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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

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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-*96377*) 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-*96377* 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-*96377*) 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-*96377* 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, *62320-62327*, 64400-64489, and 96360-*96377* 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.

CPT codes 90832-90838 include all psychotherapy *provided to a patient* with family members *as informants,* if present, for a single date of service. *Family psychotherapy (e.g., CPT codes 90846, 90847) focused on the patient addressing interactions between the patient and family members may be reported separately with psychotherapy CPT codes 90832-90838 on the same date of service if performed as a separate and distinct service during a separate time interval.*

Psychotherapy (CPT codes 90832-90838) performed in a Medicare partial hospitalization setting may be reported with more than one unit of service to reflect the amount of psychotherapy provided during 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 9101*1*0-91299 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, *92242,* 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 *69209 (removal of impacted cerumen using irrigation/lavage, unilateral) or* 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. *(Medicare does not pay separately for PCI in a branch of a major coronary artery as this payment is included in the payment for the PCI code for the corresponding major coronary artery.)* 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*n episode of care* 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.

An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility.

If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.

If inhalation drugs are administered in a continuous treatment or a series of "back-to-back" treatments exceeding one hour, CPT codes 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) should be reported instead of CPT code 94640.

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 *96360-96375, 96377* 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. *(CPT codes 90780, 96408, 96410 were deleted January 1, 2006.)*

O. Special Dermatological Procedures

1. 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.

2. Reflectance confocal microscopy (CPT codes 96931-96936) is performed to determine whether a skin lesion is malignant. Procedure to procedure edits allow physicians to report on the

same date of service excision of the lesion if malignant, but not biopsy or excision of the lesion if benign.

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 *97164* and *97168* 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 *97164* or *97168* 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 90849 (multiple family group psychotherapy) and 90853 (Group psychotherapy (other than of a multiple family group)) is *each separate and distinct therapy session* even if it lasts longer than one hour. *These are not timed codes and should not be reported with a unit of service (UOS) corresponding to any particular time interval.* 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 *group or multiple* family *group* therapy session provided by a different practitioner.

Prior to January 1, 2017 the unit of service for CPT codes 90846 (family psychotherapy (without the patient present)), 90847 (Family psychotherapy (conjoint psychotherapy) (with patient present))was each separate and distinct therapy session regardless of the length of time of the session. A practitioner could only report one unit of service for each day of family therapy, and an outpatient facility could report one unit of service for each separate and distinct therapy session provided by a different practitioner.

Effective January 1, 2017, the code descriptors for CPT codes 90846 (family psychotherapy (without the patient present), 50 minutes) and 90847 (family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes) were modified.

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.

21. Physical therapy evaluation (CPT codes 97161-97163) and occupational therapy evaluation (CPT codes 97165-97167) should not be reported with more than one unit of service (UOS) per episode of care. Physical therapy re-evaluation (CPT code 97164) and occupational therapy re-evaluation (CPT code 97168) should

not be reported with more than one unit of service (UOS) per date of service.

22. CPT code 92941 describes percutaneous transluminal revascularization of an acute total/subtotal occlusion of a coronary artery or coronary artery bypass graft during an acute myocardial infarction. This code may be reported with one unit of service. If additional revascularization procedures of coronary arteries or coronary artery bypass grafts are performed at the same patient encounter, these procedures should not be reported with CPT code 92941, but with other CPT codes such as 92920, 92924, and/or 92943.

W. General Policy Statements

1. *MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.*

2. 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.

3. 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.

4. 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.*

5. 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*.

6. 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, *62320-62327*, 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-*96377*) 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 *99151-99153*) when provided by the same physician performing a medical or surgical procedure.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-*96377*) 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-*96377* 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, *62320-62327*, 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.

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. 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.

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. 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.

11. 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.

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.