manipulation in addition to one or more fracture(s) with manipulation, a closed fracture without manipulation CPT code should not be reported separately.

These policies also apply to the closed treatment of multiple fractures not requiring application of a cast, strapping, or splint. Thus if multiple closed fractures occur in an area that would have been treated with a single cast, strapping, or splint, only one CPT code for closed fracture treatment without manipulation may be reported.

If a cast, strapping, or splint applied after an open or percutaneous treatment of a fracture also treats a closed fracture without manipulation, a closed fracture without manipulation CPT code should not be reported separately.

These principles also apply to the treatment of multiple dislocations or combinations of multiple closed fractures and dislocations. If multiple dislocations and/or fractures are treated without manipulation and stabilized with a single cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment (without manipulation) may be reported. Additionally, if a single cast, strapping, or splint treats any combination of closed dislocations and/or closed fractures without manipulation in addition to at least one closed dislocation or fracture that did require manipulation, only a single CPT code for closed treatment with manipulation of the dislocation or fracture may be reported.

Similarly, if multiple dislocations and/or fractures are treated with or without manipulation and do not require a cast, strapping, or splint, only one CPT code for closed dislocation or fracture treatment CPT code may be reported for the anatomic area that would have been treated by a single cast, strap or splint.

Finally, if a cast, strapping, or splint applied after an open or percutaneous treatment of a dislocation and/or fracture also treats a closed dislocation and/or fracture that did not require manipulation, a CPT code for closed dislocation or fracture treatment (without manipulation) should not be reported separately.

15. Application of a multi-layer compression system (CPT codes 29581-29584) includes manual therapy in the anatomic region of the multi-layer compression system. CPT code 97140 (manual therapy techniques...) should not be reported for any type of manual therapy at the same patient encounter in the anatomic region where a multi-layer compression system is applied.

16. CPT code 20650 ("insertion of wire or pin with application of skeletal traction, including removal (separate procedure)") should not be reported for insertion of wires or pins without application of skeletal traction. Since the code descriptor includes the "separate procedure" designation, this code should not be reported for application of skeletal traction with a fracture treatment or other repair code for the same anatomic region.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The code descriptors for CPT codes 20670 (removal of implant; superficial...) and 20680 (removal of implant; deep...) do not define the unit of service. CMS allows one unit of

service for all implants removed from an anatomic site. This single unit of service includes the removal of all screws, rods, plates, wires, etc. from an anatomic site whether through one or more surgical incisions. An additional unit of service may be reported only if implant(s) are removed from a distinct and separate anatomic site.

4. The MUE values for CPT codes 20931 (allograft, structural, for spine surgery only...), 20937 (autograft for spine surgery only...; morselized...), and 20938 (autograft for spine surgery only...: structural...) are one (1). Each of these codes may be reported with only one unit of service per operative procedure regardless of the number of vertebral levels fused.

5. Procedures performed on fingers should be reported with modifiers FA, F1-F9, and procedures performed on toes should be reported with modifiers TA, T1-T9. The MUE values for many finger and toe procedures are one (1) based on use of these modifiers for clinical scenarios in which the same procedure is performed on more than one finger or toe.

6. The CMS *Internet-Only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

7. CPT codes 20600-20611 are a family of codes describing arthrocentesis for aspiration and/or injection of different sized joints or bursae with or without ultrasound guidance. The unit of service (UOS) for each of these codes is a joint and its surrounding bursae, if any. A physician should not report more than one (1) UOS for arthrocentesis of any one joint regardless of whether or not the physician also aspirates or injects one or more of its surrounding bursae. For example, if a physician performs arthrocentesis of the shoulder and two bursae of the

same shoulder without ultrasound guidance, only 1 UOS of CPT code 20610 may be reported.

8. CPT codes 21248 and 21249 respectively describe partial or complete reconstruction of the mandible or maxilla with endosteal implant. The unit of service for each of these codes is the reconstruction, not the endosteal implant.

9. A physician may only report one (1) unit of service of a CPT code describing closed treatment without manipulation of fracture if the same treatment (e.g., cast, splint, strapping) treats fractures of multiple similar bones. For example, if a cast is applied without manipulation to treat fractures of multiple metatarsals of the same foot, only one unit of service of CPT code 28470 may be reported for that treatment. If no cast, splint, or strapping is utilized for closed treatment without manipulation of multiple similar bones, only one (1) unit of service may be reported for the applicable code.

10. Closed treatment without manipulation of more than one metacarpal bone of the same hand should be reported with a single unit of service (UOS) of CPT code 26600 (Closed treatment of metacarpal fracture, single; without manipulation, each bone) regardless of the number of metacarpal bones treated in that one hand. No more than one UOS of CPT code 26600 per hand may be reported regardless of the number of fractured metacarpal bones in that hand. The same principle applies to closed treatment without manipulation of fractures of multiple carpal, tarsal or metatarsal bones in one extremity.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules

[e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. If a tissue transfer procedure such as a graft (e.g., CPT codes 20900-20926) is included in the code descriptor of a primary procedure, the tissue transfer procedure is not separately reportable.

6. CPT code 20926 describes a graft of "other" tissues such as paratenon, fat, or dermis. Similar to other graft codes, this code may not be reported with another code where the code

descriptor includes procurement of the graft. Additionally, CPT code 20926 may be reported only if another graft HCPCS/CPT code does not more precisely describe the nature of the graft.

7. Some procedures routinely utilize monitoring of interstitial fluid pressure during the postoperative period (e.g., distal lower extremity procedures with risk of anterior compartment compression). CPT code 20950 (monitoring of interstitial fluid pressure) should not be reported separately for this monitoring.

8. If electrical stimulation is used to aid bone healing, bone stimulation codes (CPT codes 20974-20975) may be reported. CPT codes 64550-64595 describe procedures for neurostimulators which are utilized to control pain and should not be reported for electrical stimulation to aid bone healing. Similarly the physical medicine electrical stimulation codes (CPT codes 97014 and 97032) should not be reported for electrical stimulation to aid bone healing.

9. Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59.

10. *D*ebridement of tissue in the surgical field of another musculoskeletal procedure is not separately reportable. For example, debridement of muscle and/or bone (CPT codes 11043-11044, 11046-11047) associated with excision of a tumor of bone is not separately reportable. Similarly, debridement of tissue (e.g., CPT codes 11042, 11045, 11720-11721, 97597, 97598) superficial to, but in the surgical field, of a musculoskeletal procedure is not separately reportable. *However, debridement of tissue at the site of an open fracture or dislocation may be reported separately with CPT codes 11010-11012.*

11. This paragraph was moved to Section E (Arthroscopy), paragraph 6.

12. The NCCI has an edit with column one CPT code of 24305 (tendon lengthening, upper arm and elbow, each tendon) and column two CPT code of 64718 (neuroplasty and/or transposition; ulnar nerve at elbow). When performing the tendon lengthening described by CPT code 24305, a neuroplasty of the ulnar nerve is not separately reportable, but a transposition of the ulnar nerve at the elbow is separately reportable. If a provider performs the tendon lengthening described by CPT code 24305 and performs an ulnar nerve transposition at the elbow, the NCCI PTP edit may be bypassed by reporting CPT code 64718 appending modifier 59.

13. Some procedures (e.g., spine) frequently utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) 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 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95907-95913, 95925-95937) since they are also included in the global package.

14. Spinal arthrodesis, exploration, and instrumentation procedures (CPT codes 22532-22865) and other spinal procedures include manipulation of the spine as an integral component of the procedures. CPT code 22505 (manipulation of spine requiring anesthesia, any region) should not be reported separately.

15. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions

of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an add-on code describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

16. Fluoroscopy reported as CPT codes 76000 or 76001 should not be reported with spinal procedures unless there is a specific *CPT Manual* instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure.

17. CPT codes 28288, 28306, 28307, 28310, and 28315 should not be reported with bunionectomy CPT codes 28290-28299 for procedures performed on the ipsilateral first toe or metatarsal. CPT codes 28306, 28307, and 28310 (osteotomy procedures) should not be reported with a bunionectomy code because there are bunionectomy codes that include osteotomy of the first metatarsal or proximal phalanx of the first toe. CPT code 28288 (ostectomy ...) should not be reported with a bunionectomy code because it is a misuse of this code to report ostectomy of the median eminence of the metatarsal bone which is integral to the bunionectomy procedure. Additionally, some bunionectomy

procedures include excision of the head of the first metatarsal. CPT code 28315 (sesamoidectomy, first toe (separate procedure)) includes the “separate procedure” designation in its code descriptor. CMS payment policy does not allow separate payment for a procedure designated as a “separate procedure” when performed along with another procedure in the same anatomic area.

18. CPT codes 28008, 28060, 28062, 28250 and 29893 describe procedures that may be performed on plantar fascia. No two codes from this group should be reported for treatment of plantar fascia of the ipsilateral foot at the same patient encounter.

19. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of arthroscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an arthroscopic procedure.

20. Arthrocentesis procedures (e.g., CPT codes 20600-20611) should not be reported separately with an open or arthroscopic joint procedure when performed on the same joint. However, if an arthrocentesis procedure is performed on one joint and an open or arthroscopic procedure is performed on a different joint, the arthrocentesis procedure may be reported separately.

21. CPT codes 24361 (arthroplasty, elbow; with distal humeral prosthetic replacement) and 24363 (arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)) include removal of native joint or a failed prosthesis and replacement with a new prosthesis. CPT code 24160 (removal of prosthesis,...humeral and ulnar components) should not be reported separately with CPT codes 24361 or 24363 for removal of a prior failed prosthetic joint.

CPT codes 23470 (arthroplasty, glenohumeral joint; hemiarthroplasty) and 23472 (arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))) include removal of native joint or a failed prosthesis and replacement with a new prosthesis. CPT codes 23333(removal of foreign body, shoulder; deep (subfascial or intramuscular)), 23334 (removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component), or 23335 (removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)) should not be reported separately with CPT codes 23470 or 23472 for removal of a prior failed prosthetic joint.

22. CMS considers the shoulder to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder. This type of edit may be bypassed only if the two procedures are performed on contralateral *shoulders*.

23. A bone marrow aspiration (CPT code 38220) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, laminectomy, spinal decompression, or vertebral corpectomy CPT code if the bone marrow aspiration is obtained from the surgical field. However, if the bone marrow aspiration is obtained from an anatomic site other than vertebrae on which the orthopedic/neurosurgical procedure is performed, it may be reported separately with an NCCI-associated modifier.

24. CPT codes 38230 (bone marrow harvesting for transplantation; allogeneic) and 38232 (bone marrow harvesting for transplantation; autologous) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code for procurement of bone marrow aspirate. CPT codes 38230 and 38232 are used to report the procurement of bone marrow for future bone marrow transplantation.

25. CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.

26. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration,

and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

27. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

28. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

29. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

30. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for

diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

31. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

32. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

33. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

34. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be

separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

5. CPT codes 15851 and 15852 describe suture removal and dressing change respectively under anesthesia other than local anesthesia. These codes should not be reported when a patient requires anesthesia for a related procedure (e.g., return to the operating room for treatment of complications where an incision is reopened necessitating removal of sutures and redressing). Additionally, CPT code 15852 should not be reported with a primary procedure.

6. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure. (See Section C. Anesthesia)

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

7. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

8. Closure/repair of a surgical incision is included in the global surgical package except as noted below. Wound repair

CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes (CPT codes 12001-13153) should not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

9. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

10. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

11. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

12. The NCCI PTP edits with column one CPT codes 11055-11057 (Paring or cutting of benign hyperkeratotic lesions) each with column two CPT codes 11720-11721 (Nail debridement by any method) are often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 11720 or 11721 of these NCCI PTP 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 requiring debridement.

13. The NCCI PTP edits with column one CPT codes 17000 and 17004 (Destruction of benign or premalignant lesions) each with column two CPT code 11100 (Biopsy of single skin lesion) are often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 11100 of these NCCI PTP 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 CPT codes 11100-11101.

14. The NCCI PTP edit with column one CPT code 11719 (Trimming of nondystrophic nails) and column two 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 two CPT code 11720 of this NCCI PTP 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.

15. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another

procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

16. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

17. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

18. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

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

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 30000-39999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

Open procedures of the thorax include the approach and exploration. CPT code 32100 (thoracotomy, major; with exploration and biopsy) should not be reported separately with open thoracic procedures to describe the approach and exploration. CPT code 32100 may be separately reportable with an open thoracic procedure if: (1) it is performed on the contralateral side; (2) it is performed on the ipsilateral side through a separate skin incision; or (3) it is performed to obtain a biopsy at a different site than the other open thoracic procedure.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 date 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.

C. Respiratory System

1. The nose and mouth have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes

that describe the procedure as an integumentary procedure (CPT codes 10000-19999), a nasal procedure (CPT codes 30000-30999), or an oral procedure (CPT codes 40000-40899). If a procedure is performed on a lesion at or near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If the code descriptor of a CPT code from the respiratory system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) should not be reported separately.

2. A biopsy performed in conjunction with a more extensive nasal/sinus procedure is not separately reportable unless the biopsy is examined pathologically prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination.

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. A separate biopsy code (e.g., CPT code 31237 for nasal/sinus endoscopy) should not be reported with the removal nasal/sinus endoscopy code (e.g., CPT code 31255) because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic or surgical endoscopy of the respiratory system is performed, it is a standard of practice to evaluate the access regions. A separate HCPCS/CPT code should not be reported for this evaluation of the access regions. For example, if an endoscopic anterior ethmoidectomy is performed, a diagnostic nasal endoscopy should not be reported separately simply because the approach to the ethmoid sinus is transnasal. Similarly, fiberoptic bronchoscopy routinely includes an examination of the nasal cavity, pharynx, and larynx. A separate HCPCS/CPT code should not be reported with the bronchoscopy HCPCS/CPT code for this latter examination whether it is limited (“cursory”) or complete.

If medically reasonable and necessary endoscopic procedures are performed on two regions of the respiratory system with different types of endoscopes, both procedures may be separately reportable. For example, if a patient requires diagnostic bronchoscopy for a lung mass with a fiberoptic bronchoscope and a separate laryngoscopy for a laryngeal mass with a fiberoptic laryngoscope at the same patient encounter, HCPCS/CPT codes for

both procedures may be reported separately. It must be medically reasonable and necessary to utilize two separate endoscopes to report both codes.

If the findings of a diagnostic endoscopy lead to the decision to perform a non-endoscopic surgical procedure at the same patient encounter, the diagnostic endoscopy may be reported separately. However, if a "scout" endoscopic procedure to evaluate the surgical field (e.g., confirmation of anatomic structures, assess extent of disease, confirmation of adequacy of surgical procedure such as tracheostomy) is performed at the same patient encounter as an open surgical procedure, the endoscopic procedure is not separately reportable.

If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

A diagnostic endoscopy is not separately reportable with a surgical endoscopy per *CPT Manual* instructions. If an endoscopic procedure fails and is converted into an open procedure, the endoscopic procedure is not separately reportable with the open procedure. Neither the surgical endoscopy nor diagnostic endoscopy code should be reported with the open procedure code when a surgical endoscopy is converted to an open procedure.

Example: A patient presents with aspiration of a foreign body. A bronchoscopy is performed identifying lobar foreign body obstruction, and an attempt is made to remove this obstruction during the bronchoscopy. It would be inappropriate to report CPT codes 31622 (diagnostic bronchoscopy) and 31635 (surgical bronchoscopy with removal of foreign body). Only the "surgical" endoscopy, CPT code 31635, may be reported. In this example, if the endoscopic effort fails and a thoracotomy is performed, the diagnostic bronchoscopy may be reported separately in addition to the thoracotomy. Modifier 58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. However, the CPT code for the surgical bronchoscopy to remove the foreign body is not separately reportable because the procedure was converted to an open procedure. If the surgeon decides to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, this confirmatory bronchoscopy is not separately reportable

although the initial diagnostic bronchoscopy may still be reportable.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service may be reported. *CPT Manual* instructions indicate that surgical sinus endoscopy includes a sinusotomy (if appropriate) and a diagnostic sinus endoscopy. However, if the medically necessary procedure is a sinusotomy and a sinus endoscopy is performed to evaluate adequacy of the sinusotomy and visualize the sinus cavity for disease, it may be appropriate to report the sinusotomy HCPCS/CPT code rather than the sinus endoscopy HCPCS/CPT code.

5. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. For example, control of nasal hemorrhage (CPT code 30901) is not separately reportable for control of bleeding due to a nasal/sinus endoscopic procedure. If bleeding occurs in the postoperative period and requires return to the operating room for treatment, a HCPCS/CPT code for control of the bleeding may be reported with modifier 78 indicating that the procedure was a complication of a prior procedure requiring treatment in the operating room. However, control of postoperative bleeding not requiring return to the operating room is not separately reportable.

Like CPT code 30901, CPT codes 30801 (ablation, soft tissue of inferior turbinates...; superficial), 30903 (control of hemorrhage, anterior...), 30905 (control of hemorrhage, posterior...), and 31238 (nasal/sinus endoscopy, surgical; with control of nasal hemorrhage) should not be reported separately for control of bleeding due to a nasal/sinus endoscopic procedure or other nasal procedure.

6. When endoscopic service(s) are performed, the most comprehensive code describing the service(s) rendered should be reported. If multiple services are performed and not adequately described by a single CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended to the secondary service CPT code(s). Additionally, only medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

7. CPT codes 31292, 31293, and 31294 describe nasal/sinus endoscopy with “medial or inferior orbital wall decompression”,

"medial and inferior orbital wall decompression", and "optic nerve decompression" respectively. These procedures include the following procedures which may not be reported separately when performed on the ipsilateral side: CPT codes 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy;), 31267 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus), 31276 (Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus), 31287 (Nasal/sinus endoscopy, surgical, with sphenoidotomy;), and 31288 (Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus). CPT code 30130 (Excision inferior turbinate, partial or complete, any method) is also included and not separately reportable if performed on the ipsilateral side to allow access to the ethmoid or other sinuses in order to perform the procedures described by CPT codes 31292-31294. However, CPT code 30130 may be reported separately, if performed on the ipsilateral side, for a purpose unrelated to allowing access to the sinuses to perform the procedures described by CPT codes 31292-31294. If any of the included procedures are performed on the contralateral side from the procedures described by CPT codes 31292-31294, they may be reported separately.

8. Lavage by cannulation of a respiratory accessory sinus (e.g., CPT codes 31000 (maxillary sinus), 31002(sphenoid sinus)) is an integral component when performed with a more definitive procedure on that sinus. Lavage by cannulation should not be reported separately with another code describing a more definitive sinus procedure (e.g., CPT codes 31256, 31267, 31295) when performed on the ipsilateral sinus at the same patient encounter.

9. If laryngoscopy is required for elective or emergency placement of an endotracheal tube, the laryngoscopy is not separately reportable. CPT code 31500 describes an emergency endotracheal intubation procedure and should not be reported when an elective intubation is performed. For example, if intubation is performed in a rapidly deteriorating patient who requires mechanical ventilation, a separate HCPCS/CPT code may be reported for the intubation with adequate documentation of the reasons for the intubation.

10. An emergency endotracheal intubation procedure (CPT code 31500) is normally followed by a chest radiologic examination to confirm proper positioning of the endotracheal

tube. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

11. The descriptor for CPT code 31600 (Tracheostomy, planned (separate procedure)) includes the “separate procedure” designation. Therefore, pursuant to the CMS “separate procedure” policy, a tracheostomy is not separately reportable with laryngeal surgical procedures that frequently require tracheostomy (e.g., laryngotomy, laryngectomy, laryngoplasty).

12. If laryngoscopy is required for placement of a tracheostomy, the tracheostomy (CPT codes 31600-31610) may be reported. The laryngoscopy is not separately reportable.

13. CPT code 92511 (nasopharyngoscopy with endoscope) should not be reported separately when performed as a cursory examination with other respiratory endoscopic procedures.

14. A diagnostic thoracoscopy (CPT codes 32601, 32604, 32606) is not separately reportable with a surgical thoracoscopy on the ipsilateral side of the thorax.

A diagnostic thoracoscopy to assess the surgical field or extent of disease prior to an open thoracotomy, thoracostomy, or mediastinal procedure is not separately reportable. However, a diagnostic thoracoscopy is separately reportable with an open thoracotomy, thoracostomy, or mediastinal procedure if the findings of the diagnostic thoracoscopy lead to the decision to perform an open thoracotomy, thoracostomy, or mediastinal procedure. Modifier 58 may be reported to indicate that the diagnostic thoracoscopy and open procedure were staged or planned.

If a surgical thoracoscopy is converted to an open thoracotomy, thoracostomy, or mediastinal procedure, the surgical thoracoscopy is not separately reportable. Additionally a diagnostic thoracoscopy should not be reported in lieu of the surgical thoracoscopy with the open thoracotomy, thoracostomy, or mediastinal procedure. Neither a surgical thoracoscopy nor diagnostic thoracoscopy code should be reported with the open thoracotomy, thoracostomy, or mediastinal procedure code when a surgical thoracoscopy is converted to an open procedure.

15. A tube thoracostomy (CPT code 32551) may be performed for drainage of an abscess, empyema, or hemothorax. The code descriptor for CPT code 32551 defines it as a "separate procedure". It is not separately reportable when performed at the same patient encounter as another open procedure of the thorax unless it is performed in the thoracic cavity contralateral to the one entered to perform the open thoracic procedure.

16. A chest tube insertion procedure (e.g., CPT codes 32550, 32551, 32554, 32555) is often followed by a chest radiologic examination to confirm the proper location and positioning of the chest tube. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

17. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

18. The procedures described by CPT codes 30801 and 30802 (cautery and/or ablation of mucosa of inferior turbinates) are performed to reduce the size of the inferior turbinates of the nose. These two codes should not be reported for access to the nose or sinuses or for control of intraoperative bleeding with other codes describing nasal or sinus endoscopy or other nasal procedures. Since the procedure described by CPT code 30802 (intramural, unilateral or bilateral) is more extensive than the procedure described by CPT code 30801 (superficial, unilateral or bilateral), both codes should not be reported for the same patient encounter.

19. A diagnostic biopsy(s) of the lung from an anatomic location removed during a more extensive procedure (e.g., segmentectomy, lobectomy, thoracoscopic (VATS) lobectomy) at the same patient encounter is not separately reportable with the more extensive procedure. This principle is applicable whether the lung biopsy(s) is examined pathologically during the intraoperative procedure or postoperatively. This principle is applicable whether the biopsy(s) is for purposes of diagnosis, determining whether the more extensive procedure should be performed, or determining the extent of the more extensive procedure. This principle is also applicable regardless of the surgical approach (i.e., open or thoracoscopic (VATS)) or

technique (e.g., incisional, excisional, resection, stapled wedge) to perform the biopsy(s).

A diagnostic biopsy(s) of the lung is separately reportable with a more extensive lung procedure performed at the same patient encounter if the anatomic location of the biopsy is not included in the more extensive procedure.

D. Cardiovascular System

1. Coronary artery bypass procedures utilizing venous grafts (CPT codes 33510-33523) include procurement of the venous graft(s) as an integral component of the procedure. CPT codes 37700-37735 (ligation of saphenous veins) should not be reported separately for procurement of the venous grafts.

2. When a coronary artery bypass procedure is performed, the most comprehensive code describing the procedure should be reported. When venous grafting only is performed, only one code in the range of coronary artery bypass CPT codes 33510-33516 may be reported. No other bypass codes should be reported with these codes. One code in the range of CPT codes 33517-33523 (combined arterial-venous grafting) and one code in the range of CPT codes 33533-33536 (arterial grafting) may be reported together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, only one code in the range of CPT codes 33533-33536 may be reported.

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 76998 (ultrasonic guidance, intraoperative) appending modifier 59. CPT code 76998 should not be reported for ultrasound guidance utilized to procure the vascular graft.

4. Cardiopulmonary bypass requires insertion of cannulas into the venous and arterial circulation which is integral to the procedure. HCPCS/CPT codes for insertion of the cannulas into the venous and arterial circulation should not be reported separately.

5. CPT codes 33210 and 33211 describe insertion or replacement of temporary transvenous single and dual chamber respectively cardiac electrodes or pacemaker catheters. These

codes should not be reported with open or percutaneous cardiac procedures performed at the same patient encounter.

6. Many of the code descriptors in the CPT code range 36800-36861 (hemodialysis access, intervascular cannulation, shunt insertion) include the “separate procedure” designation. Pursuant to the CMS “separate procedure” policy, these “separate procedures” are not separately reportable with vascular revision procedures at the same site/vessel.

7. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy, and/or bypass. When a thromboendarterectomy is performed at the site of an aneurysm repair or graft insertion, the thromboendarterectomy is not separately reportable. If a bypass procedure requires an endarterectomy to insert the bypass graft, only the code describing the bypass may be reported. The endarterectomy is not separately reportable. 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 may be reported with an anatomic modifier or modifier 59. If a thromboendarterectomy is medically necessary due to vascular occlusion in a different vessel, the appropriate code may be reported with an anatomic modifier or modifier 59 indicating that the procedures were performed in non-contiguous vessels.

At a given site, only one type of bypass (venous, non-venous) code may be reported. If different vessels are bypassed with different types of grafts, separate codes may be reported. If the same vessel has multiple obstructions and requires bypass with different types of grafts in different areas, separate codes may be reported. However, it is necessary to indicate that multiple procedures were performed by using an anatomic modifier or modifier 59.

8. When an open or percutaneous vascular procedure (e.g., thromboendarterectomy) is performed, the repair and closure are included components of the vascular procedure. CPT codes 35201-35286 (repair of blood vessel including extensive repair) are not separately reportable in addition to the primary vascular procedure unless the CPT code descriptor states that repair or closure is separately reportable.

9. If a failed percutaneous vascular procedure is followed by an open procedure by the same physician at the same patient encounter (e.g., percutaneous transluminal angioplasty,

thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the HCPCS/CPT code for the completed procedure, which is usually the more extensive open procedure may be reported. If a percutaneous procedure is performed on one lesion and a similar open procedure is performed on a separate lesion, the HCPCS/CPT code for the percutaneous procedure may be reported with modifier 59 only if the lesions are in distinct and separate anatomically defined vessels. If similar open and percutaneous procedures are performed on different lesions in the same anatomically defined vessel, only the open procedure may be reported.

10. The CPT codes 36000, 36406, 36410, etc. represent very common procedures performed to gain venous access for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy, hydration, transfusion, drug administration, etc. 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 separately report the venous access services. CPT codes 96360-96361 should not be reported for infusions to maintain patency of a vascular access site.

11. When a non-coronary percutaneous intravascular interventional procedure is performed on the same vessel at the same patient encounter as diagnostic angiography (arteriogram/venogram), only one selective catheter placement code for the vessel may be reported. If the angiogram and the percutaneous intravascular interventional procedure are not performed in immediate sequence and the catheter(s) 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.

12. Open and percutaneous interventional vascular procedures include operative angiograms and/or venograms which should not be separately reported as diagnostic angiograms/venograms. The *CPT Manual* describes the circumstances under which a provider may separately report a diagnostic angiogram/venogram at the time of an interventional vascular procedure. A diagnostic angiogram/venogram may be *separately reportable* with modifier 59 *if it satisfies CPT Manual guidelines, national Medicare guidelines, and local Medicare Administrative Contractor guidelines.* If the code descriptor for

a vascular procedure specifically includes diagnostic angiography, the provider should not separately report a diagnostic angiography code.

If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the open or percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the open or 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 modifier 59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 in addition to modifier 59 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the open or percutaneous intravascular interventional procedure.

13. If a median sternotomy is utilized to perform a cardiothoracic procedure, the repair of the sternotomy is not separately reportable. CPT codes 21820-21825 (treatment of sternum fracture) should not be reported for repair of the sternotomy.

If a cardiothoracic procedure is performed after a prior cardiothoracic procedure with sternotomy (e.g., repeat procedure, new procedure, treatment of postoperative hemorrhage), removal of embedded wires is not separately reportable.

14. If a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure. For example, if a reoperation for coronary artery bypass or valve procedures requires removal of previously inserted sternal wires, removal of these wires is not separately reportable.

15. When existing vascular access lines or selectively placed catheters are utilized to procure arterial or venous samples, reporting the sample collection separately is inappropriate. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling. CPT code 75893 includes

concomitant venography if performed. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure.

16. Peripheral vascular bypass CPT codes describe bypass procedures with venous and other grafting materials (CPT codes 35501-35683). These procedures are mutually exclusive since only one type of bypass procedure may be performed at a site of obstruction. If multiple sites of obstruction are treated with different types of bypass procedures at the same patient encounter, multiple bypass procedure codes may be reported with anatomic modifiers or modifier 59. If a physician attempts a graft with one material but completes the graft with another material, only the one code describing the completed procedure should be reported.

17. Bypass grafts (CPT codes 35500-35683) include blood vessel repair. CPT codes 35201-35286 (direct repair, repair with vein graft, and repair with graft other than vein) should not be reported with a bypass graft code for the same anatomic site.

18. Vascular obstruction may be caused by thrombosis, embolism, atherosclerosis or other conditions. Treatment may include thrombectomy, embolectomy and/or endarterectomy. CPT codes describe embolectomy/thrombectomy (e.g., CPT codes 34001-34490), atherectomy (e.g., CPT codes 0234T-0238T, 37225, 37227, 37229, 37231, 37233, 37235), and thromboendarterectomy (e.g., CPT codes 35301-35390). Only the most comprehensive code describing the services performed at a given site/vessel may be reported. Therefore, for a given site/vessel, codes from more than one of the above code ranges should not be reported together. If a percutaneous interventional procedure fails (e.g., balloon thrombectomy) and the same physician performs an open procedure (e.g., thromboendarterectomy) at the same patient encounter, only the completed procedure, generally the more extensive open procedure, may be reported.

19. 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 more comprehensive atherectomy that was performed (generally the open procedure) should be reported (see sequential procedure policy, Chapter I,

Section M). Effective January 1, 2011 there are new lower extremity endovascular revascularization procedure CPT codes which include in single codes various combinations of angioplasty, atherectomy, and/or placement of stent(s). In addition effective January 1, 2011, Category I CPT codes for atherectomy of vessels in other anatomic sites are deleted and replaced by Category III CPT codes.

20. CPT codes 35800-35860 describe treatment of postoperative hemorrhage requiring return to the operating room. These codes should not be reported for the treatment of hemorrhage during the initial operative session nor treatment of postoperative hemorrhage not requiring return to the operating room. These codes should generally be reported with modifier 78 indicating that the procedure represents a return to the operating room for a related procedure in the postoperative period.

21. Many Pacemaker/Implantable Defibrillator procedures (CPT codes 33202-33249) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes (e.g., CPT codes 76000, 76001) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures may be reported separately. Additionally, ultrasound guidance is not separately reportable with these CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by CPT codes 33200-33249 or 93600-93662.

Insertion or replacement of a temporary transvenous cardiac electrode or pacemaker catheter (CPT codes 33210, 33211) during a pacemaker/implantable defibrillator procedure (CPT codes 33202-33249) or intracardiac electrophysiology procedure (CPT codes 93600-93662) is not separately reportable. CPT codes 33210 and 33211 include the “separate procedure” designation in their code descriptors and are not separately reportable with another

surgical procedure performed in the same anatomic area at the same patient encounter.

22. Electronic analysis (i.e., interrogation and programming) is integral to the insertion or replacement of a pacemaker or implantable defibrillator pulse generator. The interrogation and programming codes should not be reported separately.

23. CPT codes 33218 and 33220 describe repair of single and two transvenous electrodes respectively for a permanent pacemaker or implantable defibrillator. These procedures include incising the skin pocket for the device, removing the device, repairing the lead, and reinserting the original device. CPT codes for device removal, insertion, or replacement or skin pocket revision should not be reported for the typical procedure when the original device is replaced. However, if a new device is used to replace the original device, CPT codes 33227-33229 or 33262-33264 may be reported additionally for replacement with a new device.

24. CPT code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type...) describes an arterial infusion directly into an artery of a non-chemotherapeutic medication to treat the artery for disease (e.g., vasospasm) other than thrombolysis. This code should not be utilized to report intravenous infusions, arterial push injections (CPT code 96373), or chemotherapy infusions. It should not be reported for infusion for systemic therapy. This code should not be reported for infusion into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. This code may be reported separately when a catheter is inserted into a blood vessel for the purpose of the transcatheter therapy of the blood vessel. CPT code 75896 (Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation) may be reported for the radiological supervision and interpretation associated with the transcatheter therapy described by CPT code 37202.

Similarly CPT codes 37211-37214(transcatheter therapy with infusion for thrombolysis of non-coronary vessel) may be reported when a blood vessel is catheterized for the purpose of transcatheter infusion for thrombolysis of a non-coronary vessel. CPT code 75896 should not be reported for the radiological

supervision and interpretation associated with CPT codes 37211-37214 since these codes include radiological supervision and interpretation. With the exception of lower extremity endovascular revascularization procedures (CPT codes 37220-37235), CPT codes 37211-37214 should not be reported for infusion of a thrombolytic agent into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. Thrombolysis in a lower extremity vessel may be reported separately with an endovascular revascularization procedure (CPT codes 37220-37235).

25. The procedure described by CPT code 37204 (transcatheter occlusion or embolization (eg, for tumor destruction)...) includes infusion of the occlusion/embolization agent. It is not appropriate to separately report CPT code 77750 (infusion or instillation of radioelement solution...) if the embolization agent is a radioelement solution. Similarly it is not appropriate to separately report CPT code 77778 (interstitial radiation source application...) in addition to CPT code 37204 for infusion of the radioelement solution. (CPT code 37204 was deleted January 1, 2014.)*(CPT codes 77776 and 77777 were deleted January 1, 2016.)*

26. The *CPT Manual* defines primary and secondary percutaneous transluminal arterial mechanical thrombectomies. The *CPT Manual* contains an instruction which states: "Do not report 37184-37185 for mechanical thrombectomy performed for retrieval of short segments of thrombus or embolus evident during other percutaneous interventional procedures. See 37186 for these procedures." Based on this CPT instruction, the NCCI contains edits bundling the primary percutaneous transluminal mechanical thrombectomy (CPT code 37184) into all percutaneous arterial interventional procedures. These edits allow use of NCCI–associated modifiers if a provider performs a primary percutaneous transluminal arterial mechanical thrombectomy rather than a secondary percutaneous transluminal arterial mechanical thrombectomy (CPT code 37186) in conjunction with the other percutaneous arterial procedure.

27. CPT code 37215 describes an open or percutaneous transcatheter placement of intravascular stent(s) in the cervical carotid artery utilizing distal embolic protection. It includes all ipsilateral selective carotid arterial catheterization, all

diagnostic imaging for ipsilateral cervical and cerebral carotid arteriography, and all radiological supervision and interpretation (RS&I). Physicians should not unbundle the RS&I services. For example a provider should not report CPT code 75962 (RS&I for transluminal balloon angioplasty of a peripheral artery) for angioplasty of the cervical carotid artery which is an included service in the procedure defined by CPT code 37215. Additionally since the carotid artery is not a peripheral artery, it is a misuse of CPT code 75962 to describe a carotid artery procedure. These same principles would apply to CPT code 37216, but it is currently a noncovered service code on the Medicare Physician Fee Schedule.

28. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

29. CPT code 36002 (injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm) should not be reported for vascular sealant of an arteriotomy site. It is bundled into vascular procedures and cardiopulmonary bypass procedures in which there is an arteriotomy. If the procedure described by CPT code 36002 is performed at a separate anatomic site unrelated to use of a vascular sealant or separate patient encounter on the same date of service, it may be reported separately with an NCCI-associated modifier.

30. Operative ablation procedures (CPT codes 33250-33266) include cardioversion as an integral component of the procedures. CPT codes 92960 or 92961 (elective cardioversion) should not be reported separately with the operative ablation procedure codes unless an elective cardioversion is performed at a separate patient encounter on the same date of service. If electrophysiologic study with pacing and recording is performed during an operative ablation procedure, it is integral to the procedure and should not be reported separately as CPT code 93624 (electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy...)

31. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan-Ganz)) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569

(insertion of peripherally inserted central venous catheter) for the insertion of a single catheter. If a physician does not complete the insertion of one type of catheter and subsequently inserts another at the same patient encounter, only the completed procedure may be reported.

32. CPT codes 33203, 33265, and 33266 describe surgical endoscopic procedures (CPT code 33203 – insertion of epicardial electrodes; CPT codes 33265, 33266 – operative tissue ablation). CPT codes 32601 and 32604 describe diagnostic thoracoscopy of the pericardial sac. Since surgical endoscopy includes diagnostic endoscopy, CPT codes *32601 or* 32604 should not be reported separately with CPT codes 33203/33265/33266 for the same patient encounter.

33. If an ascending aorta graft procedure (CPT codes 33860-33864) extends anatomically into the transverse aortic arch proximal to the origin of the brachiocephalic artery, CPT code 33870 (transverse arch graft...) should not be reported separately.

34. Effective January 1, 2010, CMS discontinued use of HCPCS codes G0392 and G0393 to report percutaneous transluminal balloon angioplasty for maintenance of a hemodialysis access. CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) may be reported with one unit of service for percutaneous transluminal balloon angioplasty of all lesions in the venous outflow vessel of a hemodialysis access defined as the “vessel” originating at the arterial anastomosis through the venous outflow tract to the subclavian vein. CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) may be reported with one unit of service for percutaneous transluminal balloon angioplasty of all lesions in the arterial inflow tract.

35. Replacement of a ventricular assist device (VAD) includes removal of the old pump, insertion of a new pump, and initiation of the new pump. CPT codes describing implantation (insertion) or removal of a VAD should not be reported separately with a CPT code describing replacement of a VAD.

36. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. The chest radiologic examination is integral to the procedure, and a chest

radiologic examination (e.g., CPT codes 71010, 71020) should not be reported separately.

37. A procedure to insert a central flow directed catheter (e.g., Swan-Ganz) (CPT code 93503) is often followed by a chest radiologic examination to confirm proper positioning of the flow directed catheter. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

38. CPT code 36147 describes introduction of a needle and/or catheter into an arteriovenous shunt created for dialysis (graft/fistula). The code descriptor states that the procedure includes "all necessary imaging for the arterial anastomosis and adjacent artery through entire venous outflow".

39. Open vascular procedures include exploration of the blood vessel. CPT codes 35701, 35721, 35741, and 35761 ("exploration (not followed by surgical repair)...") should not be reported for a blood vessel on which an open vascular procedure is performed.

40. Diagnostic studies of the cervicocerebral arteries (CPT codes 36221-36227) include angiography of the thoracic aortic arch. Physicians should not separately report CPT codes 75600 or 75605 (thoracic aortography) for this examination unless it is medically reasonable and necessary to additionally examine the descending thoracic aorta. A physician should not report CPT codes 75600 or 75605 for the examination of the descending thoracic aorta with the runoff of the dye used to examine the thoracic aortic arch included in the diagnostic studies of the cervicocerebral arteries. Additionally, if an unexpected abnormality of the descending thoracic aorta is identified while examining the dye runoff in the descending aorta, CPT codes 75600 or 75605 should not be reported separately.

41. For vascular embolization procedures (CPT codes 37241-37244) physicians may separately report selective catheterization CPT codes. However, physicians should not separately report non-selective catheterization CPT codes for these procedures. *Vascular embolization procedures include associated radiological supervision and interpretation, intra-procedural guidance, road-mapping, and imaging necessary to document completion of the procedure. Angiography may be a separately reportable procedure with modifier 59 only if it satisfies guidelines for diagnostic*

angiography included in the "Vascular Embolization and Occlusion" section of the CPT Manual, national Medicare guidelines, and local Medicare Administrative Contractor guidelines.

42. Transcatheter aortic valve or mitral valve replacement procedures include fluoroscopic and/or ultrasound guidance if performed. Physicians should not report fluoroscopy CPT codes (e.g.,76000, 76001, 77002) nor ultrasound CPT codes (e.g., 76942, 76998) for guidance during these procedures.

Transthoracic echocardiography CPT codes 93306-93308, transesophageal echocardiography CPT codes 93312-93314, and Doppler echocardiography CPT codes 93320-93325 are not separately reportable by the physician performing a transcatheter aortic valve and mitral valve replacement procedure.

43. Ligation procedures of the lower extremity (e.g., CPT codes 37700-37785) include application of a compression dressing, if performed. CPT codes 29581 and 29582 (application of multi-layer compression system) should not be reported for application of a compression dressing.

E. Hemic and Lymphatic Systems

1. 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, do not report the bone marrow aspiration, CPT code 38220, in addition to the bone marrow biopsy (CPT code 38221). HCPCS/CPT code G0364 may be reported to describe the bone marrow aspiration performed with bone marrow biopsy through the same skin incision on the same date of service.

2. CPT code 38747 (abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and venal caval nodes...) should not be reported for the excision of lymph nodes that are in the

operative field of another surgical procedure. For example CPT code 38747 should not be reported for the excision of lymph nodes in the operative field of a gastrectomy, pancreatectomy, hepatectomy, colectomy, enterectomy, or nephrectomy.

3. If an iatrogenic laceration of the spleen occurs during the course of another procedure, repair of the laceration with or without splenectomy is not separately reportable. Treatment of an iatrogenic complication of surgery such as a splenic laceration is not a separately reportable service. For example if an iatrogenic laceration of the spleen occurs during an enterectomy, colectomy, gastrectomy, pancreatectomy, or nephrectomy procedure, the physician should not separately report a splenectomy CPT code (e.g., 38100, 38101, 38120).

F. Mediastinum

CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with “exploration, drainage, removal of foreign body, or biopsy”. Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 should not be reported separately for exploration of the mediastinum when performed with procedures on mediastinal structures (e.g., esophagus, bronchi, aorta, heart) or structures accessed through the mediastinum (e.g., lungs, vertebrae). These codes may be reported separately if mediastinal drainage, removal of foreign body, or biopsy is performed.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE

contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. If CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) is reported for percutaneous transluminal balloon angioplasty of one or more lesions in the venous outflow vessel of a hemodialysis access defined as the “vessel” originating at the arterial anastomosis through the venous outflow tract to the subclavian vein, it should be reported with only one (1) unit of service.

If CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) is reported for percutaneous transluminal balloon angioplasty of one or more lesions in the arterial inflow tract of a hemodialysis access, it should be reported with only one (1) unit of service.

4. CPT codes 37211 and 37212 describe transcatheter therapy infusions for thrombolysis on the “initial treatment day”. Since each of these codes may only be reported once per day, the MUE value for each of these codes is one (1). CPT codes 37213 and 37214 describe transcatheter therapy infusions for thrombolysis “continued treatment on subsequent day”. Since each of these codes may only be reported once per day, the MUE value for each of these codes is one (1).

5. The CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of

this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue

adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

5. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

6. Open procedures of the thoracic cavity require a thoracotomy for the surgical approach. A physician should not report CPT code 32100 (thoracotomy, major; with exploration and biopsy) in addition to an open thoracic procedure CPT code.

7. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Under Medicare Global Surgery Rules, drug administration services (CPT Codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

8. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

9. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

10. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

11. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances except for lung biopsy(s) performed at the same patient encounter as a more extensive lung procedure removing the anatomic area of the biopsy(s). See Chapter V, Section C, paragraph 18 for rules

regarding separate reporting of lung biopsy(s) performed at the same patient encounter as a more extensive procedure.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

12. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

13. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

14. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g.,

arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

15. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

16. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

17. A cystourethroscopy (CPT code 52000) performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.

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CHAPTER VI
SURGERY: DIGESTIVE SYSTEM
CPT CODES 40000 - 49999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 40000-49999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same

day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

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 date 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.

C. Endoscopic Services

Endoscopic services may be performed in many places of service (e.g., office, outpatient, ambulatory surgical centers (ASC)). Services that are an integral component of an endoscopic procedure are not separately reportable. These services include, but are not limited to, venous access (e.g., CPT code 36000), infusion/injection (e.g., CPT codes 96360-96376), non-invasive oximetry (e.g., CPT codes 94760 and 94761), and anesthesia provided by the surgeon.

1. Per *CPT Manual* instructions, surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code should not be reported with a surgical endoscopy code.

2. If multiple endoscopic services are performed, the most comprehensive code describing the service(s) rendered should be reported. If multiple services are performed and not adequately described by a single HCPCS/CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended

to the secondary HCPCS/CPT code. Only medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

3. If the same endoscopic procedure (e.g., polypectomy) is performed multiple times at a single patient encounter in the same region as defined by the *CPT Manual* narrative, only one CPT code may be reported with one unit of service.

4. Gastroenterological procedures included in CPT code ranges 43753-43757 and 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology when performed are integral components of an esophagogastroduodenoscopy (e.g., CPT code 43235). Gastric or duodenal intubation with or without aspiration (e.g., CPT codes 43753, 43754, 43756) should not be separately reported when performed as part of an upper gastrointestinal endoscopic procedure. Gastric or duodenal stimulation testing (e.g., CPT codes 43755, 43757) may be facilitated by gastrointestinal endoscopy (e.g., procurement of gastric or duodenal specimens). When performed concurrent with an upper gastrointestinal endoscopy, CPT code 43755 or 43757 should be reported with modifier 52 indicating a reduced level of service was performed.

5. If an endoscopy or enteroscopy is performed as a common standard of practice when performing another service, the endoscopy or enteroscopy is not separately reportable. For example, if a small intestinal endoscopy or enteroscopy is performed during the creation or revision of an enterostomy, the small intestinal endoscopy or enteroscopy is not separately reportable.

6. A “scout” endoscopy to assess anatomic landmarks or assess extent of disease preceding another surgical procedure at the same patient encounter is not separately reportable. However, an endoscopic procedure for diagnostic purposes to decide whether a more extensive open procedure needs to be performed is separately reportable. In the latter situation, modifier 58 may be utilized to indicate that the diagnostic endoscopy and more extensive open procedure were staged procedures.

If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

7. If a non-endoscopic esophageal dilation (e.g., CPT codes 43450, 43453) fails and is followed by an endoscopic esophageal dilation procedure (e.g., CPT codes 43213, 43214, 43233), only the endoscopic esophageal dilation procedure may be reported. The physician should not report the failed procedure.

8. If it is necessary to perform diagnostic or surgical endoscopy of the hepatic/biliary/pancreatic system utilizing different methodologies (e.g., biliary T-tube endoscopy, ERCP) multiple CPT codes may be reported. Modifier 51 indicating multiple procedures were performed at the same patient encounter should be appended.

9. Intubation of the gastrointestinal tract (e.g., percutaneous placement of G-tube) includes subsequent removal of the tube. CPT codes such as 43247 (upper gastrointestinal endoscopic removal of foreign body*(s)*) should not be reported for removal of previously placed therapeutic devices. If a previously placed therapeutic device must be removed endoscopically because it cannot be removed by a non-endoscopic procedure, a CPT code such as 43247 may be reported for the endoscopic removal.

10. Rules for reporting biopsies performed at the same patient encounter as an excision, destruction, or other type of removal are discussed in Section H (General Policy Statements) (paragraph 21).

11. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. For example, if a provider performs endoscopic band ligation(s) by flexible sigmoidoscopy (CPT code 45350) or colonoscopy (CPT code 45398), control of bleeding is not separately reportable with CPT codes 45334 (flexible sigmoidoscopic control of bleeding) or 45382 (colonoscopic control of bleeding) respectively.

If it is necessary to repeat an endoscopy to control bleeding at a separate patient encounter on the same date of service, the HCPCS/CPT code for endoscopy for control of bleeding is separately reportable with modifier 78 indicating that the procedure required return to the operating room (or endoscopy suite) for a related procedure during the postoperative period.

12. Only the more extensive endoscopic procedure may be reported for a patient encounter. For example if a sigmoidoscopy

is completed and the physician also performs a colonoscopy during the same patient encounter, only the colonoscopy may be reported.

13. If an endoscopic procedure fails and is converted into an open procedure at the same patient encounter, only the open procedure is reportable. Neither a surgical endoscopy nor diagnostic endoscopy procedure code should be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

14. If a transabdominal colonoscopy via colostomy 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 reportable. However, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the endoscopic procedure may be reported separately. Modifier 58 may be utilized to indicate that the diagnostic endoscopy and the open procedure were staged or planned services. (CPT code 45355 was deleted January 1, 2015.)

15. If the larynx is viewed through an esophagoscope or upper gastrointestinal endoscope during endoscopy, a laryngoscopy CPT code cannot be reported separately. However, if a medically necessary laryngoscopy is performed with a separate laryngoscope, both the laryngoscopy and esophagoscopy (or upper gastro-intestinal endoscopy) CPT codes may be reported with NCCI-associated modifiers.

16. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure. *For example, fluoroscopy (e.g., CPT code 76000) is not separately reportable with CPT codes describing gastrointestinal endoscopy for foreign body removal (e.g., 43194, 43215, 43247, 44390, 45332, 45379).*

D. Esophageal Procedures

1. CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with “exploration, drainage, removal of foreign body, or biopsy”. Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 should not be reported separately for exploration of the mediastinum when performed with an esophageal procedure. These codes may be reported separately if mediastinal drainage, removal

of foreign body, or biopsy is performed. However, these codes should not be reported separately for removal of foreign body with CPT code 43020 (esophagotomy, cervical approach, with removal of foreign body) or CPT code 43045 (esophagotomy, thoracic approach, with removal of foreign body).

E. Abdominal Procedures

1. During an open abdominal procedure exploration of the surgical field is routinely performed to identify anatomic structures and disease. An exploratory laparotomy (CPT code 49000) is not separately reportable with an open abdominal procedure.

2. Hepatectomy procedures (e.g., CPT codes 47120-47130, 47133-47142) include removal of the gallbladder based on anatomic considerations and standards of practice. A cholecystectomy CPT code is not separately reportable with a hepatectomy CPT code.

3. A medically necessary appendectomy may be reported separately. However, an incidental appendectomy of a normal appendix during another abdominal procedure is not separately reportable.

4. If a hernia repair is performed at the site of an incision for an open or laparoscopic abdominal procedure, the hernia repair (e.g., CPT codes 49560-49566, 49652-49657) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and should not be reported separately.

5. If a recurrent hernia requires repair, a recurrent hernia repair code may be reported. A code for incisional hernia repair should not be reported in addition to the recurrent hernia repair code unless a medically necessary incisional hernia repair is performed at a different site. In the latter case, modifier 59 should be appended to the incisional hernia repair code.

6. CPT code 49568 is an add-on code describing implantation of mesh or other prosthesis for incisional or ventral hernia repair. This code may be reported with incisional or ventral hernia repair CPT codes 49560-49566. Although mesh or other prosthesis may be implanted with other types of hernia repairs, CPT code 49568 should not be reported with these other hernia repair codes. If a provider performs an incisional or

ventral hernia repair with mesh/prosthesis implantation as well as another type of hernia repair at the same patient encounter, CPT code 49568 may be reported with modifier 59 to bypass edits bundling CPT code 49568 into all hernia repair codes other than the incisional or ventral hernia repair codes.

7. Removal of excessive skin and subcutaneous tissue (panniculectomy) at the site of an abdominal incision for an open procedure including hernia repair is not separately reportable. CPT code 15830 should not be reported for this type of panniculectomy. However, an abdominoplasty which requires significantly more work than a panniculectomy is separately reportable. In order to report an abdominoplasty in 2007, CPT requires the physician to report an infraumbilical abdominal panniculectomy (CPT code 15830 in 2007) plus the add-on CPT code 15847 for the abdominoplasty. Since NCCI bundles CPT code 15830 (in 2007) into abdominal wall hernia repair CPT codes, a provider should report CPT codes 15830 plus 15847 with modifier 59 appended to CPT code 15830 in order to report an abdominoplasty with an abdominal hernia repair CPT code.

8. Open enterolysis (CPT code 44005) and laparoscopic enterolysis (CPT code 44180) are defined by the *CPT Manual* as "separate procedures". They are not separately reportable with other intra-abdominal or pelvic procedures. However, if a provider performs an extensive and time-consuming enterolysis in conjunction with another intra-abdominal or pelvic procedure, the provider may append modifier 22 to the CPT code describing the latter procedure. The local carrier (A/B MAC processing practitioner service claims) will determine whether additional payment is appropriate.

9. If an iatrogenic laceration/perforation of the small or large intestine occurs during the course of another procedure, repair of the laceration/perforation is not separately reportable. Treatment of an iatrogenic complication of surgery such as an intestinal laceration/perforation is not a separately reportable service. For example CPT codes describing suture of the small intestine (CPT codes 44602, 44603) or suture of large intestine (CPT codes 44604, 44605) should not be reported for repair of an intestinal laceration/perforation during an enterectomy, colectomy, gastrectromy, pancreatectomy, hysterectomy, or oophorectomy procedure.

10. A Whipple type pancreatectomy procedure (CPT codes 48150-48154) includes removal of the gallbladder. A

cholecystectomy (e.g., CPT codes 47562-47564, 47600-47620) should not be reported separately.

11. If closure of a fistula requires excision of a portion of an organ into which the fistula passes, excision of that tissue should not be reported separately. For example, if closure of an enterocolic fistula requires removal of a portion of adjacent small intestinal tissue and a portion of adjacent colonic tissue, closure of the enterocolic fistula (CPT code 44650) includes the removal of the small and large intestinal tissue. The excision of the small intestinal or colonic tissue should not be reported separately.

12. Pelvic exenteration procedures (CPT codes 45126, 51597, 58240) include extensive removal of structures from the pelvis. Physicians should not separately report codes for the removal of pelvic structures (e.g., colon, rectum, urinary bladder, uterine body and/or cervix, fallopian tubes, ovaries, lymph nodes, prostate gland).

13. Liver allotransplantation procedures include, if performed, biliary *tract* T-tube *insertion/conversion/exchange/removal*, drainage, or stent procedures *(e.g., CPT codes 47533-47540)*. CPT codes such as 47510, 47511, 47525, 47530, or 47801 should not be reported with a liver allotransplantation procedure. *(CPT codes 47510, 47511, 47525, and 47530 were deleted January 1, 2016.)*

F. Laparoscopy

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a “scout” procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a

surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

4. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

5. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

6. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all laparoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with a laparoscopic procedure.

7. A diagnostic laparoscopy includes “washing”, infusion and/or removal of fluid from the body cavity. A physician should not report CPT codes 49082-49083 (abdominal paracentesis) or 49084 (peritoneal lavage) for infusion and/or removal of fluid from the body cavity performed during a diagnostic or surgical laparoscopic procedure.

8. Injection of air into the abdominal or pelvic cavity is integral to many laparoscopic procedures. Physicians should not separately report CPT code 49400 (injection of air or contrast into peritoneal cavity (separate procedure)) for this service.

9. CPT codes 43281 and 43282 describe laparoscopic paraesophageal hernia repair with fundoplasty, if performed, without or with mesh implantation respectively. These codes should not be reported for a figure-of-eight suture often performed during gastric restrictive procedures.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of

service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

4. Gastrointestinal endoscopy CPT codes describing dilation of stricture(s) (e.g., CPT codes 43213, 45340, 45386) include dilation of all strictures dilated during the endoscopic procedure. These codes should not be reported with more than one (1) unit of service if more than one stricture is dilated.

5. The unit of service (UOS) for CPT code 43277 (Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct) is each duct. One UOS includes trans-endoscopic balloon dilation of one or more strictures within each duct. Dilation of one or more strictures in the pancreatic duct including the major and minor ductal branches is reported as a single UOS. Similarly, dilation of one or more strictures in each of the following ducts may be reported as a single UOS for each duct: common bile duct, cystic duct, right hepatic duct, and left hepatic duct.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately

reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. The vagotomy CPT codes (e.g., 43635-43641, 64755-64760) are not separately reportable with esophageal or gastric procedures that include vagotomy as part of the service. For example, the esophagogastrostomy procedure described by CPT code 43320 includes a vagotomy if performed. The vagotomy procedures are mutually exclusive, and only one vagotomy procedure code may be reported at a patient encounter.

6. If closure of an enterostomy or fistula involving the intestine requires resection and anastomosis of a segment of intestine, the resection and anastomosis of the intestine are not separately reportable.

7. If multiple services are utilized to treat hemorrhoids at the same patient encounter, only one HCPCS/CPT code describing the most extensive procedure may be reported. If an abscess is drained during the treatment of hemorrhoids, the incision and drainage is not separately reportable unless the incision and drainage is at a separate site unrelated to the hemorrhoids. In the latter case, the incision and drainage code may be reported appending an anatomic modifier or modifier 59.

8. *Diagnostic anoscopy (CPT code 46600) is not separately reportable with an open or endoscopic procedure of the anus (e.g., 46020-46942, 0184T, 0249T, 0377T). The* diagnostic anoscopy (CPT code 46600) is an included service that is not separately reportable. It is a misuse of CPT codes describing diagnostic proctosigmoidoscopy (CPT code 45300), sigmoidoscopy (CPT code 45330), or colonoscopy (CPT code 45378) to report *an* examination limited to the anus. If the physician performs a complete diagnostic proctosigmoidoscopy, sigmoidoscopy, or colonoscopy, the procedure may be reported separately.

9. The *CPT Manual* contains groups of codes describing different approaches or methods to accomplish similar results. These codes are generally mutually exclusive of one another. For example CPT codes 45110-45123 describe different proctectomy procedures and are mutually exclusive of one another. Other examples include groups of codes for colectomy (CPT codes 44140-

44160), gastrectomy (CPT codes 43620-43635), and pancreatectomy (CPT codes 48140-48155).

10. An enterostomy closure HCPCS/CPT code should not be reported with a code for creation or revision of a colostomy. Closure of an enterostomy is mutually exclusive with the creation or revision of the colostomy.

11. If an excised section of intestine includes a fistula tract, a fistula closure code should not be reported separately. Closure of the fistula is included in the excision of intestine.

12. The mouth and anus have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes that describe the procedure as an integumentary procedure (CPT codes 10000-19999) or as a digestive system procedure (CPT codes 40000-49999). If a procedure is performed on a lesion at or near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If the code descriptor of a CPT code from the digestive system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) should not be reported separately.

13. If a physician must drain an abscess in order to complete a sialolithotomy procedure, the drainage of the abscess is not separately reportable. If a definitive surgical procedure requires access through diseased tissue, treatment of the diseased tissue for this access is not separately reportable.

14. An open cholecystectomy includes an examination of the abdomen through the abdominal wall incision. If this examination is performed laparoscopically, it is not separately reportable as CPT code 49320 (diagnostic laparoscopy).

15. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

16. CPT codes 43770-43774 describe laparoscopic gastric restrictive procedures. Only one of these procedure codes may be reported for a single patient encounter. If a patient develops a complication during the postoperative period of the initial procedure requiring return to the operating room for a different laparoscopic gastric restrictive procedure to treat the

complication, the second procedure should be reported with modifier 78.

17. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-6448*9*, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure

pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

18. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

19. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

20. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

21. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is

performed, the biopsy is not separately reportable with the more extensive procedure.

22. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

23. The NCCI PTP edit with column one CPT code 45385 (Flexible colonoscopy with removal of tumor(s), polyp(s), or lesion(s) by snare technique) and column two CPT code 45380 (Flexible colonoscopy with single or multiple biopsies) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 45380 of this NCCI PTP edit is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

24. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

25. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

26. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

27. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

28. A cystourethroscopy (CPT code 52000) performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.

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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 INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 50000-59999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules

are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a

complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

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 date 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.

C. Urinary System

1. Insertion of a urinary bladder catheter is a component of the global surgical package. Urinary bladder catheterization (CPT codes 51701, 51702, and 51703) is not separately reportable with a surgical procedure when performed at the time of or just prior to the procedure.

Additionally, many procedures involving the urinary tract include the placement of a urethral/bladder catheter for postoperative drainage. Because this is integral to the procedure, placement of a urinary catheter is not separately reportable.

2. Cystourethroscopy, with biopsy(s) (CPT code 52204) includes all biopsies during the procedure and should be reported with one unit of service.

3. Some lesions of the genitourinary tract occur at mucocutaneous borders. The *CPT Manual* contains integumentary

system (CPT codes 10000-19999) and genitourinary system (CPT codes 50000-59899) codes to describe various procedures such as biopsy, excision, or destruction. A single code from one of these two sections of the *CPT Manual* that best describes the biopsy, excision, destruction, or other procedure performed on one or multiple similar lesions at a mucocutaneous border should be reported. Separate codes from the integumentary system and genitourinary system sections of the *CPT Manual* may only be reported if separate procedures are performed on completely separate lesions on the skin and genitourinary tract. Modifier 59 should be utilized to indicate that the procedures are on separate lesions. The medical record should accurately describe the precise locations of the lesions.

4. If an irrigation or drainage procedure is necessary and integral to complete a genitourinary or other procedure, only the more extensive procedure should be reported. The irrigation or drainage procedure is not separately reportable.

5. The CPT code descriptor for some genitourinary procedures includes a hernia repair. A HCPCS/CPT code for a hernia repair is not separately reportable unless the hernia repair is performed at a different site through a separate incision. In the latter case, the hernia repair may be reported with modifier 59.

6. In general, multiple methods of performing a procedure (e.g., prostatectomy) cannot be performed at the same patient encounter. (See general policy on mutually exclusive services.) Therefore, only one method of accomplishing a given procedure may be reported. If an initial approach fails and is followed by an alternative approach, only the completed or last uncompleted approach may be reported.

7. If a diagnostic endoscopy leads to the performance of a laparoscopic or open procedure, the diagnostic endoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic endoscopy and non-endoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic endoscopy. However, if an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reportable. If the endoscopy is confirmatory or is performed to assess the surgical field (“scout endoscopy”), the endoscopy does not represent a separate diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and

should not be reported separately with a diagnostic or surgical endoscopy code.

If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

8. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical endoscopy nor a diagnostic endoscopy code should be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

9. Surgical endoscopy includes diagnostic endoscopy which is not separately reportable. If a diagnostic endoscopy leads to a surgical endoscopy at the same patient encounter, only the surgical endoscopy may be reported.

10. When multiple endoscopic procedures are performed at the same patient encounter, the most comprehensive code accurately describing the service(s) performed should be reported. If several procedures not included in a more comprehensive code are performed at the same endoscopic session, multiple HCPCS/CPT codes may be reported with modifier 51. (For example, if renal endoscopy is performed through an established nephrostomy with biopsy, fulguration of a lesion, and foreign body (calculus) removal, the appropriate CPT coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.) This policy applies to all endoscopic procedures, not only those of the genitourinary system.

11. CPT code 51700 (bladder irrigation, simple, lavage and/or instillation) is used to report irrigation with therapeutic agents or as an independent therapeutic procedure. It is not separately reportable if bladder irrigation is part of a more comprehensive service such as to gain access to or visualize the urinary system. Irrigation of a urinary catheter is included in the global surgical package. CPT code 51700 should not be misused to report irrigation of a urinary catheter.

12. CPT codes 51784 and 51785 describe diagnostic electromyography (EMG). When EMG is performed as part of a biofeedback session, neither CPT code 51784 nor 51785 should be reported unless a significant, separately identifiable diagnostic EMG service is provided. If either CPT code 51784 or CPT code

51785 is reported for a diagnostic electromyogram, a separate report must be available in the medical record to indicate this service was performed for diagnostic purposes.

13. 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 at the same patient encounter are medically reasonable and necessary (e.g., renal endoscopy through a nephrostomy and cystourethroscopy) to perform different procedures, they may be separately reported appending modifier 51 to the less extensive procedure codes. However, when multiple endoscopic approaches are utilized to attempt the same procedure, only the completed approach should be reported.

14. Endoscopic procedures include all minor related functions performed at the same encounter. Although CPT codes may exist to describe these functions, they should not be reported separately. For example, transurethral resection of the prostate includes meatotomy, urethral calibration and/or dilation, urethroscopy, and cystoscopy. Codes for the included procedures should not be reported separately.

15. When urethral catheterization or urethral dilation (e.g., CPT codes 51701-51703) is necessary to complete a more extensive procedure, the urethral catheterization/dilation is not separately reportable.

16. Ureteral anastomosis procedures are described by CPT codes 50740-50825, and 50860. In general, they represent mutually exclusive procedures that are not reported together. If one type of anastomosis is performed on one ureter, and a different type of anastomosis is performed on the contralateral ureter, the appropriate modifier (e.g., LT, RT) should be reported with the CPT code to describe the service performed on each ureter. For example, the procedure described by CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive with the procedures described by CPT codes 50800-50830 (e.g., ureteroenterostomy, ureterocolon conduit, urinary undiversion) unless performed on contralateral ureters in which case anatomic modifiers should be reported.

17. CPT codes 53502-53515 describe urethral repair codes for urethral wounds or injuries (urethrorrhaphy). When an 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.

18. CPT code 78730 (Urinary bladder, residual study) is a nuclear medicine procedure requiring use of a radio-pharmaceutical. This CPT code should not be utilized to report measurement of residual urine in the urinary bladder determined by other methods.

19. CPT code 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent) describes insertion of a self-retaining indwelling stent during cystourethroscopy with ureteroscopy and/or pyeloscopy and should not be reported to describe insertion and removal of a temporary ureteral stent during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy (*e.g.,* CPT codes 52320-52330, 52334-52355). The insertion and removal of a temporary ureteral catheter (stent) during these procedures is not separately reportable and should not be reported with CPT codes 52005 *(Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;) or 52007 (Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis).*

CPT codes 52332 and 52005 are not separately reportable for the same ureter for the same patient encounter.

20. Prostatectomy procedures (CPT codes 55801-55845) include cystoplasty or cystourethroplasty as a standard of surgical practice. CPT code 51800 (cystoplasty or cystourethroplasty...) should not be reported separately with prostatectomy procedures.

21. CPT code 50650 (ureterectomy, with bladder cuff (separate procedure)) should not be reported with other procedures on the ipsilateral ureter. Since CPT code 50650 includes the “separate procedure” designation, CMS does not allow additional payment for the procedure when it is performed with other procedures in an anatomically related area.

22. The code descriptors for CPT codes 52310 and 52315 (cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure)...) include the “separate procedure” designation. Per CMS payment

policy for procedures with the “separate procedure” designation, these codes should not be reported with other cystourethroscopy CPT codes for the same patient encounter.

23. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

24. Cystourethroscopy and transurethral procedures include fluoroscopy when performed. CPT codes describing fluoroscopy or fluoroscopic guidance (e.g. 76000, 76001, 77002) should not be reported separately with a cystourethroscopy or transurethral procedure CPT code.

25. A ureteral stent is commonly inserted at the site of an anastomosis of a ureter and another structure in order to maintain patency of the ureter. A ureteral stent is also often inserted into a ureter if the ureter is incised during a procedure (e.g., nephrectomy, cystectomy, ureteral anastomosis). With these procedures, insertion of the ureteral stent is integral to the procedure and is not separately reportable. For example, CPT code 50605 (Ureterotomy for insertion of indwelling stent, all types) should not be reported with CPT codes describing cystectomy, urinary diversion, or ureteral anastomosis for insertion of a ureteral stent to maintain patency at the site of a ureteral anastomosis.

26. Pelvic exenteration procedures (CPT codes 45126, 51597, 58240) include extensive removal of structures from the pelvis. Physicians should not separately report codes for the removal of pelvic structures (e.g., colon, rectum, urinary bladder, uterine body and/or cervix, fallopian tubes, ovaries, lymph nodes, prostate gland).

27. CPT code 50398 describes change of a nephrostomy or pyelostomy tube. If the tube change occurs in a patient without new symptoms related to the tube, CPT code 50394 (injection procedure for pyelography through a nephrostomy or pyelostomy tube) should not be reported separately for the tube check. However, if the patient has new symptoms related to the tube, the provider may separately report CPT code 50394 with an NCCI-associated modifier for the tube check. *(CPT codes 50394 and 50398 were deleted January 1, 2016.)*

28. CPT codes 52317 and 52318 describe litholapaxy (crushing/fragmentation and removal) of calculus in the urinary bladder. These codes may be reported for crushing/fragmentation with removal of calculi originating de novo in the urinary bladder. These codes should not be reported for crushing/fragmentation and removal of calculi in the urinary bladder that result from a procedure to remove, manipulate, and/or fragment calculi higher up in the urinary tract.

D. Male Genital System

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

2. The puncture aspiration of a hydrocele (e.g., CPT code 55000) is included in services involving the tunica vaginalis and proximate anatomy (e.g., scrotum, vas deferens) and in inguinal hernia repairs and should not be reported separately.

3. The *CPT Manual* contains many codes (CPT codes 52601-52649, 53850-53853, 55801-55845, 55866) which describe various methods of removing or destroying prostate tissue. These procedures are mutually exclusive, and two codes from these code ranges should not be reported together.

4. Scrotal exploration (CPT code 55110) is not separately reportable with procedures of the scrotum, scrotal sac, or its contents including the testes and epididymis. Exploration of the surgical field is not separately reportable.

5. If a prostatectomy procedure necessitates reconstruction of the bladder neck, the bladder neck reconstruction is not separately reportable. For example, CPT code 51800 (cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck...) should not be reported with a prostatectomy CPT code where the cystoplasty or cystourethroplasty is necessitated by the prostatectomy procedure.

E. 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 reportable. A diagnostic pelvic examination may be performed for the purpose of deciding to

perform a procedure. 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 CPT codes 38120, 38570-38572, 43280, 43651-43653, 44180-44227, 44970, *47562*-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, and 60650. CPT code 58555 is included in CPT codes 58558-58565.

3. Pelvic examination under anesthesia (CPT code 57410) is included in all major and most minor gynecological procedures and is not separately reportable. This procedure represents routine evaluation of the surgical field.

4. Dilation of vagina or cervix (CPT codes 57400 or 57800) in conjunction with vaginal approach procedures is not separately reportable unless the CPT code descriptor states “without cervical dilation”.

5. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a “scout” procedure to confirm a 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 separately with modifier 58 appended to the non-colposcopic procedure code. Diagnostic colposcopies (CPT codes 56820, 57420, 57452) are not separately reportable with other colposcopic procedures.

6. Pelvic exenteration procedures (CPT codes 45126, 51597, 58240) include extensive removal of structures from the pelvis. Physicians should not separately report codes for the removal of pelvic structures (e.g., colon, rectum, urinary bladder, uterine body and/or cervix, fallopian tubes, ovaries, lymph nodes, prostate gland).

7. CPT code 57250 describes posterior colporrhaphy for repair of rectocele including perineorrhaphy if performed. If a vaginal hysterectomy is accompanied by additional dissection to repair a rectocele (with perineorrhaphy if performed), both the vaginal hysterectomy CPT code and CPT code 57250 may be reported together with an NCCI-associated modifier.

8. CPT code 57240 describes anterior colporrhaphy for repair of cystocele including repair of urethrocele if performed. If a vaginal hysterectomy is accompanied by additional dissection to repair a cystocele (with repair of urethrocele if performed), both the vaginal hysterectomy CPT code and CPT code 57240 may be reported together with an NCCI-associated modifier.

9. CPT code 57260 describes a combined anteroposterior colporrhaphy. If a vaginal hysterectomy is accompanied by additional dissection to repair a rectocele (with perineorrhaphy if performed) and repair a cystocele (with repair of urethrocele if performed), both the vaginal hysterectomy CPT code and CPT code 57260 may be reported together with an NCCI-associated modifier.

10. A vaginal hysterectomy normally includes fixation of the vagina to surrounding tissues. It is a misuse of CPT code 57282 (Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)) or 57283 (Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)) to report this fixation of the vagina to describe the fixation that routinely occurs during a vaginal hysterectomy. If a more extensive colpopexy consistent with the requirements of CPT code 57282 or 57283 is performed, CPT codes 57282 or 57283 may be reported with the vaginal hysterectomy CPT code utilizing an NCCI-associated modifier.

F. Laparoscopy

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a “scout” procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

4. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

5. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

6. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all laparoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with a laparoscopic procedure.

7. A diagnostic laparoscopy includes “washing”, infusion and/or removal of fluid from the body cavity. A physician should not report CPT codes 49082-49083 (abdominal paracentesis) or 49084 (peritoneal lavage) for infusion and/or removal of fluid from the body cavity performed during a diagnostic or surgical laparoscopic procedure.

8. Injection of air into the abdominal or pelvic cavity is integral to many laparoscopic procedures. Physicians should not separately report CPT code 49400 (injection of air or contrast into peritoneal cavity (separate procedure)) for this service.

G. Maternity Care and Delivery

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

2. 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 separately reportable.

3. Antepartum care includes urinalysis which is not separately reportable.

4. Maternity procedures are assigned a global period of MMM on the Medicare Physician Fee Schedule Database. Some of these procedures (e.g., Cesarean section) are similar to surgical procedures with a global period of 000, 010, or 090 days. These types of maternity procedures are subject to global surgery and anesthesia rules. The same HCPCS/CPT codes based on these rules are bundled into this subgroup of MMM procedures as are bundled into surgical procedures with a global period of 000, 010, or 090 days.

5. Wound repair CPT codes 12001-13153 should not be reported to describe closure of a surgical incision for codes with a global period of MMM.

H. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE

contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. *The unit of service (UOS) for a procedure describing destruction or removal of renal system calculus(i) is one (1). The UOS is not each calculus. If a procedure for destruction or removal of renal system calculi is performed bilaterally, the CPT code may be reported with modifier 50 and one (1) UOS.*

For example, CPT code 52353 (cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)) should be reported with only one unit of service (UOS) per ureter *regardless of the number of calculi in the ureter*. If the procedure is performed on bilateral ureters, it may be reported with *modifier 50 and* one UOS. This code should not be reported with *a* separate UOS for each calculus.

4. The CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

I. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section

50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

6. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

7. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

9. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

10. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another

type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

11. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

12. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

13. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

14. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code

appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

15. A cystourethroscopy (CPT code 52000) performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.

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

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Chapter VIII
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CPT Codes 60000 - 69999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 60000-69999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical

package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

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 date 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.

C. Nervous System

1. A burr hole is often necessary for intracranial surgery (e.g., craniotomy, craniectomy) to access intracranial contents, to alleviate pressure, or to place an intracranial pressure monitoring device. When this service is integral to the performance of other services, CPT codes describing this service are not separately reportable if performed at the same patient encounter. A burr hole is separately reportable with another cranial procedure only if performed at a separate site unrelated to the other cranial procedure or at a separate patient encounter on the same date of service.

In addition, taps, punctures, or burr holes accompanied by drainage procedures (e.g., hematoma, abscess, cyst, etc.)

followed by other procedures are not separately reportable unless performed as staged procedures. Modifier 58 may be reported 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. An exploratory craniectomy or craniotomy (CPT code 61304 or 61305) should not be reported separately with another craniectomy/craniotomy procedure performed at the same anatomic site and same patient encounter.

4. A craniotomy is performed through a skull defect resulting from reflection of a skull flap. Replacing the skull flap during the same procedure is an integral component of a craniotomy procedure and should not be reported separately utilizing the cranioplasty CPT codes 62140 and 62141. A cranioplasty may be separately reportable with a craniotomy procedure if the cranioplasty is performed to replace a skull bone flap removed during a procedure at a prior patient encounter or if the cranioplasty is performed to repair a skull defect larger than that created by the bone flap.

5. If two procedures are performed at the same anatomic site and same patient encounter, one procedure may be bundled into the other (e.g., one procedure may be integral to the other). However, if the two procedures are performed at separate anatomic sites or at separate patient encounters, they may be separately reportable. Modifier 59 may be reported to indicate that the two procedures are distinct and separately reportable services under these circumstances.

Example: A patient with an open head injury and a contre-coup subdural hematoma requires an exploratory craniectomy for the open head injury and a burr hole drainage on the contralateral side for a subdural hematoma. The creation of a burr hole at the site of the exploratory craniectomy would be considered integral to the craniectomy. However, the contralateral burr hole drainage is a separate service not integral to the exploratory craniectomy. To correctly report the burr hole drainage for the contralateral subdural hematoma and the exploratory craniectomy, the burr hole should be reported with the appropriate modifier (e.g., 59, RT, LT). In this example the correct coding would be

CPT codes 61304 (exploratory craniectomy) with one unit of service and 61154-59 (burr hole with drainage of subdural hematoma) with one unit of service.

6. If a physician performs a craniectomy or craniotomy procedure and places a ventricular catheter, pressure recording device, or other intracerebral monitoring device through the same hole in the skull, the physician should not separately report CPT code 61107 (twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter...). CPT code 61107 may be reported separately with an NCCI-associated modifier if it is necessary to place a ventricular catheter, pressure recording device, or other intracerebral monitoring device through a different hole in the skull.

7. If a physician evacuates, aspirates, or drains an intracranial hematoma (e.g., CPT codes 61154, 61156, 61312-61315), the physician should not separately report a code for drainage of a hematoma in the overlying skin to access the intracranial hematoma. Access through diseased tissue to perform a more extensive definitive procedure is not separately reportable.

8. CPT codes 61781-61783 are add-on codes describing computer-assisted navigational procedures of the cranium or spine. CMS payment policy does not allow CPT code 69990 (microsurgical technique requiring use of operating microscope) to be reported with these codes unless CPT code 69990 is reported with another CPT code that meets the requirements of CMS *Internet-Only Manual*, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 20.4.5. This IOM section limits the separate payment for CPT code 69990 to a small number of procedures. In these situations, physicians may report modifier 59 with CPT code 69990 to indicate that the procedure described by CPT code 69990 was performed for a procedure other than the computer-assisted navigation on the same date of service.

9. The use of general intravascular access devices (e.g., intravenous lines), cardiac monitoring, oximetry, laboratory sample procurement, and other routine monitoring for patient safety during general anesthesia, monitored anesthesia care (MAC), or other anesthesia are included in the anesthesia service and are not separately reportable. For example, if a physician performing a spinal puncture for intrathecal injection administers an anxiolytic agent, the vascular access and any

appropriate monitoring is considered part of the spinal puncture procedure and is not separately reportable.

10. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure. The reporting of nerve block or facet block CPT codes for anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate.

11. If cerebrospinal fluid is withdrawn during a nerve block procedure, the withdrawal is not separately reportable (e.g., diagnostic lumbar puncture). It is integral to the nerve block procedure.

12. If a dural (cerebrospinal fluid) leak occurs during a spinal procedure, repair of the dural leak is integral to the spinal procedure. CPT code 63707 or 63709 (repair of dural/cerebrospinal fluid leak) should not be reported separately for the repair.

13. CPT code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. The procedure coded as CPT code 64721 includes the procedure coded as CPT code 29848 when performed on the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported.

14. Nerve repairs by suture (neurorrhaphies) (CPT codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury or anastomosis of nerves which are proximally associated (e.g., facial-spinal accessory, facial-hypoglossal, etc.). When neurorrhaphy is performed with a nerve graft (CPT codes 64885-64911), neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., the neurorrhaphy is integral to the procedure and is not separately reportable.

15. Implantation of neurostimulator electrodes in an area of the cerebral cortex may not be reported with two codes describing different approaches. CPT code 61860 describes implantation by craniectomy or craniotomy. CPT code 61850 describes implantation by twist drill or burr hole(s).

16. The following information was revised and published April 1, 2012. CPT codes 61885, 61886, and 63685 describe "insertion or replacement" of cranial or spinal neurostimulator pulse generators or receivers. Reporting an "insertion or replacement" CPT code necessitates use of a new neurostimulator pulse generator or receiver. CPT codes 61888 and 63688 describe "revision or removal" of cranial or spinal neurostimulator pulse generators or receivers. If the same pulse generator is removed and replaced into the same or another skin pocket, the "revision" CPT code is the only CPT code that may be reported. The "replacement" CPT code which requires use of a new neurostimulator pulse generator or receiver should NOT be reported as this Manual previously indicated. If one pulse generator is removed and replaced with a different pulse generator into the same or another skin pocket, the "replacement" CPT code may be reported. The "removal" CPT code is not separately reportable. The "insertion or replacement" CPT code is separately reportable with a "revision or removal" CPT code only if two separate batteries/generators are changed. For example, if one battery/generator is replaced (e.g., right side) and another is removed (e.g., left side), CPT codes for the "insertion or replacement" and "revision or removal" could be reported together with modifier 59.

17. Because procedures necessary to perform a column one coded procedure are included in the column one coded procedure, column two CPT codes such as 62310-62311, 62318-62319 (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive spinal/back procedures.

18. A laminectomy includes excision of all the posterior vertebral components, and a laminotomy includes partial excision of posterior vertebral components. Since a laminectomy is a more extensive procedure than a laminotomy, a laminotomy code should not be reported with a laminectomy code for the same vertebra. CPT codes 22100-22103 (partial excision of posterior vertebral component (e.g., spinous process, lamina, or facet) for intrinsic bony lesion) are not separately reportable with laminectomy or laminotomy procedures for the same vertebra.

19. Some spinal procedures may require manipulation of the spine which is integral to the procedure. CPT code 22505 (Manipulation of the spine requiring anesthesia, any region) should not be reported separately with a spinal procedure.

20. Fluoroscopy reported as CPT codes 76000 or 76001 should not be reported with spinal procedures unless there is a specific *CPT Manual* instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure.

21. CPT codes 62310-62319 describe injections of diagnostic or therapeutic substance(s) into the epidural or subarachnoid spaces at different spinal levels. Fluoroscopic guidance such as CPT code 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid))is included in these procedures and should not be reported separately with these codes.

22. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an add-on code describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the

first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

23. A bone marrow aspiration (CPT code 38220) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code if the bone marrow aspiration is obtained from the surgical field. However, if the bone marrow aspiration is obtained from an anatomic site other than vertebrae on which the orthopedic/neurosurgical procedure is performed, it may be reported separately with an NCCI-associated modifier.

24. CPT codes 38230 (bone marrow harvesting for transplantation; allogeneic) and 38232 (bone marrow harvesting for transplantation; autologous) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code for procurement of bone marrow aspirate. CPT codes 38230 and 38232 are used to report the procurement of bone marrow for future bone marrow transplantation.

25. CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.

26. Since the code descriptor for CPT code 61576 (transoral approach to skull base...(including tracheostomy)) includes a tracheostomy in the code descriptor, a CPT code describing a tracheostomy should not be reported separately.

27. For reporting CPT code 69990 (operating microscope), the reader is referred to Chapter VIII, Section F (Operating Microscope).

28. CPT code 61623 (endovascular temporary balloon arterial occlusion...concomitant neurological monitoring,...) describes a procedure that includes prolonged neurologic assessment. This code should not be utilized to report the temporary arterial occlusion that is an inherent component of CPT code 61624 (transcatheter permanent occlusion or embolization...; central nervous system (intracranial, spinal cord)).

29. Muscle chemodenervation procedures coded as CPT codes 64612-64614 occasionally require needle electromyographic (EMG) guidance. From January 1 through December 31, 2005, CMS allowed CPT code 95870 to be reported for such guidance when medically reasonable and necessary. Effective January 1, 2006, needle EMG guidance for muscle chemodenervation procedures coded as CPT codes 64612-64614 may be reported with CPT code 95874. (CPT codes 64613 and 64614 were deleted January 1, 2014.)

30. Some procedures (e.g., intracranial, spinal) utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) should not be reported by the physician performing an operative procedure since it is included in the global package. The physician performing an operative procedure should not report other CPT section 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939) since they are also included in the global package. However, when performed by a different physician during the procedure, intraoperative neurophysiology testing is separately reportable by the second physician.

31. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

32. Access to the brachial plexus for a neuroplasty or suture procedure often requires division of a scalene muscle. Since access to the surgical field to perform a surgical procedure is integral to the procedure, division of a scalene muscle is not separately reportable with a brachial plexus procedure.

33. If the injection procedure for discography (CPT codes 62290, 62291) is followed by postoperative pain, treatment of this pain is not separately reportable (e.g., CPT codes 62310, 62311). The injection procedure codes have a global surgical indicator of 000 days. Medicare Global Surgery Rules include treatment of postoperative pain in the global surgical package.

34. CPT code 61783 (stereotactic computer assisted (navigational) procedure; spinal...) should not be reported for a simple spinal decompression (e.g., CPT codes 63001-63051). Stereotactic navigational procedures are usually performed to identify anatomy for precise treatments and avoid vital structures which are not necessary for a simple spinal decompression procedure.

35. CPT code 64561 (percutaneous implantation of neurostimulator electrode array; sacral nerve...) is priced to include a “percutaneous neuro test stimulation kit”. This kit includes a “test stimulation lead”. HCPCS code A4290 (sacral nerve stimulation test lead, each) should not be reported with CPT code 64561.

D. Ophthalmology

1. When a subconjunctival injection (e.g., CPT code 68200) with local anesthetic is performed as part of a more extensive anesthetic procedure (e.g., peribulbar or retrobulbar block), the subconjunctival injection is not separately reportable. It is part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy and/or anterior vitrectomy may be performed in conjunction with cataract extraction. If an iridectomy is performed in order to complete a cataract extraction, it is an integral part of the procedure and is not separately reportable. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable. If an iridectomy or vitrectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitrectomy may be reported separately with an NCCI-associated modifier. The medical record must document the distinct medical necessity for each procedure.
A trabeculectomy is separately reportable with a cataract extraction if performed for a purpose unrelated to the cataract extraction. For example, if a patient with glaucoma requires a

cataract extraction and a trabeculectomy is the appropriate treatment for the glaucoma, the trabeculectomy may be separately reportable. However, performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not separately reportable.

3. CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye.

4. There are numerous CPT codes describing repair of retinal detachment (e.g., 67101-67113). These procedures are mutually exclusive and should not be reported separately for the ipsilateral eye on the same date of service. Some retinal detachment repair procedures include some vitreous procedures which are not separately reportable. For example, the procedure described by CPT code 67108 includes the procedures described by CPT codes 67015, 67025, 67028, 67031, 67036, 67039, and 67040.

5. The procedures described by CPT codes 68020-68200 (incision, drainage, biopsy, excision, or destruction of the conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362). CPT codes 68020-68200 should not be reported separately with CPT codes 68320-68362 for the ipsilateral eye.

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

7. Correction of lid retraction (CPT code 67911) includes a full thickness graft (e.g., CPT code 15260) as part of the procedure. A full thickness graft code such as CPT code 15260 should not be reported separately with CPT code 67911 for the ipsilateral eye.

8. If it is medically reasonable and necessary to inject anti-sclerosing agents at the same patient encounter as surgery to correct glaucoma, the injection is included in the glaucoma procedure. CPT codes such as 67500, 67515, and 68200 for injection of anti-sclerosing agents (e.g., 5-FU, HCPCS code J9190) should not be reported separately with other pressure-reducing or glaucoma procedures.

9. Since visual field examination (CPT codes 92081-92083) would be performed prior to scheduling a patient for a blepharoplasty (CPT codes 15820-15823) or blepharoptosis (CPT

codes 67901-67908) procedure, the visual field examination CPT codes should not be reported separately with the blepharoplasty or blepharoptosis procedure codes for the same date of service.

10. The CPT code descriptors for CPT code 67108 (repair of retinal detachment...) and 67113 (repair of complex retinal detachment...) include removal of lens if performed. CPT codes for removal of lens or cataract extraction (e.g., 66830-66984) should not be reported separately.

11. Medicare Anesthesia Rules prohibit the physician performing an operative procedure from separately reporting anesthesia for that procedure except for moderate conscious sedation for some procedures. CPT codes describing ophthalmic injections (e.g., CPT codes 67500, 67515, 68200) should not be reported separately with other ophthalmic procedure codes when the injected substance is an anesthetic agent. Since Medicare Global Surgery Rules prohibit the separate reporting of postoperative pain management by the physician performing the procedure, the same CPT codes should not be reported separately by the physician performing the procedure for postoperative pain management.

12. CMS payment policy does not allow separate payment for a blepharoptosis procedure (CPT code 67901-67908) and blepharoplasty procedure (CPT codes 15822, 15823) on the ipsilateral upper eyelid.

13. CPT codes 65420 and 65426 describe excision of pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT codes 65780-65782 should not be reported separately with either of these codes for the ipsilateral eye.

14. CPT codes 92018 and 92019 (ophthalmological examination and evaluation, under general anesthesia...) are generally not separately reportable with ophthalmological surgical procedures. The examination and evaluation of an eye while a patient is under general anesthesia for another ophthalmological procedure is integral to the procedure. However, there are unusual circumstances when an adequate ophthalmological examination cannot be completed without anesthesia (e.g., uncooperative pediatric patient, severe eye trauma). In such situations CPT codes 92018 or 92019 may be separately reportable with appropriate documentation.

15. Procedures of the cornea should not be reported with anterior chamber “separate procedures” such as CPT codes 65800-65815 and 66020. CMS payment policy does not allow separate payment for procedures including the “separate procedure” designation in their code descriptor when the “separate procedure” is performed with another procedure in an anatomically related area.

16. Repair of a surgical skin or mucous membrane incision (CPT codes 12001-13153) is generally included in the global surgical package. For procedures of the eye requiring a skin or mucous membrane incision (e.g., eyelid, orbitotomy, lacrimal system), simple, intermediate, and complex repair codes should not be reported separately.

17. Repair of an incision to perform an ophthalmic procedure is integral to completion of the procedure. It is a misuse of the repair of laceration codes (CPT codes 65270-65286) to separately report closure of a surgical incision of the conjunctiva, cornea, or sclera.

18. CPT codes 65280 and 6528*5* describe repair of laceration of the cornea and/or sclera. These codes should not be reported to describe repair of a surgical incision of the cornea and/or sclera which is integral to a surgical procedure (e.g., 65710-65756).

19. Posterior segment ophthalmic surgical procedures (CPT codes 67005-67229) include extended ophthalmoscopy (CPT codes 92225, 92226), if performed during the operative procedure or post-operatively on the same date of service. Except when performed on an emergent basis, extended ophthalmoscopy would normally not be performed pre-operatively on the same date of service.

20. Injection of an antibiotic, steroid, and/or nonsteroidal anti-inflammatory drug during a cataract extraction procedure (e.g., CPT codes 66820-66986) or other ophthalmic procedure is not separately reportable. Physicians should not report CPT codes such as 66020, 66030, 67028, 67500, 67515, or 68200 for such injections.

21. CPT codes 67515 (injection into Tenon’s capsule) and 68200 (subconjunctival injection) should not be reported with a paracentensis (e.g., CPT code 65800-65815) since the injections,

if performed, are integral components of the paracentesis procedure.

22. Removal of corneal epithelium (e.g., CPT codes 65435, 65436) should not be reported with removal of corneal foreign body (e.g., CPT codes 65220, 65222) or repair of laceration of the cornea (e.g., CPT codes 65275-65285) for the ipsilateral eye.

23. Repair of entropion (CPT codes 67923, 67924) or repair of ectropion (CPT codes 67916, 67917) should not be reported with excision and repair of eyelid (CPT codes 67961, 67966) for the same eyelid. The latter codes include excision and repair of the eyelid involving lid margin, tarsus, conjunctiva, canthus, or full thickness and may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement. A repair of entropion or repair of ectropion CPT code may be reported with an excision and repair of eyelid CPT code only if the procedures are performed on different eyelids. Modifiers E1, E2, E3, or E4 should be utilized to indicate that the procedures were performed on different eyelids.

24. CPT code 67028 (intravitreal injection of a pharmacologic agent (separate procedure)) should not be reported with CPT codes 65800-65815 (paracentesis of anterior chamber of the eye (separate procedure);...) when both procedures are performed on the same eye at the same patient encounter. Medicare policy does not allow two codes each defined as a "separate procedure" by its code descriptor to be reported together when performed in the same anatomic region at the same patient encounter.

25. CPT code 67028 describes intravitreal injection of a pharmacologic agent. CPT code 68200 (subconjunctival injection) performed on the ipsilateral side should not be reported separately with CPT code 67028.

E. Auditory System

1. If the code descriptor for a procedure of the auditory system includes a mastoidectomy (e.g., CPT codes 69530, 69910), an additional code describing a mastoidectomy (e.g., 69502-69511) is not separately reportable for the ipsilateral mastoid.

2. A myringotomy (e.g., CPT codes 69420, 69421) is included in a tympanoplasty or tympanostomy procedure and is not separately reportable.

3. If an otologic procedure requires a transcanal or endaural approach with incision of the tympanic membrane and access through the middle ear, exploration of the middle ear (CPT code 69440) and tympanic membrane procedures (e.g., CPT codes 69420, 69421, 69424, 69433, 69436, 69610, 69620) should not be reported separately.

4. A labyrinthotomy procedure includes vestibular function testing performed for monitoring during the procedure. Since diagnostic vestibular function testing would have been performed prior to the procedure on a different date of service, diagnostic vestibular function tests should not be reported separately with a labyrinthotomy procedure code on the same date of service.

F. Operating Microscope

1. The *Internet-Only Manual (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 20.4.5 (Allowable Adjustments) 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, 64885-64891 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. The NCCI bundles CPT code 69990 into all surgical procedures other than those listed in the *Medicare Claims Processing Manual*. Most edits do not allow use of NCCI-associated modifiers. (CPT code 64870 was deleted January 1, 2015.)

2. If a physician performs two procedures utilizing the operating microscope but only one of the procedures is on the CMS list of procedures for which CPT code 69990 is separately payable, payment for CPT code 69990 may be denied because of an edit bundling CPT code 69990 into the other procedure not on the CMS list. (Claims processing systems do not identify which procedure is linked to CPT code 69990.) In these cases, physicians may submit the claim to the local carrier (A/B MAC processing practitioner service claims) appending modifier 22 to the CPT code for the procedure on which the operating microscope was used and a letter of explanation. Although the carrier (A/B

MAC processing practitioner service claims) cannot override an NCCI PTP edit that does not allow use of NCCI-associated modifiers, the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

G. Laparoscopy

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a “scout” procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

4. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

5. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

6. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all laparoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with a laparoscopic procedure.

7. A diagnostic laparoscopy includes “washing”, infusion and/or removal of fluid from the body cavity. A physician should not report CPT codes 49082-49083 (abdominal paracentesis) or 49084 (peritoneal lavage) for infusion and/or removal of fluid from the body cavity performed during a diagnostic or surgical laparoscopic procedure.

8. Injection of air into the abdominal or pelvic cavity is integral to many laparoscopic procedures. Physicians should not separately report CPT code 49400 (injection of air or contrast into peritoneal cavity (separate procedure)) for this service.

H. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The MUE values for CPT code 63661 (removal of spinal neurostimulator electrode percutaneous array(s)...) and CPT code 63662 (removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy...) are one (1). Each code descriptor includes the removal of some or all electrode percutaneous arrays and some or all electrode plates/paddles for a neurostimulator pulse generator. If a patient has two separate neurostimulator pulse generators and some or all electrodes are removed for each neurostimulator pulse generator separately, the removal of the percutaneous array(s) or plate(s)/paddle(s) for the second neurostimulator pulse generator may be reported with modifier 59.

4. The MUE value for CPT code 64612 (chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg,

for blepharospasm, hemifacial spasm) is one (1). The unit of service for this code is all injections for chemodenervation into any and all muscles innervated by a facial nerve. A provider may separately report a unit of service for chemodenervation of any and all muscles innervated by the left facial nerve and a unit of service for chemodenervation of any and all muscles innervated by the right facial nerve. However, a provider should never report more than one unit of service for chemodenervation of one or more muscles innervated by a single facial nerve. If the procedure is performed bilaterally on the muscles of the left facial nerve and right facial nerve, it should be reported with modifier 50 and one (1) unit of service.

5. Bilateral ophthalmic procedures should be reported with modifier 50 and one (1) unit of service on a single claim line. Procedures performed on eyelids should be reported with modifiers E1-E4. The MUE values for many eyelid procedures are one (1) based on use of these modifiers for clinical scenarios in which the same procedure is performed on more than one eyelid.

6. CPT code 68840 describes probing of lacrimal canaliculi and includes probing of the lacrimal canaliculi of both the upper and lower eyelids of an eye. This code may only be reported with one (1) UOS for a single eye. If the procedure is performed bilaterally, it may be reported with modifier 50 and one (1) UOS on a single line of the claim.

7. The unit of service (UOS) for procedures to correct trichiasis (e.g., CPT codes 67820-67835) is the eye, not eyelid. The MUEs for these codes are one (1). If a procedure is performed bilaterally, it may be reported with modifier 50 and one (1) UOS.

8. CPT codes 64400-64530 describe injection of anesthetic agent for diagnostic or therapeutic purposes, the codes being distinguished from one another by the named nerve and whether a single or continuous infusion by catheter is utilized. All injections into the nerve including branches described (named) by the code descriptor at a single patient encounter constitute a single unit of service. For example, if a physician injects an anesthetic agent into multiple areas around the sciatic nerve at a single patient encounter, only one UOS of CPT code 64445 (injection, anesthetic agent; sciatic nerve, single) may be reported.

9. The CMS *Internet-Only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

I. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects

all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.* Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

6. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

7. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

9. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.
If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

10. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

11. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

12. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated

modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

13. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

14. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

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CHAPTER IX
RADIOLOGY SERVICES
CPT CODES 70000 - 79999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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Chapter IX
Radiology Services
CPT Codes 70000 - 79999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 70000-79999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules

are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for

which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”).

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 date 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.

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 may be reported.

In radiation oncology, evaluation and management CPT codes are not separately reportable except for an initial visit at which time a decision is made whether to proceed with the treatment. Subsequent evaluation and management services are included in the radiation treatment management CPT codes.

C. Non-interventional Diagnostic Imaging

Non-invasive/interventional diagnostic imaging includes but is not limited to 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 should be reported. Because the number of views necessary to obtain medically useful information may vary, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code describing the services performed rather than billing multiple codes to describe the service.

1. If imaging studies (e.g., radiographs, computerized tomography, magnetic resonance imaging) are repeated during the course of a radiological encounter due to substandard quality or need for additional views, only one unit of service for the appropriate code may be reported. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service should be reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptors for many of these services refer to a “minimum” number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service should be reported. However, if additional films are necessary due to a change in the patient’s condition, separate reporting may be appropriate.

2. CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specifically including the additional views. For example, if three views of the shoulder are obtained, CPT code 73030 (Radiologic examination, shoulder; complete, minimum of two views) with one unit of service should be reported rather than

CPT code 73020 (Radiologic examination, shoulder; one view) plus CPT code 73030.

3. When limited comparative radiographic studies are performed (e.g., post-reduction, post-intubation, post-catheter placement, etc.), the CPT code for the radiographic series should be reported with modifier 52 indicating that a reduced level of interpretive service was provided. This requirement does not apply to OPPS services reported by hospitals.

4. Some studies may be performed without contrast, with contrast, or both with and without contrast. There are separate codes to describe all of these combinations of contrast usage. When studies require contrast, the number of radiographs obtained varies between patients. All radiographs necessary to complete a study are included in the CPT code description.

5. Fluoroscopy is inherent in many radiological supervision and interpretation procedures. Unless specifically noted, fluoroscopy necessary to complete a radiologic procedure and obtain the necessary permanent radiographic record is included in the radiologic procedure and should not be reported separately.

6. Preliminary "scout" radiographs prior to contrast administration or delayed imaging radiographs are not separately reportable.

7. *CPT Manual* instructions state that in the presence of a clinical history suggesting urinary tract pathology complete ultrasound evaluation of the kidneys and urinary bladder constitutes a complete retroperitoneal ultrasound study (CPT code 76770). A limited retroperitoneal ultrasound (CPT code 76775) plus limited pelvic ultrasound (CPT code 76857) should not be reported in lieu of the complete retroperitoneal ultrasound (CPT code 76770).

8. CPT code 76380 (computer tomography, limited or localized follow-up study) should not be reported with other computed tomography (CT), computed tomography angiography (CTA), or computed tomography guidance codes for the same patient encounter.

9. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. Similarly

when an emergency endotracheal intubation procedure (CPT code 31500), chest tube insertion procedure (e.g., CPT codes 32550, 32551, 32554, 32555), or insertion of a central flow directed catheter procedure (e.g., Swan Ganz)(CPT code 93503) is performed, a chest radiologic examination is usually performed to confirm the location and proper positioning of the tube or catheter. The chest radiologic examination is integral to the procedures, and a chest radiologic examination (e.g., CPT codes 71010, 71020) should not be reported separately.

10. CPT code 77075 (Radiologic examination, osseous survey; complete (axial and appendicular skeleton)) includes radiologic examination of all bones. CPT codes for radiologic examination of other bones should not be reported in addition to CPT code 77075. However, if a separate and distinct radiologic examination with additional films of a specific area of the skeleton is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.

11. CPT code 77073 (bone length studies...) includes radiologic examination of the lower extremities. CPT codes for radiologic examination of lower extremity structures should not be reported in addition to CPT code 77073 for examination of the radiologic films for the bone length studies. However, if a separate and distinct radiologic examination with additional films of a specific area of a lower extremity is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.

12. CPT code 75635 describes computed tomographic angiography of the abdominal aorta and bilateral iliofemoral lower extremity runoff. This code includes the services described by CPT codes 73706 (computed tomographic angiography, lower extremity...) and 74175 (computed tomographic angiography, abdomen...). CPT codes 73706 and 74175 should not be reported with CPT code 75635 for the same patient encounter. CPT code 73706 plus CPT code 74175 should not be reported in lieu of CPT code 75635.

13. Ultrasound examination of a transplanted kidney and retroperitoneal structures at the same patient encounter may be reported with CPT code 76770 (ultrasound, retroperitoneal...; complete). It should not be reported with CPT code 76776

(ultrasound, transplanted kidney...) plus CPT code 76775 (ultrasound, retroperitoneal...; limited).

14. Computed tomography (CT) of the spine with intrathecal contrast should not be reported with myelography (e.g., CPT codes 72240-72270) unless both studies are medically reasonable and necessary. Radiography after injection of intrathecal contrast to perform a CT of the spine in order to confirm the location of the contrast is not separately reportable as myelography.

15. CPT code 77063 is an add-on code describing screening digital tomosynthesis for mammography. Since this procedure requires performance of a screening mammography producing direct digital images (HCPCS code G0202), CPT code 77063 may be reported with HCPCS code G0202. However, CPT code 77063 should not be reported with CPT code 77057 which describes screening mammography using radiography.

16. Screening and diagnostic mammography are normally not performed on the same date of service. However when the two procedures are performed on the same date of service, Medicare requires that the diagnostic mammography HCPCS/CPT code be reported with modifier GG (performance and payment of a screening and diagnostic mammogram on the same patient, same day) and the screening mammography HCPCS/CPT code be reported with modifier 59.

D. Interventional/Invasive Diagnostic Imaging

1. If a radiologic procedure requires that contrast be administered orally (e.g., upper GI series) or rectally (e.g., barium enema), the administration is integral to the radiologic procedure, and the administration service is not separately reportable. If a radiologic procedure requires that contrast material be administered parenterally (e.g., IVP, CT, MRI), the vascular access (e.g., CPT codes 36000, 36406, 36410) and contrast administration (e.g., CPT codes 96360-96376) are integral to the procedure and are not separately reportable.

2. Many services utilizing contrast are composed of a procedural component (CPT codes outside the 70000 section) and a radiologic supervision and interpretation component (CPT code in the 70000 section). If a single physician performs both components of the service, the physician may report both codes. However, if different physicians perform the different

components, each physician reports the CPT code corresponding to that component.

3. Many interventional procedures require contrast injections for localization and/or guidance. Unless there are CPT instructions directing the physician to report specific CPT codes for the localization or guidance, the localization or guidance is integral to the interventional procedure and is not separately reportable.

4. 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 (fluoroscopic or computed tomographic) 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 modifier 59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 in addition to modifier 59 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

5. The individual CPT codes in the 70000 section identify which injection or administration code, if any, is appropriate for a given procedure. In the absence of a parenthetical CPT note, the injection or administration service is integral to the procedure and is not separately reportable. If an intravenous line is inserted (e.g., CPT code 36000) for access in the event of a problem with the procedure or for administration of contrast, it is integral to the procedure and is not separately reportable. CPT code 36005 describes the injection procedure for contrast venography of an extremity and includes the introduction of a needle or an intracatheter (e.g., CPT code 36000). CPT code 36005 should not be reported for injections for arteriography or venography of sites other than an extremity.

6. For lymphangiography procedures, injection of dye into subcutaneous tissue is integral to the procedure. CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection...; subcutaneous or intramuscular) should not be reported separately for this injection of dye.

7. When urologic radiologic procedures require insertion of a urethral catheter (e.g., CPT code 51701-51703), this insertion is integral to the procedure and is not separately reportable.

8. Fluoroscopy reported as CPT codes 76000 or 76001 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and should not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately.

9. Computed tomography (CT) and computed tomographic angiography (CTA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate CT and CTA reports, only one procedure, either the CT or CTA, for the anatomic region may be reported. Both a CT and CTA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the CT and one for the CTA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

Similarly magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA, for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the MRI and one for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

10. Computed tomography of the heart (CPT codes 75571-75573) and computed tomographic angiography of the heart (CPT code 75574) include electrocardiographic monitoring if performed. CPT codes 93000-93010 (electrocardiogram...) and 93040-93042 (rhythm ECG...) should not be reported separately with CPT codes 75571-75574 for the ECG monitoring integral to these procedures.

11. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the physician should not separately report a post procedure mammography code (e.g.,

77051, 77052, 77055-77057, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.

12. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an add-on code describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

13. CPT code 50398 describes change of a nephrostomy or pyelostomy tube. If the tube change occurs in a patient without new symptoms related to the tube, CPT code 50394 (injection

procedure for pyelography through a nephrostomy or pyelostomy tube) should not be reported separately for the tube check. However, if the patient has new symptoms related to the tube, the provider may separately report CPT code 50394 with an NCCI-associated modifier for the tube check. *(CPT codes 50394 and 50398 were deleted January 1, 2016.)*

14. Diagnostic studies of the cervicocerebral arteries (CPT codes 36221-36227) include angiography of the thoracic aortic arch. Physicians should not separately report CPT codes 75600 or 75605 (thoracic aortography) for this examination unless it is medically reasonable and necessary to additionally examine the descending thoracic aorta. A physician should not report CPT codes 75600 or 75605 for the examination of the descending thoracic aorta with the runoff of the dye used to examine the thoracic aortic arch included in the diagnostic studies of the cervicocerebral arteries. Additionally, if an unexpected abnormality of the descending thoracic aorta is identified while examining the dye runoff in the descending aorta, CPT codes 75600 or 75605 should not be reported separately.

15. 3D rendering of an imaging modality (e.g., CPT codes 76376, 76377) should not be reported for mapping the sites of multiple biopsies or other needle placements under radiologic guidance. For example, a provider performing multiple prostate biopsies under ultrasound guidance (e.g., CPT code 76942) should not report CPT codes 76376 or 76377 for developing a map of the locations of the biopsies.

E. Nuclear Medicine

The general policies described above apply to nuclear medicine as well as standard diagnostic imaging.

1. The injection of a radiopharmaceutical is an integral component of a nuclear medicine procedure. CPT codes for vascular access (e.g., CPT code 36000) and injection of the radiopharmaceutical (e.g., CPT codes 96360-96376) are not separately reportable.

2. 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, a SPECT study of a limited area is not

separately reportable with a planar study of the same area. 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 size of the scanned area (e.g., bone imaging), both planar and SPECT scans may be necessary and reported separately.

3. Myocardial perfusion imaging (CPT codes 78460-78465) is not reportable with cardiac blood pool imaging by gated equilibrium (CPT codes 78472-78473) because the two types of tests utilize different radiopharmaceuticals.

4. CPT codes 76376 and 76377 (3D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78012-78999). However, CPT code 76376 or 76377 may be separately reported with modifier 59 on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported.

5. CPT codes 78451-78452 (myocardial perfusion imaging;... additional quantification...) include calculation of the heart-lung ratio if obtained. CPT code 78580 (pulmonary perfusion imaging, particulate) should not be reported for calculation of the heart-lung ratio during the processing of a SPECT myocardial perfusion procedure.

6. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82...) and A9526 (Nitrogen N-13 Ammonia...) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG,...) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

7. Positron emission tomography (PET) procedures include a finger stick blood glucose level. CPT codes 82948 (glucose; blood, reagent strip) or 82962 (glucose, blood by glucose monitoring device(s)...) should not be reported separately for the measurement of the finger stick blood glucose included in a PET procedure.

8. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic...) describes a radiopharmaceutical utilized for

nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

9. Generally diagnostic nuclear medicine procedures are performed on different dates of service than therapeutic nuclear medicine procedures. However, if a diagnostic nuclear medicine procedure is performed on an organ and the decision to proceed with a therapeutic nuclear medicine procedure on the same organ on the same date of service is based on results of the diagnostic nuclear medicine procedure, both procedures may be reported on the same date of service utilizing an NCCI-associated modifier. A physician should not report a radiopharmaceutical therapy administration code for the radionuclide administration that is integral to diagnostic nuclear imaging procedures.

10. A three phase bone and/or joint imaging study (CPT code 78315) includes initial vascular flow imaging. CPT code 78445 (non-cardiac vascular flow imaging...) should not be reported separately for the vascular flow imaging integral to CPT code 78315.

11. Non-cardiac vascular flow imaging, when performed, is integral to a nuclear medicine procedure. CPT code 78445 (non-cardiac vascular flow imaging...) should not be reported with any other nuclear medicine procedure code.

12. Supervision and handling of radionuclides is integral to nuclear medicine procedures (e.g., CPT codes 78012-79999.) Physicians should not separately report CPT code 77790 (supervision, handling, and loading of radiation source) for this service.

F. Radiation Oncology

1. Except for an initial visit evaluation and management (E&M) service at which the decision to perform radiation therapy is made, E&M services are not separately reportable with radiation oncology services with one exception as noted below. Effective January 1, 2010, CMS eliminated payment for consultation E&M CPT codes 99241-99255. The initial E&M visit for radiation oncology services may be reported with office/outpatient E&M CPT codes 99201-99215, initial hospital care E&M CPT codes 99221-99223, subsequent hospital care E&M CPT codes 99231-99233, or observation/inpatient hospital care with same day admission and discharge E&M CPT codes 99234-99236.

The only radiation oncology services that may be reported with E&M services in addition to an initial visit E&M service are CPT codes *77770-77772*(remote afterloading high dose rate radionuclide brachytherapy...). *(CPT codes 77785-77787 were deleted January 1, 2016.)* E&M services reported with these brachytherapy codes must be significant, separate and distinct from radiation treatment management services.

2. 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 are reported on the same date of service.

3. The *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 13, Section 70.2 (Services Bundled Into Treatment Management Codes) defines services that may not be reported separately with radiation oncology procedures. Based on these requirements, the NCCI contains edits bundling the following CPT codes into all radiation therapy services:

11920-11921 (Tattooing)
16000-16030 (Treatment of burns)
36000, 36410, 36425 (Venipuncture or Introduction of catheter)
51701-51703 (Urinary bladder catheterization)
96360-96368 (Intravenous infusion)
90832-90838 (Psychotherapy)
90839-90840 (Psychotherapy)
90846 (Psychotherapy)
90847 (Psychotherapy)
90863, M0064(Pharmacologic management)
(HCPCS code M0064 was deleted January 1, 2015.)
97802-97804 (Medical nutrition therapy)
99143-99144 (Anesthesia – Moderate conscious sedation)
99185 (Regional hypothermia)(CPT code 99185 was deleted January 1, 2010.)
99201-99215 (Evaluation & Management)
99217-99239 (Evaluation & Management)
99281-994*98* (Evaluation & Management)

4. Brachytherapy (CPT codes 77750-77790) includes radiation treatment management (CPT codes 77427 and 77431) and continuing medical physics consultation (CPT code 77336). CPT codes 77427, 77431, and 77336 should not in general be reported separately with brachytherapy services. However, if a patient receives external beam radiation treatment and brachytherapy treatment during the same time period, radiation treatment management and continuing medical physics consultation may be reported for the external beam radiation treatments. Additionally, if a patient has multi-step brachytherapy, it may be appropriate to separately report continuing medical physics consultation with the brachytherapy.

5. The procedure described by CPT code 37204 (transcatheter occlusion or embolization (eg, for tumor destruction)...) includes infusion of the occlusion/embolization agent. It is not appropriate to separately report CPT code 77750 (infusion or instillation of radioelement solution...) if the embolization agent is a radioelement solution. Similarly it is not appropriate to separately report CPT code 77778 (interstitial radiation source application*, complex,*...) in addition to CPT code 37204 for infusion of the radioelement solution. (CPT code 37204 was deleted January 1, 2014.) *(CPT codes 77776 and 77777 were deleted January 1, 2016.)*

6. The procedure described by CPT code 77778 (interstitial radiation source application*, complex,*...) require*s* that a radiation source be applied interstitially. Reporting a CPT code requires that all essential components of the procedure are performed. These codes should not be reported by a radiation oncologist for intraoperative work with another physician who surgically places catheters interstitially unless the radiation oncologist also applies the radiation source at the same patient encounter. The intraoperative work of the radiation oncologist may be reportable with a non-brachytherapy code. If the radiation source application occurs postoperatively in a different room, the radiation oncologist may report CPT codes *77770-77772*(remote afterloading high dose rate radionuclide brachytherapy...) for the radiation source application. *(CPT codes 77776,77777, and 77785-77787 were deleted January 1, 2016.)*

7. Stereotactic radiosurgery (SRS) treatment delivery (CPT codes 77371-77373) includes stereotactic guidance for placement of the radiation therapy fields for treatment delivery. CPT codes 77014 (computed tomography guidance for placement of radiation therapy fields) and 76950 (ultrasonic guidance for placement of radiation therapy fields) should not be reported additionally for guidance for placement of the radiation therapy field for SRS treatment delivery.

8. Since CPT code 0197T (intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy...) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields), 77014 (computed tomography guidance for placement of radiation therapy fields), or 77421 (stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy). (CPT codes 0197T and 77421 were deleted January 1, 2015.)

9. Since CPT code 77387 (guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking when performed) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields) or 77014 (computed tomography guidance for placement of radiation therapy fields).

10. Partial breast high dose rate brachytherapy may be performed two times a day. The first therapeutic radiology simulation for the course of therapy may be complex and reported as CPT code 77290. However, subsequent simulations during the course of therapy should be reported as CPT code 77280.

11. Intensity modulated treatment (IMRT) delivery (e.g., CPT codes 77418,77385, 77386) is not normally reported with treatment device design and construction CPT codes 77332-77334. The latter codes are generally reported for treatment device(s) design and construction for external beam radiation therapy. IMRT planning (CPT code 77301) includes many treatment device(s) required for IMRT. Multi-leaf collimator (MLC) device(s) (CPT code 77338) may be reported separately once per IMRT plan. However, patients receiving IMRT occasionally require an additional treatment device at a later date due to decreased tumor volume or patient weight. This device may be reported with CPT codes 77332-77334. (CPT code 77418 was deleted January 1, 2015.)

12. CPT code 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) should not be reported with CPT code 77385 (Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple) if the IMRT is compensator based. However, if the IMRT is not compensator based, CPT code 77338 may be reported separately.

13. Calculations described by CPT code 77300, if performed, are integral to some clinical brachytherapy procedures (e.g., CPT codes 77767-77772, 77778). CPT code 77300 should not be reported with these clinical brachytherapy procedure codes.

14. Calculations described by CPT code 77300 are integral to the procedure described by CPT code 77295 (three-dimensional radiotherapy plan, including dose volume histograms). CPT code 77300 should not be reported with CPT code 77295.

15. Intensity modulated radiotherapy (IMRT) plan (CPT code 77301) includes therapeutic radiology simulation-aided field settings. Simulation field settings for IMRT should not be reported separately with CPT codes 77280-77295. Although procedure to procedure edits based on this principle exist in NCCI for procedures performed on the same date of service, these edits should not be circumvented by performing the two procedures described by a code pair edit on different dates of service.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

4. The MUE values for J0152 (injection, adenosine for diagnostic use, 30 mg...) and J1245 (injection, dipyridamole, per 10 mg) were set for single pharmacologic stress tests. For the unusual patient who requires two different types of pharmacologic stress tests (e.g., myocardial perfusion and echocardiography) on the same date of service, the amount of drug utilized for each stress test should be reported on separate lines of a claim with modifier 59 appended to the code on one of the claim lines. (HCPCS code J0152 was deleted January 1, 2014.)

5. The code descriptor for CPT code 77417 states “Therapeutic radiology port *image*(s)”. The MUE value for this code is one (1) since it includes all port films.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of

this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with

the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

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

6. Based on CPT coding instructions xeroradiography (e.g., CPT code 76150) is not separately reportable with mammography studies. (CPT code 76150 was deleted January 1, 2011.)

7. Guidance for placement of radiation fields by computerized tomography or by ultrasound (CPT codes 77014 or 76950) for the same anatomical area is mutually exclusive of one another.

8. Ultrasound guidance and diagnostic ultrasound (echography) procedures may be reported separately only if each service is distinct and separate. If a diagnostic ultrasound study identifies a previously unknown abnormality that requires a therapeutic procedure with ultrasound guidance at the same patient encounter, both the diagnostic ultrasound and ultrasound guidance procedure codes may be reported separately. However, a previously unknown abnormality identified during ultrasound guidance for a procedure should not be reported separately as a diagnostic ultrasound procedure.

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

10. CPT code 77790 (supervision, handling, loading of radiation source) is not separately reportable with any of the remote afterloading brachytherapy codes (e.g., CPT codes *77770-77772*) since these procedures include the supervision, handling, and loading of the radioelement. *(CPT codes 77785-77787 were deleted January 1, 2016.)*

11. Bone studies such as CPT codes 77072-77076 require a series of radiographs. Separate reporting of a bone study and individual radiographs obtained in the course of the bone study is inappropriate.

12. Radiological supervision and interpretation codes include all radiological services necessary to complete the service. CPT codes for fluoroscopy/fluoroscopic guidance (e.g., 76000, 76001, 77002, 77003) or ultrasound/ultrasound guidance (e.g., 76942, 76998) should not be reported separately.

Radiological guidance procedures include all radiological services necessary to complete the procedure. CPT codes for fluoroscopy (e.g., 76000, 76001) should not be reported separately with a fluoroscopic guidance procedure. CPT codes for ultrasound (e.g., 76998) should not be reported separately with an ultrasound guidance procedure. A limited or localized follow-up computed tomography study (CPT code 76380) should not be reported separately with a computed tomography guidance procedure.

13. Abdominal ultrasound examinations (CPT codes 76700-76775) and abdominal duplex examinations (CPT codes 93975, 93976) are generally performed for different clinical scenarios although there are some instances where both types of procedures are medically reasonable and necessary. In the latter case, the abdominal ultrasound procedure CPT code should be reported with an NCCI-associated modifier.

14. Tumor imaging by positron emission tomography (PET) may be reported with CPT codes 78811-78816. If a concurrent computed tomography (CT) scan is performed for attenuation correction and anatomical localization, CPT codes 78814-78816 should be reported rather than CPT codes 78811-78813. A CT scan for localization should not be reported separately with CPT codes 78811-78816. However, a medically reasonable and necessary diagnostic CT scan may be separately reportable with an NCCI-associated modifier.

15. Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 77081, 76977, or G0130. Although it may be medically reasonable and necessary to report both axial and peripheral bone density studies on the same date of service, NCCI PTP edits prevent the reporting of multiple CPT codes for the axial bone density study or multiple CPT codes for the peripheral site bone density study on the same date of service.

16. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples, reporting sample collection separately is inappropriate. CPT codes 36500 (venous catheterization for selective organ blood

sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling with or without venography. CPT code 75893 includes concomitant venography. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure.

17. Radiologic studies with contrast (e.g., CT, CTA, MRI, MRA, angiography) utilize subtraction techniques as a standard of practice. CPT code 76350 (subtraction in conjunction with contrast studies) should not be reported with procedures that typically utilize contrast. (CPT code 76350 was deleted January 1, 2011.)

18. CPT codes 70540-70543 are utilized to report magnetic resonance imaging of the orbit, face, and/or neck. Only one code may be reported for an imaging session regardless of whether one, two, or three areas are evaluated in the imaging session.

19. An MRI study of the brain (CPT codes 70551-70553) and MRI study of the orbit (CPT codes 70540-70543) are separately reportable only if they are both medically reasonable and necessary and are performed as distinct studies. An MRI of the orbit is not separately reportable with an MRI of the brain if an incidental abnormality of the orbit is identified during an MRI of the brain since only one MRI study is performed.

20. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

21. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

22. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

23. Physicians should not report radiologic supervision and interpretation codes, radiologic guidance codes, or other radiology codes where the radiologic procedure is integral to another procedure being performed at the same patient encounter. Procedure to procedure edits that bundle these radiologic codes into the relevant procedure codes have modifier indicators of "1" allowing use of NCCI-associated modifiers to bypass them. An NCCI-associated modifier may be used to bypass such an edit if and only if the radiologic procedure is performed for a purpose unrelated to the procedure to which it is integral. For example, fluoroscopy is integral to a cardiac catheterization procedure and should not be reported separately with a cardiac catheterization. However, if on the same date of service the physician performs another procedure in addition to the cardiac catheterization, the additional procedure requires fluoroscopy, and fluoroscopy is not integral to the additional procedure, the fluoroscopy procedure may be reported separately with an NCCI-associated modifier.

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CHAPTER X
PATHOLOGY / LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 80000-89999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

Pathology and laboratory CPT codes describe services to evaluate specimens (e.g., blood, body fluid, tissue) obtained from patients in order to provide information to the treating physician.

Generally, pathology and laboratory specimens are prepared, screened, and/or tested 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 or interpreted 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. If a pathologist provides significant, separately identifiable face-to-face patient care services that satisfy the criteria set forth in the E&M guidelines developed by CMS and the AMA, a pathologist may report the appropriate code 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 verify 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 verification 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 (1) unit of service rather than two (2).

By contrast some laboratory tests if positive require additional separate follow-up testing which is implicit in the physician's order. For example, if an RBC antibody screen (CPT code 86850) is positive, the laboratory routinely proceeds to identify the RBC antibody. The latter testing is separately reportable. Similarly, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable. In these cases, the initial positive results have limited clinical value without the additional testing. The additional testing is separately reportable because it is not performed to complete the ordered test. Furthermore, the ordered test if positive requires the additional testing in order to have clinical value. This type of testing is a category of reflex testing that must be distinguished from other reflex testing performed on a positive test result which may have clinical value without additional testing. An example of a latter type of test is a serum protein electrophoresis with a monoclonal protein band. A laboratory should not routinely perform serum immunofixation or serum immunoelectrophoresis to identify the type of monoclonal protein unless ordered by the treating physician. If the patient has a known monoclonal gammopathy, perhaps identified at another laboratory, the serum immunofixation or immunoelectrophoresis would not be appropriate unless ordered by the treating physician.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 date 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.

C. Organ or Disease Oriented Panels

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of groups 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 may be reported as a lipid panel (CPT code 80061).

NCCI contains edits pairing each panel CPT code (column one code) with each CPT code corresponding to the individual laboratory tests that are included in the panel (column two code). These edits allow use of NCCI-associated modifiers to bypass them if one or more of the individual laboratory tests are repeated on the same date of service. The repeat testing must be medically reasonable and necessary. Modifier 91 may be utilized to report this repeat testing. Based on the *Internet-only Manuals(IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 16, Section 100.5.1, the repeat testing cannot be performed to "confirm initial results; due to testing problems with specimens and equipment or for any other reason when a normal, one-time, reportable result is all that is required."

D. Evocative/Suppression Testing

Evocative/suppression testing requires the administration of pharmaceutical agents to determine a patient's response to those agents. CPT codes 80400-80440 describe the laboratory components of the testing. Administration of the pharmaceutical agent may be reported with CPT codes 96365-96376. In the facility setting, these codes may be reported by the facility, but not the physician. In the non-facility setting, these codes may be reported by the physician. While supplies necessary to perform the testing are included in the testing CPT codes, the appropriate HCPCS Level II J code for the pharmacologic agent may be reported separately. Separate evaluation and management services including prolonged services (e.g., prolonged infusion) should not be reported separately unless a significant, separately identifiable service medically reasonable and necessary E&M is provided and documented. (CPT code 80440 was deleted January 1, 2015.)

E. Drug Testing

Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed. The *Internet-only Manual*, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 10 (Background) indicates that a laboratory test is a covered benefit only if the test result is utilized for management of the beneficiary's specific medical problem. Testing to confirm that a urine specimen is unadulterated is an internal control process that is not separately reportable.

F. Molecular Pathology

1. Physician (M.D. or D.O.) interpretation of a molecular pathology procedure (e.g., CPT codes 81161 and 81200-81408) may be reported with HCPCS code G0452 when medically reasonable and necessary. It should not be reported with CPT code 88291 (cytogenetics and molecular cytogenetics, interpretation and report). (See Section L (Medically Unlikely Edits (MUEs)), Paragraph 4 for reporting requirements related to HCPCS code G0452.)

2. Molecular pathology procedures (e.g., CPT codes 81161 and 81200-81408) include all aspects of sample preparation, cell lysis, internal measures to assure adequate quantity of DNA or RNA, and performance of the assay. *These procedures include DNA analysis and RNA analysis if performed.*

3. Quantitation of extracted DNA *and/or RNA* is included in the payment for a molecular pathology procedure (e.g., CPT codes 81161 and 81200-81408). Other HCPCS/CPT codes such as CPT code 84311 (spectrophotometry...) should not be reported for this quantitation.

4. Scraping tumor off an unstained slide, if performed, is included in the payment for a molecular pathology procedure (e.g., CPT codes 81161 and 81200-81408). A physician should not report microdissection (CPT codes 88380 or 88381) for this process. The microdissection CPT codes require a pathologist to use laser capture microdissection (CPT code 88380) or a

dissecting microscope (CPT code 88381) to separate malignant cells from normal cells.

G. Chemistry

1. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) describes direct measurement of 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 (greater than or equal to 400 mg/dl) to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier 59.

2. CPT code 83912 describes a medically reasonable and necessary “interpretation and report” associated with molecular diagnostic testing described with CPT codes 83890-83909. CPT code 83912 should not be reported as an “interpretation and report” with CPT codes 87470-87801, 87901-87904 or 88271-88275. (CPT codes 83890-83909 and 83912 were deleted January 1, 2013.)

3. Free thyroxine (CPT code 84439) is generally considered to be a better measure of the hypothyroid or hyperthyroid state than total thyroxine (CPT code 84436). If free thyroxine is measured, it is not considered appropriate to measure total thyroxine with or without thyroid hormone binding ratio (CPT code 84479). NCCI does not permit payment of CPT codes 84436 or 84479 with CPT code 84439.

4. HCPCS code G0434 (drug screen..., by CLIA waived test or moderate complexity test, per patient encounter) is utilized to report urine drug screening performed by a test that is CLIA waived or CLIA moderate complex. The code is reported with only one (1) unit of service regardless of the number of drugs screened. HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened. If a provider performs urine drug screening, it is generally not necessary for that provider to send an additional specimen from the patient to another laboratory for urine drug screening for the same drugs.

5. CPT code 83704 (lipoprotein, blood; quantitation of lipoprotein particle numbers...(eg, by nuclear magnetic resonance

spectroscopy)) (NMR lipoprotein panel) is generally not reported on the same date of service as CPT codes 80061 (lipid panel...), 82465 (cholesterol,...total), 84478 (triglycerides), and 83718 (lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)). Typically a lipid panel is performed, and if necessary, the physician may order an NMR lipoprotein panel as a follow-up study to further characterize the abnormality. However, uncommonly a patient might have a previously diagnosed lipid panel abnormality and separate NMR lipoprotein panel abnormality that require retesting after a therapeutic intervention.

H. Hematology and Coagulation

1. If a treating physician orders an automated complete blood count with automated differential WBC count (CPT code 85025) or without automated differential WBC count (CPT code 85027), the laboratory sometimes examines a blood smear in order to complete the ordered test based on laboratory selected criteria flagging the results for additional verification. The laboratory should NOT report CPT code 85007 (microscopic blood smear examination with manual WBC differential count) or CPT code 85008 (microscopic blood smear examination without manual WBC differential count) for the examination of a blood smear to complete the ordered automated hemogram test (CPT codes 85025 or 85027). The same principle applies if the treating physician orders any type of blood count and the laboratory's practice is to perform an automated complete blood count with or without automated differential WBC count.

2. If a treating physician orders an automated hemogram (CPT code 85027) and a manual differential WBC count (CPT code 85007), both codes may be reported. However, a provider may not report an automated hemogram with automated differential WBC count (CPT code 85025) with a manual differential WBC count (CPT code 85007) because this combination of codes results in duplicate payment for the differential WBC count. CMS does not pay twice for the same laboratory test result even if performed by two different methods unless the two methods are medically reasonable and necessary.

3. Multiple CPT codes describe bone and bone marrow biopsy and/or aspiration and interpretation of the specimens. If a bone biopsy is performed for evaluation of bone matrix structure, the appropriate CPT codes to report are CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology interpretation.

If a bone marrow aspiration is performed without biopsy, the procedure may be reported as CPT code 38220. Interpretation of the aspirate smear may be reported as CPT code 85097. Both codes may be reported by the same physician if both the procedure and interpretation are performed by that physician. If a cell block is prepared from the bone marrow aspirate, interpretation of the cell block should be reported as CPT code 88305.

Bone marrow biopsy may be reported with CPT code 38221. If bone marrow aspiration is also performed through the same skin incision, it should be reported with HCPCS code G0364. However, it should not be reported with CPT code 38220. Interpretation of the bone marrow biopsy may be reported with CPT code 88305.

The bone marrow aspiration procedure (CPT code 38220) should not be reported separately with the bone marrow biopsy procedure (CPT code 38221) unless the two procedures are performed through medically reasonable and necessary separate skin incisions or at separate patient encounters on the same date of service.

When it is medically necessary to evaluate both bone structure and bone marrow and both can be evaluated from a single biopsy, only one code (CPT code 38221 or 20220) should be reported for the surgical procedure. If two separate biopsies are medically necessary, both may be reported appending modifier 59 to one of the codes. If only one specimen is submitted for surgical pathology, only one surgical pathology code (CPT codes 88305 or 88307 as appropriate) may be reported even if the report includes evaluation of both bone structure and bone marrow morphology.

I. Transfusion Medicine

Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT code 86945 (irradiation of blood product, each unit) should not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) should not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (frozen blood, each unit; freezing...), 86931 (frozen blood, each unit; thawing), and/or 86932 (frozen blood, each unit; freezing (includes preparation) and thawing) should not be reported separately since the P code includes the freezing and thawing processes. If a P code describes a pooled blood product, CPT code 86965 (pooling of

platelets or other blood products) should not be reported separately since the P code includes the pooling of the blood products. If the P code describes a “frozen” plasma product, CPT code 86927 (fresh frozen plasma, thawing, each unit) should not be reported separately since the P code includes the thawing process.

J. Microbiology

1. CPT codes 87040-87158 describe microbiological 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.

2. Infectious agent molecular diagnostic testing utilizing nucleic acid probes is reported with CPT codes 87470-87801, 87901-87904. These CPT codes include all the molecular diagnostic processes, and CPT codes 83890-83913 should not be additionally reported with these CPT codes. If the provider performs infectious agent molecular diagnostic testing utilizing nucleic acid probes (87470-87801, 87901-87904) on the same date of service as non-infectious agent molecular diagnostic testing or infectious agent molecular diagnostic testing utilizing methodology that does not incorporate nucleic acid probes, the molecular diagnostic testing CPT codes 83890-83913 may be reported separately with an NCCI-associated modifier. (CPT codes 83890-83913 were deleted January 1, 2013.)

3. CPT codes 87631-87633 describe infectious agent detection by nucleic acid for respiratory viruses for multiple types or subtypes of viral targets at one time. The codes differ based on the number of viral targets tested. CPT codes 87501-87503 describe infectious agent detection by nucleic acid for influenza viruses. If multiplex testing is performed for multiple respiratory viral targets including influenza viral targets, this testing would be reported with CPT codes 87631-87633. CPT codes 87501-87503 should not be reported separately for the influenza viral target testing.

If multiplex testing is initially performed for multiple respiratory viral targets including one or more influenza viral targets and based on those results it is medically reasonable and

necessary that additional testing for different influenza types or subtypes is performed, CPT codes 87501-87503 may be reported for the additional influenza virus testing.

4. The test described by CPT code 87624 (Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)) generally includes detection of HPV types 16, 18, and 45 as well as other high risk types. CPT code 87625 (Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed) describes detection of the subset of HPV types 16, 18 and 45. It would be incorrect to report CPT code 87625 as a component of screening for a larger number of HPV types (CPT code 87624) as CPT code 87624 specifies any combination of high risk types, and therefore should not be broken down and billed separately for subgroups when the HPV types are tested at the same time. However, there are some clinical scenarios defined by nationally accepted guidelines where identifying a particular subset of types (CPT code 87625) may be medically reasonable and necessary on a patient with a positive test result for the test described by CPT code 87624. In those instances in which two separate sequential services are medically necessary, such as when a national guideline supports the use of specific type identification after a positive result on a broad assay, CPT code 87625 may be reported separately and billed with an appropriate modifier.

K. Anatomic Pathology (Cytopathology and Surgical Pathology)

1. Cytopathology codes describe varying methods of preparation and examination of different types of specimens. For a single specimen, only one code from a group of related codes describing a group of services that could be performed on the specimen with the same end result (e.g., 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) should be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier 59 should be utilized to indicate that different levels of service were provided for different specimens from different anatomic sites. This information should be documented in the cytopathology reports. A cytopathology preparation from a fluid, washing, or brushing should be reported using one code from the CPT code range 88104-88112. It is inappropriate to additionally report CPT codes 88160-88162 because the smears are included in the codes

referable to fluids (or washings or brushings) and CPT codes 88160-88162 reference “any other source” which would exclude fluids, washings, or brushings.

2. CPT codes 88321-88325 describe surgical pathology consultation services to review slides, tissues, or other material obtained, prepared, and interpreted at a different location by a different pathologist and referred to another pathologist for a second opinion. These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or other 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., ECGs, radiographs, etc.). CPT codes 88321-88325 are reported with one unit of service regardless of the number of specimens, paraffin blocks, stained slides, etc.

When reporting CPT codes 88321-88325, physicians should not report other pathology CPT codes such as 88312, 88313, 88187, 88188, 88189, 88342, 88341, 88344, etc., for interpretation of stains, slides or other material previously interpreted by another pathologist. CPT codes 88312, 88313, 88342, 88341, and 88344 may be reported with CPT codes 88321-88325 only if the physician performs these staining procedure(s) and interprets these newly stained slide(s). CPT code 88323 may be reported for consultation and report on referred material if the physician performs additional necessary de novo routine staining (e.g., hematoxylin-eosin, giemsa) on additional slides.
CPT codes 88321-88325 should not be reported with a face-to-face evaluation of a patient. If a physician provides an evaluation and management (E&M) service to a patient, and, in the course of the E&M service, specimens obtained elsewhere are reviewed as well, this review is part of the E&M service and is not reported separately. Only the E&M service should be reported.

3. Medicare does not pay for duplicate testing. Immunocytochemistry (e.g., CPT codes 88342, 88341, 88344, 88360, 88361) and flow cytometry (e.g., CPT codes 88184-88189) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The physician may report both CPT codes if both methods are required because the initial method does not explain all the light microscopic findings. The physician may 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 (CPT codes 88184, 88187, 88188, 88189, 88342, 88341, and 88344) establishes the diagnosis, the same or 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.

4. Quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging) should not be reported as CPT codes 88342, 88341 and 88344 with CPT code 88358. Prior to January 1, 2004, it should have been 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 CPT codes 88342, 88341, and 88344.

5. 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 have been 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 have been 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.

6. Prior to January 1, 2005, qualitative, semi-quantitative, and quantitative (tissue) *in situ* hybridization should have been reported as CPT code 88365 when performed by a physician (limited to M.D./D.O.). After January 1, 2005, quantitative or semi-quantitative in situ hybridization (tissue or cellular) performed by computer-assisted technology should be

reported as CPT code 88367, 88373, or 88374 when performed by a physician (limited to M.D./D.O.). After January 1, 2005, quantitative or semi-quantitative in situ hybridization (tissue or cellular) performed by manual methods should be reported as CPT code 88368, 88369, or 88377 when performed by a physician (limited to M.D./D.O.). Do not report more than one in situ hybridization CPT code (88364-88369, 88373, 88374, 88377) for the same probe tested on a specimen. In situ hybridization reported with qualitative grading such as 1^{+} to 4^{+} should be reported as CPT code 88365, 88364, or 88366.

7. When *in situ* hybridization is performed on tissue or cellular specimens by a non-physician (provider other than M.D./D.O.), it should be reported using appropriate CPT codes in the range 88271-88275. For each reportable probe, a provider should not report CPT codes both from the code group 88364-88369, 88373, 88374, 88377 and the range 88271-88275. *In situ* hybridization reported as CPT codes *8*8364-88369, 88373, 88374, 88377 includes both physician (limited to M.D./D.O.) and non-physician (non-M.D./D.O.) services to obtain a reportable probe result. The physician (limited to M.D./D.O.) work component of 88364-88369, 88373, 88374, 88377 requires that a physician (limited to M.D./D.O.) rather than laboratory scientist or technician read, quantitate (88367-88369, 88373, 88374, 88377), and interpret the tissues/cells stained with the probe(s). If this work is performed by a laboratory scientist or technician, CPT codes 88271-88275 should be reported.
When a physician (limited to M.D./D.O.) reads/quantitates (CPT codes 88367-88369, 88373, 88374,88377) and interprets (CPT codes 88364-88369, 88373, 88374, 88377) the tissues/cells stained with the probe(s), the provider may report the global code or professional component (modifier 26) as appropriate. When the professional component of CPT codes 88364-88369, 88373, 88374, 88377 is reported by the physician (limited to M.D./D.O.), the laboratory may report the technical component (modifier TC), and a hospital reporting an outpatient laboratory test may report the appropriate CPT code. If a non-physician (provider other than M.D./D.O.) reads and quantitates the tissues/cells stained with the probe(s), the laboratory should not report the technical component (-TC) of CPT codes 88367-88369, 88373, 88374, and 88377, and a hospital reporting an outpatient laboratory test should not report CPT codes 88367-88369, 88373, 88374, 88377. The laboratory or hospital may report these services with CPT codes 88271-88275.

8. 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 (e.g., 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. (CPT codes 86064, 86379, and 86587 were deleted January 1, 2006.)

9. CPT codes 88384-88386 describe array-based evaluations of multiple molecular probes. Although CPT code 88384 is Carrier (A/B MAC processing practitioner service claims) priced, CPT codes 88385 and 88386 are payable from the Medicare Physician Fee Schedule and include significant physician work. If array-based evaluation of multiple molecular probes is performed by a laboratory scientist or technician rather than a physician, it should not be reported with global CPT code 88385 or 88386 since these codes include physician work. Rather, it should be reported as 88385-TC or 88386-TC which includes the non-physician work including interpretation. (CPT codes 88384-88386 were deleted January 1, 2013.)

10. Gross examination of a specimen is an integral component of pathology consultation during surgery (CPT codes 88329-88334) and surgical pathology gross and microscopic examination (CPT codes 88302-88309). CPT code 88300 (Level I – surgical pathology, gross examination only) should not be reported with any of the previously listed CPT codes for examination of the same specimen.

11. *In accordance with code descriptor changes for HCPCS codes G0416-G0419 effective January 1, 2015, CMS requires that surgical pathology, including gross and microscopic examination, of any and all submitted prostate needle biopsy specimens from a single patient be reported with one unit of service of HCPCS code G0416 rather than CPT code 88305.*

Instructions for HCPCS codes G0416-G0419 in this Manual have

undergone changes from year to year. For historical purposes, the prior instructions are reproduced.

From the calendar year 2015 Manual:

"13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens."

From the calendar year 2014 Manual:

"13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens."

From the calendar year 2013 Manual:

"13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service

corresponding to the number of separately identified and submitted biopsy specimens."

L. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. CMS payment policy allows only one unit of service for CPT codes 88321, 88323, and 88325 per beneficiary per provider on a single date of service. Providers should not report these codes on separate lines of a claim utilizing CPT modifiers to bypass the MUEs for these codes.

4. The code descriptors for CPT codes 83912 (molecular diagnostics; interpretation and report) and 88291 (cytogenetics and molecular cytogenetics, interpretation and report) do not define the units of service for these codes. The MUE value for each of these codes is "1". CMS interprets these codes to include the synthesis with interpretation and report of all molecular diagnostic testing or cytogenetic/molecular cytogenetic testing respectively performed on a single date of service. These codes should not be reported with separate units of service based on the number of specimens or tests on a single date of service. (CPT code 83912 was deleted January 1, 2013.)

On January 1, 2013 HCPCS code G0452 (molecular pathology procedure; physician interpretation and report) was implemented to report medically reasonable and necessary interpretations of molecular pathology procedures by physicians (M.D. or D.O.). This code may be reported if: (1) the interpretation is requested

by the attending physician; (2) the interpretation results in a written narrative report; and (3) the interpretation requires the exercise of medical judgment. This code may not be reported for an interpretation by a laboratory scientist. This code may be reported with a maximum of one (1) unit of service (UOS) for a Tier 1 molecular pathology procedure CPT code for each distinct source of a specimen. For example, if separate interpretations and reports for the same CPT coded Tier 1 molecular pathology procedure are reported for testing on a bone marrow specimen and a lymph node specimen, two UOS may be reported for the G0452. Since each Tier 2 molecular pathology procedure CPT code includes a list of numerous specific molecular pathology procedures, one UOS may be reported for each physician interpretation for each separately listed molecular pathology procedure for each distinct source of a specimen. A physician should not report more than one UOS for any Tier 1 molecular pathology CPT code for testing on a specimen from a single source. For Tier 2 molecular pathology CPT codes, a physician should not report more than one UOS for each listed molecular pathology procedure on a specimen from a single source.

5. The MUE values for CPT codes 86021 (antibody identification; leukocyte antibodies) and 86022 (antibody identification; platelet antibodies) are “1”. The code descriptors are plural, and CMS priced each of these codes to include all antibodies to leukocytes and platelets respectively in a single unit of service.

6. The unit of service (UOS) for CPT codes 88172 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site) and 88177 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site...) is the evaluation episode. An evaluation episode consists of examination of a set of cytologic material to determine whether the material is adequate for diagnosis. The evaluation episode ends when a pathologist renders an assessment advising the operating physician whether the submitted material is adequate. The operating physician utilizes the cytologic diagnosis to determine whether additional cytologic material should be obtained for examination. The evaluation episode is independent of the number of passes of the needle into a lesion and the number of slides examined. A second or additional evaluation episode (i.e., CPT code 88177) cannot begin before an assessment is rendered by the

pathologist to the operating physician, and the operating physician uses the assessment to determine whether additional needle passes should be performed. If the operating physician performs multiple needle passes into a lesion while the pathologist is examining the material from each pass as rapidly as possible, only one evaluation episode may be reported since the operating physician does not wait for the pathologic result to determine whether additional passes are necessary. CPT code 88172 may be reported with one UOS for each separate lesion evaluated.

7. The unit of service for gross and microscopic surgical pathology (CPT codes 88300-88309), pathology consultation during surgery (CPT codes 88329, 88331, 88333), electron microscopy (CPT codes 88348, 88349) and morphometric analysis (CPT codes 88355-88358) is the specimen. A specimen is defined as tissue(s) that are submitted for individual and separate attention, examination, and diagnosis. Separate specimens are usually submitted in separate containers. It must be medically reasonable and necessary to submit the specimens for individual attention, examination, and diagnosis. For example, if colonoscopy identifies two separate polyps at 15 cm and 25 cm, it may be medically reasonable and necessary to submit them as separate specimens. If one of the polyps is malignant, it may be important to know for future therapy which one was malignant. Multiple biopsies of the same polyp are usually submitted as a single specimen. (CPT code 88349 was deleted January 1, 2015.)

8. The unit of service for special stains (CPT codes 88312-88313) is each stain. If it is medically reasonable and necessary to perform the same stain on more than one specimen or more than one block of tissue from the same specimen, additional units of service may be reported for the additional specimen(s) or block(s). Physicians should not report more than one unit of service for a stain performed on a single tissue block. For example it is common practice to cut multiple levels from a tissue block and stain each level with the same stain. The multiple levels from the same block of tissue stained with the same stain should not be reported as additional units of service. Only one unit of service may be reported for the stain on multiple levels from the single tissue block. Additionally, controls performed with special stains should not be reported as separate units of service for the stain.

For cytology specimens from a single anatomic site only one unit of service may be reported for each special stain regardless of

the number of slides from that site stained with the special stain.

For hematology smears only one unit of service may be reported for each special stain regardless of the number of smears from an anatomic site stained with the special stain. For example if multiple smears of peripheral blood are stained with an iron stain, only one unit of service may be reported. Similarly, if three smears from a bone marrow aspirate are stained with an acid fast stain, only one unit of service may be reported. Smears from peripheral blood, one iliac crest, and contralateral iliac crest are from three separate anatomic sites.

The unit of service for immunohistochemistry/immunocytochemistry (CPT codes 88342, 88341, and 88344) is each single or multiplex antibody stain procedure per specimen. If a single immunohistochemical/immunocytochemistry stain procedure for one or more antibodies is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen.

For immunohistochemistry reported as CPT codes 88360 or 88361 the unit of service is each single or multiplex antibody(s) stain procedure per specimen. If a single or multiplex antibody immunohistochemical stain procedure reported as CPT codes 88360 or 88361 is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service for CPT codes 88360 or 88361 per specimen for an immunohistochemical multiplex antibody stain procedure even if it contains multiple separately interpretable antibodies.

An immunohistochemistry stain procedure with multiple antibodies that are not separately interpretable (e.g., antibody cocktail) may only be reported as one (1) unit of service per specimen.

9. Morphometric analysis of tumor immunohistochemistry utilizing a multiplex antibody stain should be reported with one (1) unit of service of CPT code 88360 or 88361 per specimen. It should not be reported with one or more units of service of CPT codes 88341, 88342, or 88344.

10. The unit of service for in situ hybridization reported as CPT codes 88364-88369, 88373, 88374, 88377 is each single or multiplex probe staining procedure per specimen. If a single or multiplex probe staining procedure is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service for CPT codes 88366, 88374, or 88377 per specimen for each multiplex probe staining procedure even if it contains multiple separately interpretable probes.

11. The unit of service for immunofluorescent antibody studies (e.g., CPT codes 88346, *88350*) is each antibody staining procedure per specimen. If a single antibody staining procedure for one or more antibodies is performed on multiple blocks from a surgical specimen, multiple slides from a cytologic specimen, or multiple slides from a hematologic specimen, only one unit of service may be reported for each separate specimen. Physicians should not report more than one unit of service for an immunofluorescent antibody stain per specimen for an immunofluorescent antibody staining procedure even if it contains multiple separately interpretable antibodies.

12. The MUE value for CPT code 86807 (Serum screening for cytotoxic percent reactive antibody (PRA); standard method) is two (2). One unit of service may be reported for a PRA test result for class I HLA antigens, and one unit of service may be reported for a PRA test result for class II HLA antigens. Payment for this procedure is based on the test result, not the methodologic steps utilized to obtain the test result. If multiple steps each utilizing cytotoxic antibody testing of a panel of lymphocytes are performed to obtain the final PRA test result for the class I HLA antigens, only one unit of service for 86807 may be reported. The same principle applies to the final PRA test result for class II HLA antigens.

13. CPT codes 88380 and 88381 describe microdissection procedures and include sample preparation of microscopically identified target cells. Microdissection of “normal tissue” to compare to target tumor tissue is not separately reportable as an additional unit of service. Comparison to “normal tissue” is a necessary component of the test since an interpretation of the tumor tissue cannot be rendered without it.

14. The *CPT Manual* instructions preceding CPT codes 87260-87660 (infectious agent antigen detection) state that separate results for different species or strain of organism should be coded separately with modifier 59. Based on this instruction the MUE value for each of these codes, except CPT code 87400, *was* one (1) *when these edits were claim line edits*. For these codes each claim line *was* adjudicated separately against the MUE value for the code on that claim line. *Now that these MUEs have been converted to date of service edits, the MUE values are based on data reflecting the total number of units of service of each code paid on a single date of service.*

15. Since CPT code 87400 (Infectious agent antigen detection by *immunoassay technique, (eg,* enzyme immunoassay *[EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA])* qualitative or semiquantitative, multiple-step method; Influenza, A or B, each) allows separate UOS for influenza A and influenza B, the MUE value for CPT code 87400 is two (2).

16. Infectious agents may be identified by antigen detection (e.g., CPT codes 87301-87450), immunofluorescence microscopy (e.g., CPT codes 87260-87299), or nucleic acid probe (e.g., CPT codes 87470-87501, 87510-87592, 87640-87799) techniques. If a single test procedure produces results for multiple species or strains of an organism, only one (1) unit of service (UOS) of a CPT code may be reported for that test procedure. However, if separate medically reasonable and necessary test procedures are performed for different species or strains of an organism, the same CPT code may be reported for each test procedure utilizing modifier 59 for the second and additional test procedures. For example, if a single amplified probe nucleic acid detection test procedure identifies more than one species of Candida organisms, only one (1) UOS may be reported for CPT code 87481 (infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique).

17. CPT code 81373 (HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each) is reported with one (1) unit of service (UOS) for each HLA Class I locus typed. This code may be reported with a maximum of two (2) UOS even though there are three HLA Class I loci. If all three loci are typed, the laboratory would report one (1) UOS of CPT

code 81372 (HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)) rather than three (3) UOS of CPT code 81373. Similarly, CPT code 81380 (HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each) may also be reported with a maximum of two (2) UOS even though there are three HLA Class I loci. If all three loci are typed, the laboratory would report one (1) UOS of CPT code 81379 (HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)) rather than three (3) UOS of CPT code 81380.

M. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the National Correct Coding Initiative Policy Manual for Medicare Services, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

5. CPT codes 80500 and 80502 describe clinical pathology consultation services. CMS has specific rules for reporting these services. There must be a written order for the clinical pathology consultation from the treating physician. A standing order is not an acceptable substitute for an individual written order by the treating physician. (Federal Register, Volume 62, Number 211, October 31, 1997, Page 59077) The consultation must be related to an abnormal test result that requires medical judgment by a physician (M.D. or D.O.). Since the clinical pathology consultation requires that medical judgment be exercised, the nature of the consultation must include information that could not be provided by a laboratory scientist, technologist, or technician. A written report documenting the consultation must appear in the medical record. A clinical pathology consultation does not require face-to-face patient contact. If face-to-face contact is medically reasonable and necessary, an evaluation and management (E&M) CPT code may be reported in lieu of a clinical pathology consultation code. Since E&M services include interpretation of laboratory test results, a clinical pathology consultation code should never be reported with an E&M code on the same date of service. CPT codes 80500 and 80502 should never be reported for consultation related to a pathology or laboratory service that includes a physician interpretation.

6. Medicare does not pay for duplicate testing. 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.

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

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 90000-99999. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

1. CPT codes 96360-96379 and C8957 describe hydration and therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs. CPT codes 96401-96549 describe administration of chemotherapy or other highly complex drug or biologic agents. Issues related to chemotherapy administration are discussed in this section as well as Section N (Chemotherapy Administration).

2. CPT codes 96360, 96365, 96374, 96409, and 96413 describe “initial” service codes. For a patient encounter only one “initial” service code may be reported unless it is medically reasonable and necessary that the drug or substance

administrations occur at separate intravenous access sites. To report two different "initial" service codes use NCCI-associated modifiers.

3. If both lumina of a double lumen catheter are utilized for infusions of different substances or drugs, only one "initial" infusion CPT code may be reported. The double lumen catheter permits intravenous access through a single vascular site. Thus, it would not be correct to report two "initial" infusion CPT codes, one for each lumen of the catheter.

4. Because the placement of peripheral vascular access devices is integral to intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 96360-96368, 96374-96379, 96409-96417) should not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, this service may be reported separately. Since intra-arterial infusion often 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 may be reported separately.

5. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D_5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and should not be reported separately. Similarly, the fluid utilized to administer drug(s)/substance(s) is incidental hydration and should not be reported separately.

Transfusion of blood or blood products includes the insertion of a peripheral intravenous line (e.g., CPT codes 36000, 36410) which is not separately reportable. Administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is incidental hydration and is not separately reportable.

If therapeutic fluid administration is medically necessary (e.g., correction of dehydration, prevention of nephrotoxicity) before

or after transfusion or chemotherapy, it may be reported separately.

6. Hydration concurrent with other drug administration services is not separately reportable.

7. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services should not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

8. The drug and chemotherapy administration CPT codes 96360-96375 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility based evaluation and management CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians should not report drug administration services in a facility setting, a facility based evaluation and management CPT code (e.g., 99281-99285) should not be reported by a physician with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the evaluation and management code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

Under OPPS, hospitals may report drug administration services (CPT codes 96360-96376) and chemotherapy administration services

(CPT codes 96401-96425) with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

9. Flushing or irrigation of an implanted vascular access port or device of a drug delivery system prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Do not report CPT code 96523.

10. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir for systemic drug delivery) and CPT code 96521 (refilling and maintenance of portable pump) should not be reported with CPT code 96416 (initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump. Similarly under the OPPS, CPT codes 96521 (refilling and maintenance of portable pump) and 96522 (refilling and maintenance of implantable pump or reservoir for systemic drug delivery (e.g., intravenous, intra-arterial)) should not be reported with HCPCS/CPT code C8957 (initiation of prolonged intravenous infusion (more than 8 hours)).

CPT codes 96521 and 96522 should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

11. Medicare Anesthesia Rules prevent separate payment for anesthesia services for a medical or surgical service when provided by the physician performing the service. Drug administration services, CPT codes 96360-96376 should not be reported for anesthesia provided by the physician performing a medical or surgical service.

12. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services. 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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

13. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported with HCPCS codes G0008, G0009, or G0010 respectively. Administration of other immunization(s) not excluded by law is reported with CPT codes 90460-90461 or 90471-90474 depending upon the patient’s age and physician counseling of the patient/family. Based on CPT instructions a physician should report administration of all immunizations other than influenza, pneumococcal, or hepatitis B vaccines on a single date of service from either of these two

code ranges and should not report a combination of CPT codes from the two code ranges.

14. Similar to drug and chemotherapy administration CPT codes, CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I) is not separately reportable with vaccine administration HCPCS/CPT codes 90460-90474, G0008-G0010. Other evaluation and management (E&M) CPT codes are separately reportable with a vaccine administration code if the E&M service is significant and separately identifiable, in which case the E&M CPT code may be reported with modifier 25.

15. CPT codes 96361 and 96366 are utilized to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes may be reported only if the infusion is medically reasonable and necessary for the patient's treatment or diagnosis. They should not be reported for "keep open" infusions as often occur in the emergency department or observation unit.

C. Psychiatric Services

CPT codes for psychiatric services include diagnostic (CPT codes 90791, 90792) and therapeutic (individual, group, other) procedures. Since psychotherapy includes continuing psychiatric evaluation, CPT codes 90791 and 90792 are not separately reportable with individual*, group, family, crisis, or other* psychotherapy codes *for the same date of service*.

Psychotherapy and group psychotherapy may be reported on the same date of service if the two services are performed during separate time intervals. Family psychotherapy (i.e., CPT codes 90846, 90847) is not separately reportable with psychotherapy CPT codes 90832-90838 for the same patient encounter since the latter codes include psychotherapy with family members. Physicians should not report psychotherapy CPT codes 90832-90838 with CPT code 90847 (family psychotherapy with patient present) for the same date of service. CPT codes 90832-90838 include all psychotherapy with family members, if present, for a single date of service.

Interactive services (diagnostic or therapeutic) are distinct 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...". Interactive complexity to psychiatric services is reported with add-on CPT code 90785.

Diagnostic psychiatric evaluation is reported with one of two CPT codes. CPT code 90791 is psychiatric evaluation without medical evaluation and management (E&M), and CPT code 90792 is psychiatric evaluation with medical E&M. E&M codes (e.g., 99201-99215) should not be reported with either of these diagnostic psychiatric codes.

Individual psychotherapy codes are time based codes. There are separate codes for psychotherapy without E&M service (CPT codes 90832, 90834, 90837) and add-on codes (CPT codes 90833, 90836, 90838) for psychotherapy to be reported in conjunction with the appropriate E&M code.

Pharmacologic management is included in psychiatric services that are reported with E&M services or that include medical services. HCPCS code M0064 (pharmacologic management) is not separately reportable with diagnostic or therapeutic psychiatric services (e.g., CPT codes 90785-90845, 90847-90880). HCPCS code M0064 requires face-to-face patient contact by the practitioner licensed to perform the service. Facilities may report HCPCS code M0064 (pharmacologic management services) with a psychotherapy code if the two services are performed at separate patient encounters on the same date of service. (HCPCS code M0064 was deleted January 1, 2015.)

For practitioner services E&M codes are not separately reportable on the same date of service as psychoanalysis (CPT code 90845), narcosynthesis (CPT code 90865), or hypnotherapy (CPT code 90880). These psychiatric services include E& M services provided on the same date of service. Facilities may separately report E&M codes and psychoanalysis, narcosynthesis, or hypnotherapy if the services are performed at separate patient encounters on the same date of service.

1. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes should not be reported separately with an evaluation and management (E&M), psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol

or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 should not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening" services which are not covered under the Medicare program. Where CPT codes 99408 and 99409 are covered by State Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS codes (e.g., G0442 (annual alcohol misuse screening, 15 minutes), G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS code, the HCPCS code is not separately reportable. For example, if a patient presents with symptoms suggestive of depression, the provider should not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

D. Biofeedback

Biofeedback services utilize electromyographic techniques to detect and record muscle activity. CPT codes 95860-95872 (EMG) should not be reported separately 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 code(s) (e.g., CPT codes 95860-95872) may be reported separately. Modifier 59 should be appended to the EMG code to indicate that the service was a separately identifiable diagnostic service. Recording an objective electromyographic response to biofeedback is not sufficient to separately report a diagnostic EMG CPT code.

E. Dialysis

Renal dialysis procedures coded as CPT codes 90935, 90937, 90945, and 90947 include evaluation and management (E&M) services related to the dialysis procedure and the renal failure. If the physician additionally performs on the same date of service medically reasonable and necessary E&M services unrelated to the dialysis procedure or renal failure that are significant and separately identifiable, these services may be separately reportable. CMS allows physicians to additionally report if appropriate CPT codes 99201-99215, 99221-99223, 99238–99239, and 99291-99292. These codes must be reported with modifier 25 if performed on the same date of service as the dialysis procedure.

Per CMS payment policy any E&M service related to the renal failure (e.g., hypertension, fluid overload, uremia, electrolyte imbalance) or dialysis procedure performed on the same date of service as the dialysis procedure should not be reported separately even if performed at a separate patient encounter. E&M services for conditions unrelated to the dialysis procedure or renal failure may be reported separately with modifier 25 *only if they cannot be performed during the dialysis session.*

F. Gastroenterology

1. Gastroenterological procedures included in CPT code ranges 43753-43757 and 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology when performed are integral components of an esophagogastroduodenoscopy (e.g., CPT code 43235). Gastric or duodenal intubation with or without aspiration (e.g., CPT codes 43753, 43754, 43756) should not be separately reported when performed as part of an upper gastrointestinal endoscopic procedure. Gastric or duodenal stimulation testing (e.g., CPT codes 43755, 43757) may be facilitated by gastrointestinal endoscopy (e.g., procurement of gastric or duodenal specimens).

When performed concurrent with an upper gastrointestinal endoscopy, CPT code 43755 or 43757 should be reported with modifier 52 indicating a reduced level of service was performed.

2. The gastroesophageal reflux test described by CPT code 91035 requires attachment of a telemetry pH electrode to the esophageal mucosa. If a physician uses endoscopic guidance to attach the electrode, the physician should not report CPT code 43235 (esophagogastroduodenoscopy,...; diagnostic...) for the guidance procedure. The guidance is not separately reportable. Additionally it would be a misuse of CPT code 43235 since this code does not describe guidance, but a more extensive diagnostic endoscopy.

Similarly the procedures described by CPT codes 91110 (gastrointestinal tract intraluminal imaging, esophagus through ileum) and 91112 (gastrointestinal transit and pressure measurement, stomach through colon) require a patient to swallow a capsule. If the patient cannot swallow a capsule, and a physician places it in the stomach using endoscopic guidance, CPT code 43235 should not be reported unless the physician performs a medically reasonable and necessary complete diagnostic upper gastrointestinal endoscopy procedure. CPT code 43235 should not be reported with modifier 52 for endoscopic guidance to place the capsule in the stomach.

G. Ophthalmology

1. General ophthalmological services (CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management (E&M) codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-92014) should not be reported separately. The E&M service includes the general ophthalmological services.

2. Special ophthalmologic services represent specific services not included in a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services and may be reported separately.

3. For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are integral to the procedure and are not separately reportable. Therefore, CPT codes 36000 (introduction

of a needle or catheter), 36410 (venipuncture), 96360-96368 (IV infusion), 96374-96376 (IV push injection), and selective vascular catheterization codes are not separately reportable with services requiring intravenous injection (e.g., CPT codes 92230, 92235, 92240, 92287).

4. CPT codes 92230 and 92235 (fluorescein angioscopy and angiography) include selective catheterization and injection procedures for angiography.

5. Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (e.g., CPT codes 92132, 92133, 92134) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59 to CPT code 92250. (CPT code 92135 was deleted January 1, 2011.)

6. Posterior segment ophthalmic surgical procedures (CPT codes 67005-67229) include extended ophthalmoscopy (CPT codes 92225, 92226), if performed during the operative procedure or post-operatively on the same date of service. Except when performed on an emergent basis, extended ophthalmoscopy would normally not be performed pre-operatively on the same date of service.

7. CPT code 92071 (fitting of contact lens for treatment of ocular surface disease) should not be reported with a corneal procedure CPT code for a bandage contact lens applied after completion of a procedure on the cornea.

H. Otorhinolaryngologic Services

1. CPT coding for otorhinolaryngologic services includes codes for diagnostic tests that may be performed qualitatively during physical examination or quantitatively with electrical recording equipment. The procedures described by CPT codes 92552-92557, 92561-92588, and 92597 may be reported only if calibrated electronic equipment is utilized. Qualitative assessment of these tests by the physician is included in the evaluation and management service.

2. Speech language pathologists may perform services coded as CPT codes 92507, 92508, or 92526. They do not perform services coded as CPT codes 97110, 97112, 97150, or 97530, which are generally performed by physical or occupational therapists. Speech language pathologists should not report CPT codes 97110, 97112, 97150, 97530, or 97532 as unbundled services included in the services coded as 92507, 92508, or 92526.

3. A single practitioner should not report CPT codes 92507 (treatment of speech, language, voice...; individual) and/or 92508 (treatment of speech, language, voice...; group) on the same date of service as CPT codes 97532 (development of cognitive skills to improve...) or 97533 (sensory integrative techniques to enhance...). However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes 92507 and/or 92508 on the same date of service that an occupational therapist performs the procedures described by CPT codes 97532 and/or 97533, a provider entity that employs both types of practitioners may report both services utilizing an NCCI-associated modifier.

4. Treatment of swallowing dysfunction and/or oral function for feeding (CPT code 92526) may utilize electrical stimulation. HCPCS code G0283 (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code 92526 for electrical stimulation during the procedure. The NCCI PTP edit (92526/G0283) for Medicare Carriers (A/B MACs processing practitioner service claims) does not allow use of NCCI-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit in OCE for Fiscal Intermediaries does allow use of NCCI-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different patient encounters on the same date of service.

5. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

6. Removal of cerumen by an audiologist prior to audiologic function testing is not separately reportable. If the cerumen is impacted, cannot be removed by the audiologist, and requires removal by a physician, the physician may report HCPCS code G0268 (Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing). The physician should not report CPT code 69210 (removal of impacted cerumen requiring instrumentation, unilateral) for this service.

7. CPT code 92540 (basic vestibular evaluation...) includes all the services separately included in CPT codes 92541 (spontaneous nystagmus test...), 92542 (positional nystagmus test...), 92544 (optokinetic nystagmus test...), and 92545 (oscillating tracking test...). Therefore, none of the component test CPT codes (92541, 92542, 92544, and 92545) may be reported with CPT code 92540. Additionally, if all four component tests are performed, CPT code 92540 should be reported rather than the four separate individual CPT codes. If one, two, or three of the component tests are performed without the others, the individual test codes may be reported separately. However, if two or three component test codes are reported, NCCI-associated modifiers should be utilized.

8. CPT code 95992 describing canalith repositioning procedure(s) is reported with no more than one (1) unit of service per day and includes all services necessary to achieve the canalith repositioning. Other CPT codes (e.g., 97110, 97112, 97140, 97530) should not be reported separately for services related to the canalith repositioning.

9. Comprehensive central auditory function evaluation (CPT codes 92620, 92621) includes, when performed, filtered speech test (CPT code 92571), staggered spondaic word test (CPT code 92572), and synthetic sentence identification test (CPT code 92576).

I. Cardiovascular Services

Cardiovascular medicine services include non-invasive and invasive diagnostic testing including intracardiac testing as well as therapeutic services (e.g., electrophysiological procedures).

1. If cardiopulmonary resuscitation (CPR) is performed without other evaluation and management (E&M) services, only CPT code 92950 (Cardiopulmonary resuscitation (e.g., in cardiac arrest)) should be reported. For example, if a physician directs cardiopulmonary resuscitation and the patient's attending physician resumes the care of the patient after the patient has been revived, the first physician may report CPT code 92950 but not an E&M code.

2. Critical care E&M services (CPT codes 99291 and 99292) and prolonged E&M services (CPT codes 99354-99357) are reported based on time. Providers should not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged provider E&M service time. For example, the time devoted to performing cardiopulmonary resuscitation (CPT code 92950) should not be included in critical care E&M service time.

3. There is no CPT code to report emergency cardiac defibrillation. It is included in cardiopulmonary resuscitation (CPT code 92950). If emergency cardiac defibrillation without cardiopulmonary resuscitation is performed in the emergency department or critical/intensive care unit, the cardiac defibrillation service is not separately reportable. Physicians should not report CPT code 92960 (cardioversion, elective...; external) for emergency cardiac defibrillation. CPT code 92960 describes a planned elective procedure. If a planned elective external cardioversion is performed by a physician reporting critical care time (CPT codes 99291, 99292), the time to perform the elective external cardioversion should not be included in the critical care time.

4. A number of diagnostic and therapeutic cardiovascular procedures (e.g., CPT codes 92950-92998, 93451-93533, 93600-93624, 93640-93657) routinely utilize intravenous or intra-arterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques. Since these services are integral components of the more comprehensive procedures, codes for routine vascular access, ECG monitoring, and injection/infusion services are not separately reportable. Fluoroscopic guidance is integral to diagnostic and therapeutic intravascular procedures and is not separately reportable. HCPCS/CPT codes describing radiologic supervision and interpretation for specific interventional vascular procedures may be separately reportable.

5. Cardiac output measurements (CPT codes 93561-93562) are routinely performed during cardiac catheterization procedures. Per CPT instruction, CPT codes 93561-93562 should not be reported separately with cardiac catheterization codes.

6. CPT codes 93797 and 93798 describe comprehensive services provided by a physician for cardiac rehabilitation. Since these codes include all services necessary for cardiac rehabilitation, evaluation and management (E&M) codes should not be reported separately unless a significant, separately identifiable E&M service is performed and documented in the medical record. The physician should report the E&M service with modifier 25 to indicate that it was significant and separately identifiable.

7. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) should not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately.

8. Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported utilizing an NCCI-associated modifier.

9. If a physician in attendance for a cardiac stress test obtains a history and performs a limited physical examination related to the cardiac stress test, a separate evaluation and management (E&M) code should not be reported separately unless a significant, separately identifiable E&M service is performed unrelated to the performance of the cardiac stress test. The E&M code should be reported with modifier 25 to indicate that it is a significant, separately identifiable E&M service.

10. Cardiovascular stress tests include insertion of needle and/or catheter, infusion/injection (pharmacologic stress tests) and ECG strips (e.g., CPT codes 36000, 36410, 96360-96376, 93000-93010, 93040-93042). These services should not be reported separately.

11. Microvolt T-wave alternans (MTWA) (CPT code 93025) testing requires a submaximal stress test that differs from the traditional exercise stress test (CPT codes 93015-93018) which utilizes a standard exercise protocol. CPT codes 93015-93018 should not be reported separately for the submaximal stress test integral to MTWA testing. *CPT codes 93015-93018 should not be reported on the same date of service as CPT code 93025.*

12. CPT codes 93040-93042 describe diagnostic rhythm ECG testing. They should not be reported for cardiac rhythm monitoring in any site of service.

13. Routine monitoring of ECG rhythm and review of daily hemodynamics including cardiac output are part of critical care evaluation and management (E&M) services. Separate reporting of ECG rhythm strips and cardiac output measurements (CPT codes 93040-93042, 93561, 93562) with critical care E&M services is inappropriate. An exception to this principle may include a sudden change in patient status associated with a change in cardiac rhythm requiring a diagnostic ECG rhythm strip and return to the critical care unit. If reported separately, the time for this service is not included in the critical care time calculated for reporting the critical care E&M service.

14. Percutaneous coronary artery interventions (PCI) include stent placement, atherectomy, and balloon angioplasty. There are CPT codes describing various combinations of these PCI procedures. There are five major coronary arteries (left main, left anterior descending, left circumflex, right, and ramus intermedius). Only one PCI code may be reported for all PCIs of a major coronary artery through the native circulation. However, PCI treatment of a different second segment of a major coronary artery through a bypass graft may also be reported with a different PCI code for revascularization treatment through a coronary artery bypass. Two PCI codes should never be reported for treatment of the same segment of a major coronary artery or one of its branches. For reporting purposes there are two coronary branches of the left anterior descending (diagonals), left circumflex (marginals), and right (posterior descending,

posterolaterals) coronary arteries. For reporting purposes, there are no recognized branches of the left main and ramus intermedius coronary arteries. Only one PCI code may be reported for each of up to two branches of a major coronary artery with recognized branches. PCI of a third branch of a major coronary artery with recognized branches should not be reported. One PCI code may be reported for each coronary artery bypass graft plus each branch off the main graft. PCI performed on a major coronary artery or coronary artery branch accessed through a bypass graft may be reported using a bypass graft PCI code. If a single lesion extends from one target vessel (major coronary artery, coronary bypass graft, or coronary artery branch) into another target vessel and can be revascularized with a single intervention, only one PCI code should be reported even though two target vessels are treated.

15. Cardiac catheterization, percutaneous coronary artery interventional procedures (angioplasty, atherectomy, or stenting), and internal cardioversion include insertion of a needle and/or catheter, infusion, fluoroscopy and ECG rhythm strips (e.g., CPT codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 96360-96376, 71034, 76000-76001, 93040-93042). All these services are components of a cardiac catheterization, percutaneous coronary artery interventional procedure, or internal cardioversion and are not separately reportable.

16. A cardiac catheterization procedure or a percutaneous coronary artery interventional procedure may require ECG tracings to assess chest pain during the procedure. These ECG tracings are not separately reportable. Diagnostic ECGs performed prior to or after the procedure may be separately reportable with modifier 59.

17. Percutaneous coronary artery interventions (e.g., stent, atherectomy, angioplasty) include coronary artery catheterization, radiopaque dye injections, and fluoroscopic guidance. CPT codes for these procedures (e.g., 93454-93461, 76000) should not be reported separately. If medically reasonable and necessary diagnostic coronary angiography precedes the percutaneous coronary artery intervention, a coronary artery or cardiac catheterization and associated radiopaque dye injections may be reported separately. However, fluoroscopy is not separately reportable with diagnostic coronary angiography or cardiac catheterization.

18. While withdrawing the catheter during a cardiac catheterization procedure, physicians often inject a small amount of dye to examine the renal arteries and/or iliac arteries. These services when medically reasonable and necessary may be reported with HCPCS codes G0275 or G0278. A physician should not report CPT codes 75722 or 75724 (renal angiography) unless the renal artery(s) is (are) catheterized and a complete renal angiogram including the venous phase is performed and interpreted. A physician should not report CPT codes 75625 (abdominal aortography) or 75630 (abdominal aortography with bilateral iliofemoral lower extremity angiography) unless a complete study including venous phase is performed and interpreted. In order to report angiography CPT codes 75625, 75630, 75722, 75724, or others with a cardiac catheterization procedure, the angiography procedure must be as complete a procedure as it would be without concomitant cardiac catheterization. (CPT codes 75722 and 75724 were deleted January 1, 2012.) (HCPCS code G0275 was deleted January 1, 2014.)

19. 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. (CPT codes 75722 and 75724 were deleted January 1, 2012.) (HCPCS code G0275 was deleted January 1, 2014.)

20. Placement of an occlusive device such as an angio seal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported with HCPCS code G0269. A physician should not separately report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

21. Many Pacemaker/Implantable Defibrillator procedures (CPT codes 33202-33249) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it

is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes (e.g., CPT codes 76000, 76001) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures may be reported separately. Additionally, ultrasound guidance is not separately reportable with these HCPCS/CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by CPT codes 33202-33249 or 93600-93662.

22. Endomyocardial biopsy requires intravascular placement of catheters into the right ventricle under fluoroscopic guidance. Physicians should not separately report a right heart catheterization or selective vascular catheterization CPT code for placement of these catheters. A right heart catheterization CPT code may be separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. *The right heart catheterization CPT code may be reported only if a complete right heart catheterization procedure is performed. If an abbreviated right heart catheterization is medically reasonable and necessary, it may be reported with CPT code 93799 (unlisted cardiovascular service or procedure).* Fluoroscopy codes (e.g., CPT codes 76000, 76001) are not separately reportable for an endomyocardial biopsy.

23. CPT codes 93600 (Bundle of His recording), 93602 (Intra-atrial recording), 93603 (Right ventricular recording), 93610 (Intra-atrial pacing), and 93612 (Intraventricular pacing) should not be reported with a code describing insertion or replacement of an electrode or device (pacemaker, defibrillator) because they are integral to the procedure. If a physician performs a medically reasonable and necessary limited diagnostic electrophysiology test preceding the insertion or replacement of the electrode or device to determine the necessity to proceed with insertion or replacement of an electrode or device, the appropriate CPT codes describing the limited diagnostic electrophysiology testing may be reported with an NCCI-associated modifier. The limited diagnostic electrophysiology testing to determine the necessity to proceed with insertion or replacement of the electrode or device may be performed at the same or different patient encounter.

24. Occasionally it is medically reasonable and necessary to perform echocardiography (CPT codes 93303-93318) utilizing intravenous push injections of contrast. The injection of contrast (e.g., CPT codes 96365, 96374, 96375, 96376) is not separately reportable.

HCPCS codes C8921-C8930 describe echocardiography procedures with contrast and include echocardiography without contrast if performed at the same patient encounter. Under OPPS, facilities should report the appropriate code from the HCPCS code range C8921-C8930 when echocardiography is performed with contrast rather than the corresponding CPT code in the code range 93303-93350. Since the HCPCS codes C8921-C8930 include echocardiography without contrast if performed at the same patient encounter as echocardiography with contrast, a code from the HCPCS code range C8921-C8930 and the corresponding code from the CPT code range 93303-93352 should not be reported separately for the same patient encounter for echocardiography.

CPT code 93352 is an add-on code that describes use of echocardiographic contrast during stress echocardiography. It may be reported by physicians with CPT codes 93350 or 93351 in the appropriate site of service. CPT code 93352 is not separately payable under OPPS.

25. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

26. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan-Ganz)) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569 (insertion of peripherally inserted central venous catheter) for the insertion of a single catheter. If a physician does not complete the insertion of one type of catheter and subsequently inserts another at the same patient encounter, only the completed procedure may be reported.

27. A procedure to insert a central flow directed catheter (e.g., Swan-Ganz) (CPT code 93503) is often followed by a chest radiologic examination to confirm proper positioning of the flow

directed catheter. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

28. Since cardioversion includes interrogation and programming of an implantable defibrillator if performed, interrogation and programming of an implantable defibrillator system (e.g., CPT codes 93282-93284, 93289, 93292, and 93295) should not be reported separately with a cardioversion procedure (e.g., CPT codes 92960, 92961).

29. Since electronic analysis of an antitachycardia pacemaker system includes interrogation and programming of the pacemaker system, interrogation and programming of a pacemaker system (e.g., CPT codes 93279-93281, 93286, and 93288) should not be reported separately with electronic analysis of an antitachycardia pacemaker system (CPT code 93724).

30. CPT code 92961 (cardioversion, elective...; internal (separate procedure)) is not separately reportable with a cardiac catheterization or percutaneous cardiac interventional procedure. CPT code 92961 is defined as a “separate procedure”, and CMS payment policy does not allow separate payment for a “separate procedure” performed with another procedure in an anatomically related region through similar access. The internal cardioversion, like a cardiac catheterization or a percutaneous cardiac interventional procedure, is performed using similar percutaneous vascular access and placement of one or more catheters into the heart under fluoroscopy. CPT codes for percutaneous vascular access, radiopaque dye injections, and fluoroscopic guidance should not be reported separately.

31. CPT code 93623 (programmed stimulation and pacing after intravenous drug infusion) is an add-on code that may be reported per *CPT Manual* instructions only with CPT codes 93610, 93612, 93619, 93620, or 93653-93656. Although CPT code 93623 may be reported for intravenous drug infusion for diagnostic programmed stimulation and pacing, it should not be reported for injections of a drug with stimulation and pacing following an intracardiac catheter ablation procedure (e.g., CPT codes 93650-93657) to confirm adequacy of the ablation. Confirmation of the adequacy of ablation is included in the intracardiac catheter ablation procedure.

32. Transesophageal echocardiography (TEE) monitoring (CPT code 93318) without probe placement is not separately reportable by a physician performing critical care evaluation and management (E&M) services. However, if a physician places a transesophageal probe to be used for TEE monitoring on the same date of service that the physician performs critical care E&M services, CPT code 93318 may be reported with modifier 59. The time necessary for probe placement should not be included in the critical care time reported with CPT codes 99291 and 99292 as is true for all separately reportable procedures performed on a patient receiving critical care E&M services. Diagnostic TEE services may be separately reportable by a physician performing critical care E&M services.

J. Pulmonary Services

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories.

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

2. If a physician in attendance for pulmonary diagnostic testing or therapy obtains a limited history and performs a limited physical examination related to the pulmonary testing or therapy, separate reporting of an evaluation and management (E&M) service is not appropriate. If a significant, separately identifiable E&M service is performed unrelated to the performance of the pulmonary diagnostic testing or therapy, an E&M service may be reported with modifier 25.

3. If multiple spirometric determinations are necessary to complete the service described by a CPT code, only one unit of service should be reported. For example, CPT code 94070 describes bronchospasm provocation with an administered agent and utilizes multiple spirometric determinations as in CPT code 94010. A single unit of service includes all the necessary spirometric determinations.

4. Complex pulmonary stress testing (CPT code 94621) 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, ECG 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 complex pulmonary stress test. It is also inappropriate to report a cardiac stress test and the component codes used to perform a simple pulmonary stress test (CPT code 94620) when a complex pulmonary stress test is 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, the professional components for both a cardiac and pulmonary stress test may be reported. Modifier 59 should be reported with the secondary procedure. Both tests must satisfy the requirement for medical necessity. (Since a complex pulmonary stress test includes electrocardiographic recordings, the technical components for both the cardiac stress test and the pulmonary stress test should not be reported separately.)

5. Pursuant to the *Federal Register* (Volume 58, Number 230, 12/2/1993, Pages 63640-63641), ventilation management CPT codes (94002-94004 and 94660-94662) are not separately reportable with evaluation and management (E&M) CPT codes. If an E&M code and a ventilation management code are reported, only the E&M code is payable.

6. The procedure described by CPT code 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour) does not include any physician work RVUs. When performed in a facility, the procedure utilizes facility staff and supplies, and the physician does not have any practice expenses related to the procedure. Thus, a physician should not report this code when the physician orders it in a facility. This code should not be reported with CPT codes 99217-99239, 99281-99285, 99466-99467, 99291-99292, 99468-99469, 99471-99472, 99478-99480, 99304-99318, and 99324-99337 unless the physician supervises the performance of the procedure at a separate patient encounter on the same date of service outside the facility where the physician does have practice expenses related to the procedure.

7. CPT code 94060 (bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator

administration) describes a diagnostic test that is utilized to assess patient symptoms that might be related to reversible airway obstruction. It does not describe treatment of acute airway obstruction. CPT code 94060 includes the administration of a bronchodilator. It is a misuse of CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) to report 94640 for the administration of the bronchodilator included in CPT code 94060. The bronchodilator medication may be reported separately.

8. CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 should only be reported once during a single patient encounter regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) should not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately.

9. CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) generally should not be reported for the same patient encounter. The demonstration and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it utilizes the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the two services may be reported separately.

10. Practitioner ventilation management (e.g., CPT codes 94002-94005, 94660, 94662) and critical care (e.g., CPT codes 99291, 99292, 99466-99486) include respiratory flow volume loop (CPT code 94375), breathing response to carbon dioxide (CPT code 94400), and breathing response to hypoxia (CPT code 94450) testing if performed.

K. Allergy Testing and Immunotherapy

The *CPT Manual* divides allergy and clinical immunology into testing and immunotherapy. Immunotherapy includes codes for the preparation of antigen (allergen) and separate codes for allergen administration.

1. If percutaneous or intracutaneous (intradermal) single test (CPT codes 95004 or 95024) and "sequential and incremental" tests (CPT codes 95017, 95018, 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. A single test and a "sequential and incremental" test for the same dilution of an allergen should not be reported separately on the same date of service. For example, if the single test for an antigen is positive and the physician proceeds to "sequential and incremental" tests with three additional *different* dilutions of the same antigen, the physician may report one unit of service for the single test code and three units of service for the "sequential and incremental" test code.

2. Photo patch tests (CPT code 95052) consist of applying a patch(s) containing allergenic substance(s) to the skin and exposing the skin to light. Physicians should not unbundle this service by reporting both CPT code 95044 (patch or application tests) plus CPT code 95056 (photo tests) rather than CPT code 95052.

3. Evaluation and management (E&M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. Obtaining informed consent is included in the immunotherapy service and should not be reported with an E&M code. If E&M services are reported, modifier 25 should be utilized.

4. In general allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. Allergy testing is performed prior to immunotherapy to determine the offending allergens. CPT codes for allergy testing and immunotherapy are generally not reported on the same date of service unless the physician provides allergy immunotherapy and testing for additional allergens on the same day. Physicians should not report allergy testing CPT codes for allergen potency

(safety) testing prior to administration of immunotherapy. Confirmation of the appropriate potency of an allergen vial for immunotherapy is an inherent component of immunotherapy. Additionally, allergy testing is an integral component of rapid desensitization kits (CPT code 95180) and is not separately reportable.

L. Neurology and Neuromuscular Procedures

The *CPT Manual* defines codes for neuromuscular diagnostic and therapeutic services. Sleep testing, nerve and muscle testing, and electroencephalographic procedures are included. The *CPT Manual* guidelines for sleep testing are very precise and should be followed carefully when reporting these services.

1. Sleep testing differs from polysomnography in that the latter requires sleep staging. Sleep staging includes a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. A “sleep study” and “polysomnography” should not be reported separately for the same patient encounter.

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 (e.g., speed of paper, number of channels). EEG testing should not be reported separately with polysomnography unless a complete diagnostic EEG is performed separately in the usual manner at a separate patient encounter on the same date of service. If a complete diagnostic EEG is performed at a separate patient encounter on the same date of service as a polysomnography, modifier 59 should be appended to the EEG code.

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) describe different services than those provided during sleep testing or polysomnography. These procedures may be reported separately with sleep testing only if they are performed as significant, separately identifiable services distinct from EEG testing included in sleep testing or polysomnography. In the latter situation, the EEG codes must be reported with modifier 59 to indicate that a different service was performed.

4. If nerve testing (e.g., EMG, nerve conduction velocity) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the range of CPT codes 95851-95943 are not separately reportable. These codes describe significant, separately identifiable diagnostic services requiring a formal report in the medical record. Electrical stimulation used to identify or locate nerves during a procedure involving treatment of a cranial or peripheral nerve (e.g., nerve block, nerve destruction, neuroplasty, transection, excision, repair) is integral to the procedure and is not separately reportable.

5. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) should not be reported by the physician performing an operative or anesthesia 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 report other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939) since they are also included in the global package.

6. The NCCI PTP edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two 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 two CPT code 95900 of this NCCI PTP edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters. (CPT codes 95900 and 95903 were deleted January 1, 2013.)

M. Central Nervous System Assessments/Tests

1. Neurobehavioral status exam (CPT code 96116) should not be reported when a mini-mental status examination is performed. CPT code 96116 should never be reported with psychiatric diagnostic examinations (CPT codes 90791 or 90792). CPT code 96116 may be reported with other psychiatric services or evaluation and management services only if a complete neurobehavioral status exam is performed. If a mini-mental status examination is performed by a physician, it is included in the evaluation and management service.

2. CPT codes 96101-96103 describe psychological testing differing by method of performance and interpretation. Two or more codes from this code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different psychological tests. Similarly, CPT codes 96118-96120 describe neuropsychological testing differing by method of performance and interpretation. Two or more codes from this latter code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different neuropsychological tests.

3. The psychiatric diagnostic interview examination (CPT codes 90791, 90792) and psychological/neuropsychological testing (CPT codes 96101, 96118) must be distinct services. *CPT Manual* instructions permit physicians "to integrate other sources of clinical data" into the report that is generated for CPT codes 96101 or 96118. Since the procedures described by CPT codes 96101 and 96118 are timed procedures, physicians should be careful to avoid reporting time for duplicating information included in the psychiatric diagnostic interview examination and report.

4. A physician may report CPT codes 96101 (psychological testing...) or 96118 (neuropsychological testing...) only if the physician personally administers at least one test to the patient.

5. Central nervous system (CNS) assessment/test CPT codes (e.g., 96101-96105, 96118-96125) should not be reported for tests that are reportable as part of an evaluation and management service when performed. In order to report a CNS assessment/test CPT code the test cannot be self administered. It must be administered by a physician, psychologist, technician, or computer as required by the code descriptor of the reported CPT code. The test must assess CNS function (e.g., psychological health, aphasia, neuropsychological health) per requirements of the CNS assessment/test CPT code descriptors. The assessment must utilize tests described by the code descriptor or other tests not available in the public domain.

N. Chemotherapy Administration

1. The CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter only one "initial" service code may be reported unless it is medically

reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report two different "initial" service codes use NCCI-associated modifiers.

2. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services should not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

3. The drug and chemotherapy administration HCPCS/CPT codes 90760-90775 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility based evaluation and management CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians should not report drug administration services in a facility setting, a facility based evaluation and management CPT code (e.g., 99281-99285) should not be reported with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the evaluation and management code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

Under OPPS, hospitals may report drug administration services and facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant

and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

4. Flushing or irrigation of an implanted vascular access port or device prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Under these circumstances, do not report CPT code 96523.

5. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir) and CPT code 96521(refilling and maintenance of portable pump) should not be reported with CPT code 96416(initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump.

CPT codes 96521 and 96522 should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

6. A concurrent intravenous infusion of an antiemetic or other non-chemotherapeutic drug with intravenous infusion of chemotherapeutic agents may be reported separately as CPT code 96368 (concurrent intravenous infusion). CPT code 96368 may be reported with a maximum of one unit of service per patient encounter regardless of the number of concurrently infused drugs or the length of time for the concurrent infusion(s). Hydration concurrent with chemotherapy is not separately reportable.

7. Prior to January 1, 2005, the NCCI PTP edits with column one CPT codes 96408 (Intravenous chemotherapy administration by push technique) and 96410 (Intravenous chemotherapy administration by infusion technique, up to one hour) each with column two CPT code 90780 (Therapeutic or diagnostic intravenous infusion up to one hour) were often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 90780 of these NCCI PTP edits was only appropriate if the 90780 procedure was for hydration, antiemetic, or other non-chemotherapy drug administered before, after, or at different patient encounters than the chemotherapy. Modifier 59 should not have been used for "keep open" infusion for the chemotherapy.

O. Special Dermatological Procedures

Medicare does not allow separate payment of E&M CPT code 99211 with photochemotherapy procedures (CPT codes 96910-96913) for services performed by a nurse or technician such as examining a patient prior to a subsequent procedure for burns or reactions to the prior treatment. If a physician performs a significant separately identifiable medically reasonable and necessary E&M service on the same date of service, it may be reported with modifier 25.

P. Physical Medicine and Rehabilitation

1. 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 PTP 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.

2. NCCI contains PTP 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 medically reasonable and necessary, it may be reported with modifier 59 appended to CPT code 97002 or 97004 as appropriate.

3. The procedure coded as CPT code 97755 (assistive technology assessment...direct one-on-one contact with written report, each 15 minutes) is intended for use on severely impaired patients requiring adaptive technology. For example, a patient with the use of only one or no limbs might require the use of high level adaptive technology.

4. The NCCI PTP edit with column one CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column two 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 two CPT code 97530 of this NCCI PTP edit is appropriate only 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.

5. Based on *CPT Manual* instructions debridement CPT codes 97597-97602 should not be reported in conjunction with surgical debridement (CPT codes 11042-11047) for the same wound. Similarly, CPT code 97602 should not be reported in conjunction with CPT codes 97597 and 97598 for the same wound.

6. Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation or pulmonary rehabilitation services are included in the cardiac rehabilitation or pulmonary rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation or pulmonary rehabilitation services, both types of services may be reported utilizing an NCCI-associated modifier. Similarly physical and occupational therapy services are not separately

reportable with therapeutic pulmonary procedures (e.g., HCPCS codes G0237-G0239) for the same patient encounter.

7. CPT Code 97610 (low frequency, non-contact, non-thermal ultrasound..., per day) is not separately reportable for treatment of the same wound with other active wound care management CPT codes (97597-97606) or wound debridement CPT codes (e.g., CPT codes 11042-11047, 97597, 97598). This paragraph was relocated from Chapter XII, Section C (NCCI Procedure to Procedure (PTP) Edit Specific Issues), Paragraph 1 when CPT code 0183T was replaced by CPT code 97610 on January 1, 2014.

Q. Medical Nutrition Therapy

1. CPT codes 97802-97804 (medical nutrition therapy;...) are utilized to report Medicare covered medical nutrition therapy services after an initial referral each year. If during the same year there is a change in the patient's diagnosis, medical condition, or treatment regimen, the treating physician may make a second referral for medical nutrition therapy. These services should be reported with HCPCS codes G0270-G0271 (medical nutrition therapy... following second referral in same year for change in diagnosis, medical condition or treatment regimen...) rather than CPT codes 97802-97804.

2. Medical nutrition therapy services (CPT codes 97802-97804) performed at the same patient encounter as a cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service are included in the cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service and are not separately reportable. The Medicare program provides a medical nutrition therapy benefit to beneficiaries for medical nutrition therapy related to diabetes mellitus or renal disease. If a physician provides a Medicare covered medical nutrition service to a beneficiary with diabetes mellitus or renal disease on the same date of service as a cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition therapy service may be separately reportable with an NCCI-associated modifier. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service.

R. 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. Further since a single therapeutic intervention is recognized per region, a physician should not report OMT and an injection for the same region. Epidural or nerve block injections performed on the same date of service as OMT, unrelated to the OMT, and in a different region than the OMT, may be reported with OMT using modifier 59.

S. Chiropractic Manipulative Treatment

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

T. Miscellaneous Services

1. When CPT code 99175 (Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison) is reported, observation time provided predominantly to monitor the patient for a response to an emetogenic agent should not be included in other timed codes (e.g., critical care, prolonged services).

2. If hypothermia is accomplished by regional infusion techniques, chemotherapy administration CPT codes should not be reported unless chemotherapeutic agents are also administered at the same patient encounter.

3. Therapeutic phlebotomy (CPT code 99195) is not separately reportable with autologous blood collection (CPT codes 86890, 86891), plasmapheresis, or exchange transfusion. Services

integral to performing the phlebotomy (e.g., CPT codes 36000, 36410, 96360-96376) are not separately reportable.

4. Physician attendance and supervision of hyperbaric oxygen therapy (CPT code 99183) includes evaluation and management (E&M) services related to the hyperbaric oxygen therapy. E&M services integral to this procedure include, but are not limited to, updating history and physical, examining the patient, reviewing laboratory results and vital signs with special attention to pulmonary function, blood pressure, and blood sugar levels, clearing patient for procedure, monitoring and/or assisting with patient positioning, evaluating and treating the patient for barotrauma and other complications, prescribing appropriate medications, etc. A physician should not report an E&M CPT code for these services. If a physician performs unrelated, significant, and separately identifiable E&M services on the same date of service, the physician may report those E&M services with modifier 25.

U. Evaluation and Management (E&M) Services

CPT codes for evaluation and management (E&M) services are principally included in the CPT code range 99201-99499. The codes describe the site of service (e.g., office, hospital, home, nursing facility, emergency department, critical care), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter), and various miscellaneous services (e.g., prolonged physician service, care plan oversight service). E&M services are further classified by the complexity of the relevant clinical history, physical examination, and medical decision making. Some E&M codes are based on the duration of the encounter (e.g., critical care services).

Effective January 1, 2010 Medicare does not recognize consultation E&M CPT codes 99241–99255 for billing and payment purposes. If a physician performs a consultation E&M, the physician may report the appropriate level of E&M service for the site of service where the consultation E&M occurs.

Rules governing the reporting of more than one E&M code for a patient on the same date of service are very complex and are not described herein. However, the NCCI contains numerous edits based on several principles including, but not limited to:

1. A physician may report only one “new patient” code on a single date of service.

2. A physician may report only one code from a range of codes describing an initial E&M service on a single date of service.

3. A physician may report only one “per diem” E&M service from a range of per diem codes on a single date of service.

4. A physician should not report an “initial” per diem E&M service with the same type of “subsequent” per diem service on the same date of service.

5. E&M codes describing observation/inpatient care services with admission and discharge on same date (CPT codes 99234-99236) should not be reported on the same date of service as initial hospital care per diem codes (99221-99223), subsequent hospital care per diem codes (99231-99233), or hospital discharge day management codes (99238-99239).

The prolonged service with direct face-to-face patient contact E&M codes (CPT codes 99354-99357) may be reported in conjunction with other evaluation and management codes. These prolonged service E&M codes are add-on codes that may generally be reported with the E&M codes listed in the CPT instruction following each CPT code in the code range 99354-99357.

Since critical care (CPT codes 99291-99292) and prolonged E&M services (CPT codes 99354-99357) are reported based on time, providers should not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged provider E&M service time.

Evaluation and management services, in general, are cognitive services, and significant procedural services are not included in 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. For example, cleansing of traumatic lesions, closure of lacerations with adhesive strips, application of dressings, counseling and educational 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 practitioner services in addition to patient history, examination, and medical decision making are included in the evaluation and management associated with critical and intensive care. Per *CPT Manual* instructions, services not separately reportable by practitioners reporting critical care CPT codes 99291 and 99292 include, but are not limited to, 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 (ECGs, blood pressures, hematologic data), gastric intubation (CPT codes 43752,43753), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94002-94004, 94660, 94662), and vascular access procedures (CPT codes 36000, 36410, 36600). However, facilities may separately report these services with critical care CPT codes 99291 and 99292.

Per *CPT Manual* instructions practitioner inpatient neonatal and pediatric critical and intensive care services (i.e., CPT codes 99468-99480) include the same services included in critical care CPT codes 99291 and 99292 as well as additional services listed in the *CPT Manual* specific to neonatal and pediatric critical and intensive care services. These services should not be reported separately by practitioners reporting CPT codes 99468-99480. However, facilities may separately report these services with CPT codes 99468-99480.

Per Medicare rules critical and intensive care CPT codes include thoracic electrical bioimpedance (CPT code 93701) which should not be reported separately.

Certain sections of CPT codes include codes describing specialty-specific services which primarily involve evaluation and management services. When codes for these services are reported, a separate evaluation and management service from the range of CPT codes 99201-99499 should not be reported on the same date of service. Examples of these codes include general and special ophthalmologic services and general and special diagnostic and therapeutic psychiatric services.

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MACs processing practitioner service claims.) All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 date 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. Examples of "XXX" procedures include allergy testing and immunotherapy, physical therapy services, and neurologic and vascular diagnostic testing procedures.

Pediatric and neonatal critical and intensive care CPT codes (99468-99480) are per diem codes that are generally reported by only one physician on each day of service. These codes are reported by the physician directing the inpatient critical or intensive care of the patient. These codes should not be reported by other physicians performing critical care services on the same date of service. Critical care services provided by a second physician of a different specialty may be reported with CPT codes 99291 and 99292. However, if a neonate or infant becomes critically ill on a day when initial or subsequent intensive care service (CPT codes 99477-99480) has been performed by one physician and is transferred to a critical care level of care provided by a different physician in a different group, the second physician may report a per diem critical care service (CPT codes 99468-99476).

6. CPT codes 99238 and 99239 describe hospital discharge day management. These codes should not be reported with initial hospital care (CPT codes 99221-99223) or initial observation care (CPT codes 99218-99220) for the same date of service. If a physician provides initial hospital care or observation care on the same day as discharge, the services should be reported with CPT codes 99234-99236 (observation or inpatient hospital care with admission and discharge on the same date of service). Additionally, CPT codes 99238 and 99239 include all physician services provided to the patient on the date of discharge. The

physician should not report another E&M CPT code (e.g., 99201-99215, 99281-99285) on the same date of service that the physician reports CPT code 99238 or 99239.

7. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes should not be reported separately with an evaluation and management (E&M), psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 should not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening" services which are not covered under the Medicare program. Where CPT codes 99408 and 99409 are covered by State Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409.

8. Transesophageal echocardiography (TEE) monitoring (CPT code 93318) without probe placement is not separately reportable by a physician performing critical care evaluation and management (E&M) services. However, if a physician places a transesophageal probe to be used for TEE monitoring on the same date of service that the physician performs critical care E&M services, CPT code 93318 may be reported with modifier 59. The time necessary for probe placement should not be included in the critical care time reported with CPT codes 99291 and 99292 as is true for all separately reportable procedures performed on a patient receiving critical care E&M services. Diagnostic TEE services are separately reportable by a physician performing critical care E&M services.

9. Practitioner ventilation management (e.g., CPT codes 94002-94005, 94660, 94662) and critical care (e.g., CPT codes 99291, 99292, 99466-99486) include respiratory flow volume loop (CPT code 94375), breathing response to carbon dioxide (CPT code 94400), and breathing response to hypoxia (CPT code 94450) testing if performed.

V. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. For purposes of reporting units of service (UOS) for antigen preparation (i.e., CPT codes 95145-95170), the physician reports “number of doses”. Medicare defines a dose for reporting purposes as 1 milliliter (ml). Thus, if a physician prepares a 10 ml vial of antigen, the physician may only report a maximum of 10 UOS for that vial even if the number of actual administered doses is greater than 10. Medicare payment amounts for these codes were determined by dividing the practice expenses for a 10 ml vial into ten doses. (See *Internet-Only Claims Processing Manual*, Publication 100-04, Chapter 12, Section 200 (B)(7)).

4. CPT code 94681 (oxygen uptake, expired gas analysis; including CO_2 output, percentage oxygen extracted) may be reported one time per day. It includes rest and exercise determinations.

5. The unit of service for CPT codes 90846 (family psychotherapy without patient present), 90847 (family

psychotherapy with patient present), 90849 (multiple family group psychotherapy), and 90853 (Group psychotherapy (other than of a multiple family group)) is the patient encounter even if it lasts longer than one hour. A practitioner may report only one unit of service on a single date of service. An outpatient facility may report one unit of service for each separate and distinct family or group therapy session provided by a different practitioner.

Effective January 1, 2009, group therapy services provided in a PHP (partial hospitalization program) should be reported with HCPCS codes G0410 or G0411 which are timed codes. Prior to January 1, 2009, CMS permitted PHPs to report group therapy services utilizing CPT code 90853 with a unit of service corresponding to forty five to sixty minutes of therapy.

6. CPT code 90845 (psychoanalysis) includes all psychoanalysis services performed by a physician on a single date of service.

7. CPT codes 90867, 90868, and 90869 describe delivery of therapeutic repetitive transcranial magnetic stimulation (TMS) treatment. CPT code 90867 may be reported only once with a single unit of service during a course of TMS treatment since it describes the initial treatment. CPT codes 90868 and 90869 may be reported with only one unit of service per day since they are not timed codes and only one treatment session would be performed on a single date of service.

8. The MUE values for CPT codes 93797 and 93798 (physician services for outpatient cardiac rehabilitation... (per session)) are two (2). Medicare allows a maximum of two one-hour sessions per day.

9. The MUE value for CPT code 92546 (sinusoidal vertical axis rotational testing) is one (1). Since there is only one vertical axis and the word “testing” references all testing, not individual tests, only one unit of service may be reported for a patient encounter. Because it is highly unlikely that a provider would perform this testing at two separate patient encounters on the same date of service, correct reporting of this code on more than one line of a claim should be very uncommon.

10. CPT codes 92081-92083 describe visual field examinations. The visual field examination (one unit of service)

includes examination of both the right and left eyes. Additionally if a physician performs visual field examination with the eyelids in the patient's usual position and with the eyelids taped up at the same patient encounter, the visual field examination code should be reported with only one (1) unit of service.

11. The MUE value for CPT code 93568 (injection procedure during cardiac catheterization; for pulmonary angiography) is one (1). The code descriptor indicates that the angiography includes all pulmonary vessels and their branches. The code should not be reported with separate units of service for different parts of the pulmonary vasculature.

12. The code descriptor for CPT code 95887 states: "Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)". The MUE for this code is one (1) since the code descriptor includes all non-extremity "muscle(s)". A physician should not report this code with more than one (1) unit of service on more than one line of a claim for the same date of service.

13. CPT code 91122 describes anorectal manometry which includes all measurements performed at the same patient encounter. The MUE value for this code is one (1) since it is unlikely that this procedure would be performed more than once on a single date of service.

14. CPT code 95873 describes electrical stimulation for guidance in conjunction with chemodenervation, and CPT code 95874 describes needle electromyography for guidance in conjunction with chemodenervation. During a patient encounter only one of these codes may be reported with a maximum of one (1) unit of service for guidance in conjunction with chemodenervation regardless of the number of muscles chemodenervated.

15. CPT codes 90935 and 90937 describe a hemodialysis procedure (i.e., session) with single or repeated evaluations respectively by a physician or other qualified health care provider. Each of these codes may be reported with a single unit of service for a single hemodialysis procedure (i.e., session.)

CPT codes 90945 and 90947 describe a dialysis procedure (i.e., session) other than hemodialysis with single or repeated evaluations respectively by a physician or other qualified health care provider. Each of these codes may be reported with a single unit of service for a single dialysis procedure (i.e., session) other than hemodialysis.

16. CPT codes 93922 and 93923 describe bilateral noninvasive physiologic studies of the upper or lower extremities. The MUE value for each of these codes is one (1) since it is unlikely that this testing would be performed on both the upper and lower extremities on the same date of service. In the unusual situation where testing on both the upper and lower extremities are performed on the same date of service, the appropriate code may be reported on two lines of a claim each with one (1) UOS and modifier 59 appended to the code on one of the claim lines.

17. The CMS *Internet-Only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

18. Some allergy testing CPT codes (e.g., 95004, 95017-95052) are reported based on the number of individual tests performed. CMS payment policy does not allow including testing of positive or negative controls in the number of tests reported. For example, if percutaneous testing (CPT code 95018) with penicillin allergens administering six allergens plus a positive and negative control is performed, only six tests may be reported for CPT code 95018.

19. Audiologic function testing (CPT codes 92550-92588) includes testing of both ears, and only 1 unit of service for any of these CPT codes may be reported for the described testing on

both ears. If only one ear is tested, the appropriate CPT code should be reported with modifier 52.

20. The unit of service for CPT code 93505 (endomyocardial biopsy) is the procedure to obtain the endomyocardial biopsy and includes biopsy specimens from one or more endomyocardial sites.

W. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive

strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration,

and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96375 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

6. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

7. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

9. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure”

when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

10. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

11. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

12. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

13. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

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

Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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Chapter XII
Supplemental Services
HCPCS Level II Codes A0000 - V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to HCPCS codes in the range A0000-V9999. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to HCPCS Level II codes are clarified in this chapter.

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare & Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicare carriers, Fiscal Intermediaries, and A/B MACs for Part B services.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM.

The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M

service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 date 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.

C. NCCI Procedure to Procedure (PTP) Edit Specific Issues

1. HCPCS code M0064 describes a brief face-to-face office visit with a practitioner licensed to perform the service for the sole purpose of monitoring or changing drug prescriptions used in the treatment of psychiatric disorders. HCPCS code M0064 is not

separately reportable with CPT codes 90785-90853 (psychiatric services). (HCPCS code M0064 was deleted January 1, 2015.)

2. HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an evaluation and management (E&M) service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E&M service is not separately reportable. However, if a significant, separately identifiable E&M service is performed to evaluate other medical problems, both the screening pap smear and the E&M service may be reported separately. Modifier 25 should be appended to the E&M CPT code indicating that a significant, separately identifiable E&M 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 reasonable and medically necessary E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported. However, if the Medicare covered reasonable and medically necessary E&M service and the screening service, 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."

5. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82...) and A9526 (Nitrogen N-13 Ammonia...) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG,...) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

6. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic...) describes a radiopharmaceutical utilized for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

7. HCPCS code A4220 describes a refill kit for an implantable pump. It should not be reported separately with CPT codes 95990 (refilling and maintenance of implantable pump..., spinal... or brain...) or 95991 (refilling and maintenance of implantable pump,... spinal... or brain... requiring skill of physician or other qualified health care professional) since Medicare payment for these two CPT codes includes the refill kit.

Similarly, HCPCS code A4220 should not be reported separately with CPT codes 62369 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill) or 62370 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)) since Medicare payment for these two CPT codes includes the refill kit.

8. HCPCS code E0781 describes an ambulatory infusion pump utilized by a patient for infusions outside the physician office or clinic. It is a misuse of this code to report the infusion pump typically utilized in the physician office or clinic.

9. HCPCS codes G0422 and G0423 (intensive cardiac rehabilitation;...per session) include the same services as the cardiac rehabilitation CPT codes 93797 and 93798 but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as six hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) should not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation service.

Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported utilizing an NCCI-associated modifier.

10. Pulmonary rehabilitation (HCPCS code G0424) includes therapeutic services and all related monitoring services to improve respiratory function. It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)). Pulmonary rehabilitation should not be reported with HCPCS codes G0237 (therapeutic procedures to increase strength or endurance of respiratory muscles... (includes monitoring)), G0238 (therapeutic procedures to improve respiratory function... (includes monitoring)), or G0239 (therapeutic procedures to improve respiratory function or increase strength... (includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary

function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)).

Physical or occupational therapy services performed at the same patient encounter as pulmonary rehabilitation services are included in the pulmonary rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as pulmonary rehabilitation services, both types of services may be reported utilizing an NCCI-associated modifier. Similarly physical and occupational therapy services are not separately reportable with therapeutic pulmonary procedures for the same patient encounter.

Medical nutrition therapy services (CPT codes 97802-97804) performed at the same patient encounter as a pulmonary rehabilitation or pulmonary therapeutic service are included in the pulmonary rehabilitation or pulmonary therapeutic service and are not separately reportable. The Medicare program provides a medical nutrition therapy benefit to beneficiaries for medical nutrition therapy related to diabetes mellitus or renal disease. If a physician provides a Medicare covered medical nutrition service to a beneficiary with diabetes mellitus or renal disease on the same date of service as a pulmonary rehabilitation or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition therapy service may be separately reportable with an NCCI-associated modifier. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the pulmonary rehabilitation or pulmonary therapeutic service.

11. This paragraph was revised and moved to Section D (Medically Unlikely Edits (MUEs)), Paragraph 13.

12. HCPCS code G0434 (drug screen..., by CLIA waived test or moderate complexity test, per patient encounter) is utilized to report urine drug screening performed by a test that is CLIA waived or CLIA moderate complex. The code is reported with only one (1) unit of service regardless of the number of drugs screened. HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened. If a provider

performs urine drug screening, it is generally not necessary for that provider to send an additional specimen from the patient to another laboratory for urine drug screening for the same drugs.

For a single patient encounter only G0431 or G0434 may be reported. The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter. HCPCS code G0431 describes a more extensive procedure than HCPCS code G0434. Physicians should not unbundle urine drug screen testing and report HCPCS codes G0431 and G0434 for the same patient encounter.

13. *In accordance with code descriptor changes for HCPCS codes G0416-G0419 effective January 1, 2015, CMS requires that surgical pathology, including gross and microscopic examination, of any and all submitted prostate needle biopsy specimens from a single patient be reported with one unit of service of HCPCS code G0416 rather than CPT code 88305.*

Instructions for HCPCS codes G0416-G0419 in this Manual have undergone changes from year to year. For historical purposes, the prior instructions are reproduced.

From the calendar year 2015 Manual:

"13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens."

From the calendar year 2014 Manual:

"13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a

saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens."

From the calendar year 2013 Manual:

"13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens."

14. Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT code 86945 (irradiation of blood product, each unit) should not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) should not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (frozen blood, each unit; freezing...), 86931 (frozen blood, each unit; thawing), and/or 86932 (frozen blood, each unit; freezing (includes preparation) and thawing) should not be reported separately since the P code includes the freezing and thawing processes. If a P code describes a pooled blood product, CPT code 86965 (pooling of platelets or other blood products) should not be reported separately since the P code includes the pooling of the blood products. If the P code describes a "frozen" plasma product, CPT code 86927 (fresh frozen plasma, thawing, each unit) should not be reported separately since the P code includes the thawing process.

15. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes should not be reported separately with an evaluation and management (E&M), psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 should not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening" services which are not covered under the Medicare program. Where CPT codes 99408 and 99409 are covered by State Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS codes (e.g., G0442 (annual alcohol misuse screening, 15 minutes), G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS code, the HCPCS code is not separately reportable. For example, if a patient presents with symptoms suggestive of depression, the provider should not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

16. HCPCS code G0269 describes placement of an occlusive device into a venous or arterial access site after an open or percutaneous vascular procedure. Since this code is status "B" on the Medicare Physician Fee Schedule Database, payment for this service is included in the payment for the vascular procedure. For OPPS, HCPCS code G0269 has payment status indicator "N" indicating that payment is packaged into the payment for other services paid. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

17. HCPCS code V2790 (amniotic membrane for surgical reconstruction, per procedure) should not be reported separately with CPT codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since Medicare payment for these two CPT codes includes the amniotic membrane.

D. Medically Unlikely Edits (MUEs)

1 MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. MUE values of HCPCS codes for discontinued drugs are zero (0).

4. The MUE value of HCPCS codes describing compounded inhalation drugs is zero (0) because compounded drugs are not FDA approved. The CMS *Internet-Only Manual, Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.1 requires that claims

processing contractors only pay for FDA approved drugs unless CMS issues other instructions.

5. In 2011 new HCPCS code J0171 (injection, adrenalin, epinephrine, 0.1 mg) replaced deleted HCPCS code J0170 (injection, adrenalin, epinephrine, up to 1 ml ampule). HCPCS code J0170 was often reported incorrectly. A 1 ml ampule of adrenalin/epinephrine contains 1.0 mg of adrenalin/epinephrine in a 1:1,000 solution. However, a 10 ml prefilled syringe with a 1:10,000 solution of adrenalin/epinephrine also contains only 1.0 mg of adrenalin/epinephrine. Thus a physician must recognize that ten (10) units of service for HCPCS code J0171 correspond to a 1 ml ampule or 10 ml of a prefilled syringe (1:10,000 (0.1 mg/ml) solution).

6. There are two HCPCS codes describing injectable dexamethasone. HCPCS code J1094 (injection, dexamethasone acetate, 1 mg) is no longer manufactured and has an MUE value of zero(0). HCPCS code J1100 (injection, dexamethasone sodium phosphate, 1 mg) is currently available. When billing for dexamethasone, physicians should be careful to report the correct formulation with the correct HCPCS code.

7. Based on the code descriptor, HCPCS code J3471 (injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 units)) should not be reported with more than 999 units of service. Per the CMS ASP (Average Sale Price) NDC (National Drug Code) HCPCS Crosswalk table, HCPCS code J3472 (injection, hyaluronidase, ovine, preservative free, per 1000 USP units) should be reported for a product that is no longer available. Therefore, if a physician utilizes more than 999 USP units of the product described by J3471, the physician may report HCPCS code J3471 on more than one line of a claim appending modifier 59 to additional claim lines and should report no more than 999 units of service on any one claim line.

8. The Medically Unlikely Edit (MUE) values for practitioner services for oral immunosuppressive, oral anti-cancer, and oral anti-emetic drugs are set at zero (0). Practitioners providing these medications to patients must bill the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), rather than the Part A/Part B Medicare Administrative Contractors (A/B MACs), using the National Drug Codes(NDC). A/B MACs do not pay codes for these oral medications when submitted on practitioner claims. The MUE values for outpatient hospital services are based on the amount of drug that might be

administered to a patient on a single date of service. Facilities may not report to the A/B MAC more than a one day supply of any of these drugs for a single date of service. Outpatient hospital facilities may submit claims to DME MACs for a multiple day supply of these drugs provided on a single date of service.

9. If a HCPCS drug code descriptor defines the unit of service as "per dose", only one (1) UOS may be reported per drug administration procedure even if more than the usual amount of drug is administered. For example, HCPCS code J7321 (Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose) describes a drug that may be injected into the knee joint. Only one (1) UOS may be reported for injection of the drug into each knee joint even if the amount of injected drug exceeds the usual amount of drug injected.

10. The MUE values for HCPCS codes G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) are one (1) since the UOS for each code is defined as "per patient encounter" and the likelihood that a patient needs this type of testing at more than one encounter on a single date of service is very small. These codes include all drug screening at the patient encounter and should not be reported with multiple UOS at the same patient encounter.

11. HCPCS codes Q9951 and Q9965-Q9967 describe low osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered. The MUE value for HCPCS code Q9951 (Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml) is zero (0). When this MUE value was established, no low osmolar contrast material products with iodine concentration of 400 mg iodine or greater per ml were identified. HCPCS code Q9951 is often incorrectly reported for low osmolar contrast material products with lower iodine concentrations. Similarly HCPCS codes Q9958-Q9964 describe high osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered.

12. HCPCS code K0462 (Temporary replacement for patient owned equipment being repaired, any type) may be reported with

one (1) unit of service (UOS) for each item of patient owned equipment that is being repaired. Component parts of a patient owned piece of equipment being repaired should not be reported separately. For example, if a patient owned CPAP (continuous positive airway pressure) blower requires repair, the supplier may report one (1) UOS for K0462. The supplier should not report an additional UOS for an integral humidifier even if it also requires repair. Additionally the supplier should not report an additional UOS for a detachable humidifier unless it also requires repair at the same time.

13. Generally only one unit of service for an item of durable medical equipment (DME) (e.g., oxygen concentrator, wheelchair base) may be paid on a single date of service. Medicare does not allow payment for backup or duplicate durable medical equipment. More than one unit of service may be paid on a single date of service for accessories and supplies related to DME when appropriate. Prosthetics and orthotics may also be paid with more than one unit of service on a single date of service when appropriate.

14. HCPCS code P9604 describes a flat rate one way travel allowance for collection of medically necessary laboratory specimen(s) drawn from a home bound or nursing home bound patient. A round trip should be reported with modifier LR and one (1) unit of service (UOS) rather than two (2) UOS. The reported UOS should be prorated for multiple patients drawn at the same address and for stops at the homes of Medicare and non-Medicare patients as described in the Medicare Internet-Only Manual, Publication 100-04 (Medicare Claims Processing Manual), Chapter 16 (Laboratory Services), Section 60.2.

15. The CMS *Internet-Only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on

different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

16. HCPCS codes G0406-G0408 describe follow-up inpatient consultation services via telehealth and HCPCS codes G0425-G0427 describe emergency or initial inpatient telehealth consultation services via telehealth. These codes should not be reported by a practitioner on the same date of service that the practitioner reports a face-to-face evaluation and management code. These codes are utilized to report telehealth services that, if performed with the patient physically present, would be reported with corresponding CPT codes.

Since follow-up inpatient consultation services with a patient present are reported utilizing per diem CPT codes 99231-99233, HCPCS codes G0406-G0408 may only be reported with a single unit of service per day.

Since initial inpatient consultation services with a patient present are reported utilizing per diem CPT codes 99231-99233, HCPCS codes G0425-G0427 may only be reported with a single unit of service per day when reporting inpatient telehealth consultation services. However, if HCPCS codes G0425-G0427 are utilized to report emergency department services, reporting rules are comparable to CPT codes 99281-99285.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

6. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

7. Closure/repair of a surgical incision is included in the global surgical package except as noted below. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM. Simple, intermediate, and complex wound repair codes may be reported with

Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes (CPT codes 12001-13153) should not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

9. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

10. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of

the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

11. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

12. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

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CHAPTER XIII
Category III Codes
CPT Codes 0001T – 0999T
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

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Category III Codes
CPT Codes 0001T – 0999T

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 0001T-0999T. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

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 sections 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 Initiative Policy Manual for Medicare Services"*.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with

procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting

E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 date 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.

C. NCCI Procedure to Procedure (PTP) Edit Specific Issues

1. CPT code 0183T is deleted effective January 1, 2014 and replaced by CPT code 97610. This paragraph was relocated to Chapter XI, Section P. (Physical Medicine and Rehabilitation), Paragraph 7.

2. Since CPT code 0197T (intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy...) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields), 77014 (computed tomography guidance for placement of radiation therapy fields), or 77421 (stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy). (CPT codes 0197T and 77421 were deleted on January 1, 2015)

D. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient

Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

2. Providers reporting services under Medicare’s hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

3. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

4. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

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, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

6. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

7. Closure/repair of a surgical incision is included in the global surgical package except as noted below. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical incisions for procedures with global surgery indicators of 000, 010, 090, or MMM. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes (CPT codes 12001-13153) should not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

8. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

9. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

10. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding

rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

11. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

12. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.