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

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Chapter I
General Correct Coding Policies

A. Introduction

Healthcare providers utilize HCPCS/CPT codes to report medical services performed on patients to Medicare Carriers 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 Assoication's (AMA) *CPT Manual* which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare and 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. There are two NCCI edit tables: "Column One/Column Two Correct Coding Edit Table" and "Mutually Exclusive Edit Table". 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.) All edits are included in the "Column One/Column Two Correct Coding Edit Table" except those that are based on the "mutually exclusive" (Chapter I, Section P) and "gender specific" (Chapter I, Section Q) criteria in which case the edits are included in the "Mutually Exclusive Edit Table".

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 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.

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 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 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; positioning of patient
- Insertion of intravenous access for medication administration
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia section)
- 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, simple debridement of traumatized tissue, lysis of simple 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 including analgesic devices (peri-incisional TENS unit, institution of Patient Controlled Analgesia)
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where CMS policy permits separate payment

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

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

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

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

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

Specific examples consist of:

<u>Medical:</u>

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

interpretation, since it is an integral component of the interpretation.

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

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

Surgical:

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

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

3. Lysis of adhesions and exploratory laparotomy reported with colon resection or other abdominal surgery. These

procedures represent gaining access to the organ system of interest and are not separately reported.

C. Medical/Surgical Package

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

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

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

Furthermore, CPT codes describing services to gain visualization of the airway (nasal endoscopy, laryngoscopy, bronchoscopy) were created for the purpose of coding a diagnostic or therapeutic

service and are not to be reported as a part of intubation services.

When vascular access is obtained, the access generally requires maintenance of an infusion or use of an anticoagulant (heparin lock injection) (e.g., HCPCS/CPT codes 90760-90775, C8950-C8952). These services are necessary for the maintenance of the access and are not to be separately reported. Additionally, use of an anticoagulant for access maintenance cannot be separately reported (e.g., CPT code 37201).

The global surgical package includes the administration of fluids and drugs during the operative procedure. CPT codes 90760-90775 should not be separately reported.

Under the Outpatient Prospective Payment System (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 HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

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

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

2. When anesthesia is provided by the physician performing the primary service, the anesthesia services are included in the primary procedure (CMS Anesthesia Rules), and the operating physician should not report CPT codes 90760-90775 for administration of anesthetic agents. If it is medically

necessary for a separate provider (anesthesiologist/ anesthetist) to provide the anesthesia services (e.g., monitored anesthesia care), a separate service may be reported.

3. Many procedures require cardiopulmonary monitoring, either by the physician performing the procedure or an anesthesiologist/certified registered nurse anesthetist. Because these services are integral and routine, they are not reported separately. Examples of these types of services are cardiac monitoring, intermittent EKG procurement, oximetry or ventilation management (e.g., CPT codes 93000, 93005, 93040, 93041, 94656, 94760, 94761, 94770.

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

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

6. When a definitive surgical procedure requires access through abnormal tissue (e.g., diseased skin, abscess, hematoma,

seroma, etc.), separate services for this access (e.g., debridement, incision and drainage) are not reported. For example, if a patient presents with a pilonidal cyst and it is determined that it is medically necessary to excise this cyst, it would be appropriate to submit a bill for CPT code 11770 (excision of pilonidal cyst); it would not, however, be appropriate to also report CPT code 10080 (incision and drainage of pilonidal cyst), as it was necessary to perform the latter to accomplish the primary procedure.

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

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

9. When an endoscopic service is performed to establish the location of a lesion, confirm the presence of a lesion, establish anatomic landmarks, or define the extent of a lesion, the endoscopic service is not separately reported as it is a medically necessary part of the overall surgical service. Additionally, when an endoscopic procedure fails and is converted to an open procedure, only the successful open procedure may be reported. For example, if a failed laparoscopic cholecystectomy is converted to an open cholecystectomy, only the open cholecystectomy may be reported.

10. A number of CPT codes describe services necessary to address the treatment of complications of the primary procedure (e.g., bleeding or hemorrhage). When the services described by

CPT codes as complications of a primary procedure require a return to the operating room, they may be reported separately; generally, due to global surgery policy, they should be reported with modifier -78 indicating that the service necessary to treat the complication required a return to the operating room during the postoperative period. When a complication described by codes defining complications arises during an operative session, however, a separate service for treating the complication is not to be reported. An operative session ends upon release from the operating or procedure suite (as defined in MCM §4821 or *Internet-Only Manuals (IOM), Medicare Claims Processing Manual,* Publication 100-04, Chapter 12, Section 40.1).

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, or ZZZ. 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.

Since NCCI 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 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. 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. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

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

E. Modifiers and Modifier Indicators

1. In order to expand the information provided by CPT codes, a number of modifiers have been created by the AMA, and the CMS. These modifiers, in the form of two characters, either numbers, letters, or a combination of each, are intended to transfer specific information regarding a certain procedure or service. Modifiers are attached to the end of a HCPCS/CPT code and give the physician a mechanism to indicate that a service or procedure has been modified by some circumstance but is still described by the code definition.

Like CPT codes, the use of modifiers (either AMA or CMS-defined modifiers) requires explicit understanding of the purpose of each modifier. It is also important to identify when the purpose of a

modifier has been expanded or restricted by a third party payer. It is essential to understand the specific meaning of the modifier by the payer to which a claim is being submitted before using it.

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

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

b. **Modifier -25**: Modifier –25 is identified in the *CPT Manual* as a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service". This modifier may be appended to an evaluation and management (E&M) code reported with another procedure on the same day of service. The NCCI includes edits bundling E&M codes into various procedures not covered by global surgery rules. If in addition to the procedure the physician performs a significant and separately identifiable E&M service beyond the usual pre-procedure, intra-procedure, and post-procedure physician work, the E&M may be reported with modifier –25 appended. The E&M and procedure(s) may be related to the same or different diagnoses.

c. **Modifier -58:** Modifier -58 is described as a "staged or related procedure or service by the same physician during the postoperative period." It indicates that a procedure was

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

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

NCCI 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 if the two procedures are performed at different anatomic sites or different patient encounters. Carrier 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 edit unless the proper criteria for use of the modifier is 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 consisting of two surgical procedures or two diagnostic procedures 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.

An exception to this general principle about misuse of modifier –59 applies to some code pair edits consisting of a surgical procedure and a diagnostic procedure. If the diagnostic procedure precedes the surgical procedure and is the basis on which the decision to perform the surgical procedure is made, the two procedures may be reported with modifier -59 under appropriate circumstances. However, if the diagnostic procedure is an inherent component of the surgical procedure, it cannot be reported separately. If the diagnostic procedure follows the surgical procedure at the same patient encounter, modifier -59 may be utilized if appropriate.

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 or different lesions in the same

organ. However, 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 a single anatomic site. Treatment of posterior segment structures in the eye constitute a single anatomic site.

Example: 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 38221 and 38220 are different procedures, they are bundled when performed through the same skin incision at a single patient encounter.

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

NCCI-associated modifiers include:

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

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

the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations as recognized by coding conventions. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers generally should not be utilized.

F. Standard Preparation/Monitoring Services

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

G. Anesthesia Service Included in the Surgical Procedure

Under the CMS Anesthesia Rules, 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 service. 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 may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by same physician performing the

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 service include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion/injection (CPT codes 90760-90768, 90774-90775). 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.

H. HCPCS/CPT Procedure Code Definition

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

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

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

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

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

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

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

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

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

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

I. HCPCS/CPT Coding Manual Instruction/Guideline

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

J. Separate Procedure

If a HCPCS/CPT code descriptor includes the term “separate procedure”, the HCPCS/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 through the same skin incision, orifice, or surgical approach.

If a HCPCS/CPT code with the “separate procedure” designation is performed at a separate patient encounter on the same date of service or at the same patient encounter through a separate skin incision, orifice, or surgical approach, it may be reported in addition to another procedure. Modifier -59 may be appended to the “separate procedure” HCPCS/CPT code to indicate that it qualifies as a separately reportable service.

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

K. Family of Codes

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

L. More Extensive Procedure

When procedures are performed together that are basically the same, or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is included in the more extensive procedure. In the following situations, the procedure viewed as the more complex would be reported:

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

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

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

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

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

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

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

M. Sequential Procedure

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

failed laparoscopic cholecystectomy followed by an open cholecystectomy at the same session. Only the code for the successful procedure, in this case the open cholecystectomy, should be reported.

N. Laboratory Panel

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

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

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

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

O. Misuse of Column Two Code with Column One Code

In general, CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating “with or without” a service.) A provider should not report a CPT code out of the context for which it was intended. Providers who are familiar with procedures or services described in areas or sections of CPT will understand the specific language of the descriptor as well as the intent for which the code was developed. On the other hand, a provider who, for example, is unfamiliar with an area of CPT may fail to understand the intent of certain codes. Either intentionally or unintentionally, a provider may report a service or procedure using a CPT code that

may be construed to describe the service/procedure but that, in no way, was intended to be used in this fashion.

CPT codes describing services or procedures that would not typically be performed with other services or procedures but may be construed to represent other services have been identified and paired with the column one CPT codes. Additionally, pairs of codes have been identified which would not be reported together because another code more accurately describes the services performed.

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

P. Mutually Exclusive 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.

CPT codes that are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same patient encounter can be identified as code pairs. These code pairs should not be reported together. In order to identify these code pairs, an independent table of mutually exclusive edits has been developed as part of the NCCI.

Many edits in the mutually exclusive edit table allow the use of NCCI-associated modifiers. For example, the two procedures of a code pair edit may be performed at different anatomic sites (eg, contralateral eyes) or separate patient encounters on the same date of service.

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

Many procedure codes have a gender-specific classification within their narrative. These codes are not reported with codes having the opposite gender designation because this would reflect a conflict in gender classification either by the definition of the code descriptions themselves (as they appear in the *CPT Manual*) or by the fact that the performance of these procedures on the same patient would be anatomically impossible.

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

R. Add-on Codes

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

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

edits with add-on codes 69990 (microsurgical techniques requiring use of operating microscope) and 95920 (intraoperative neurophysiology testing).

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

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

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

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

S. Excluded Service

Because some procedures are identified as excluded from coverage under the Medicare program as "excluded services", there is no need to address the issue of correct coding with these codes. In

the development of National Correct Coding Policy and Correct Coding Edits, these excluded services have been ignored.

T. Unlisted Service or Procedure

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

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

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

correspondence is received from the AMA, national medical societies, CMS Central and Regional Offices, Contractor Medical Directors, Medicare Part B carriers, individual providers, physicians' consultants and other interested parties. The comments and recommendations are evaluated and considered for possible modification or deletion of existing code pairs/edits or additions of new code pairs/edits. Subsequently based on the contributions from these sources, CMS Central Office decides which code pairs/edits are modified, deleted, or added.

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 allowable by the same provider for the same beneficiary on the same date of service. Units of service in excess of an MUE are denied. MUEs do not exist for all HCPCS/CPT codes. At the current time, there is no modifier that will bypass an MUE.

The scheduled effective date for MUEs is January 1, 2007. Edits will be added in a multi-phasic process. Initial MUEs will be based on anatomic considerations. For example, the MUE for a hysterectomy will be one since the vast majority of women have only one uterus.