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CHAPTER XII
SUPPLEMENTAL SERVICES
HCPCS LEVEL II CODES A0000 - V9999
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 HCPCS codes in the range A0000-V9999. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

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

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

Specific issues unique to HCPCS Level II codes are clarified in this chapter.

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare & Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicare carriers, Fiscal Intermediaries, and A/B MACs for Part B services.

B. Evaluation and Management (E&M) Services

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

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM.

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

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

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

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

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M

service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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

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

C. NCCI *Procedure to Procedure (PTP) Edit* Specific Issues

1. HCPCS code M0064 describes a brief face-to-face office visit with a practitioner licensed to perform the service for the sole purpose of monitoring or changing drug prescriptions used in the treatment of psychiatric disorders. HCPCS code M0064 is not

separately reportable with CPT codes 90785-90853 (psychiatric services). *(HCPCS code M0064 was deleted January 1, 2015.)*

2. HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an evaluation and management (E&M) service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E&M service is not separately reportable. However, if a significant, separately identifiable E&M service is performed to evaluate other medical problems, both the screening pap smear and the E&M service may be reported separately. Modifier 25 should be appended to the E&M CPT code indicating that a significant, separately identifiable E&M service was rendered.

3. HCPCS code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E&M) services under certain circumstances. If a Medicare covered reasonable and medically necessary E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported. However, if the Medicare covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

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

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

5. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82...) and A9526 (Nitrogen N-13 Ammonia...) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG,...) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

6. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic...) describes a radiopharmaceutical utilized for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

7. HCPCS code A4220 describes a refill kit for an implantable pump. It should not be reported separately with CPT codes 95990 (refilling and maintenance of implantable pump..., spinal... or brain...) or 95991 (refilling and maintenance of implantable pump,... spinal... or brain... requiring skill of physician or other qualified health care professional) since Medicare payment for these two CPT codes includes the refill kit.

Similarly, HCPCS code A4220 should not be reported separately with CPT codes 62369 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill) or 62370 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)) since Medicare payment for these two CPT codes includes the refill kit.

8. HCPCS code E0781 describes an ambulatory infusion pump utilized by a patient for infusions outside the physician office or clinic. It is a misuse of this code to report the infusion pump typically utilized in the physician office or clinic.

9. HCPCS codes G0422 and G0423 (intensive cardiac rehabilitation;...per session) include the same services as the cardiac rehabilitation CPT codes 93797 and 93798 but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as six hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) should not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation service.

Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported utilizing an NCCI-associated modifier.

10. Pulmonary rehabilitation (HCPCS code G0424) includes therapeutic services and all related monitoring services to improve respiratory function. It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)). Pulmonary rehabilitation should not be reported with HCPCS codes G0237 (therapeutic procedures to increase strength or endurance of respiratory muscles... (includes monitoring)), G0238 (therapeutic procedures to improve respiratory function... (includes monitoring)), or G0239 (therapeutic procedures to improve respiratory function or increase strength... (includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary

function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)).

Physical or occupational therapy services performed at the same patient encounter as pulmonary rehabilitation services are included in the pulmonary rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as pulmonary rehabilitation services, both types of services may be reported utilizing an NCCI-associated modifier. Similarly physical and occupational therapy services are not separately reportable with therapeutic pulmonary procedures for the same patient encounter.

Medical nutrition therapy services (CPT codes 97802-97804) performed at the same patient encounter as a pulmonary rehabilitation or pulmonary therapeutic service are included in the pulmonary rehabilitation or pulmonary therapeutic service and are not separately reportable. The Medicare program provides a medical nutrition therapy benefit to beneficiaries for medical nutrition therapy related to diabetes mellitus or renal disease. If a physician provides a Medicare covered medical nutrition service to a beneficiary with diabetes mellitus or renal disease on the same date of service as a pulmonary rehabilitation or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition therapy service may be separately reportable with an NCCI-associated modifier. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the pulmonary rehabilitation or pulmonary therapeutic service.

11. *This paragraph was revised and moved to Section D (Medically Unlikely Edits (MUEs)), Paragraph 13.*

12. HCPCS code G0434 (drug screen..., by CLIA waived test or moderate complexity test, per patient encounter) is utilized to report urine drug screening performed by a test that is CLIA waived or CLIA moderate complex. The code is reported with only one (1) unit of service regardless of the number of drugs screened. HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened. If a provider

performs urine drug screening, it is generally not necessary for that provider to send an additional specimen from the patient to another laboratory for urine drug screening for the same drugs.

For a single patient encounter only G0431 or G0434 may be reported. The testing described by G0431 includes all CLIA high complexity urine drug screen testing as well as any less complex urine drug screen testing performed at the same patient encounter. HCPCS code G0431 describes a more extensive procedure than HCPCS code G0434. Physicians should not unbundle urine drug screen testing and report HCPCS codes G0431 and G0434 for the same patient encounter.

13. HCPCS codes G0416-G0419 describe surgical pathology, including gross and microscopic examination, of separately identified and submitted prostate needle biopsy specimens from a saturation biopsy sampling procedure. CMS requires that these codes rather than CPT code 88305 be utilized to report surgical pathology on prostate needle biopsy specimens only if the number of separately identified and submitted needle biopsy specimens is ten or more. Surgical pathology on nine or fewer separately identified and submitted prostate needle biopsy specimens should be reported with CPT code 88305 with the unit of service corresponding to the number of separately identified and submitted biopsy specimens.

14. Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT code 86945 (irradiation of blood product, each unit) should not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) should not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (frozen blood, each unit; freezing...), 86931 (frozen blood, each unit; thawing), and/or 86932 (frozen blood, each unit; freezing (includes preparation) and thawing) should not be reported separately since the P code includes the freezing and thawing processes. If a P code describes a pooled blood product, CPT code 86965 (pooling of platelets or other blood products) should not be reported separately since the P code includes the pooling of the blood products. If the P code describes a “frozen” plasma product, CPT code 86927 (fresh frozen plasma, thawing, each unit) should not be reported separately since the P code includes the thawing process.

15. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes should not be reported separately with an evaluation and management (E&M), psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 should not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening" services which are not covered under the Medicare program. Where CPT codes 99408 and 99409 are covered by State Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS codes (e.g., G0442 (annual alcohol misuse screening, 15 minutes), G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS code, the HCPCS code is not separately reportable. For example, if a patient presents with symptoms suggestive of depression, the provider should not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

16. HCPCS code G0269 describes placement of an occlusive device into a venous or arterial access site after an open or percutaneous vascular procedure. Since this code is status "B" on the Medicare Physician Fee Schedule Database, payment for this service is included in the payment for the vascular procedure. For OPPS, HCPCS code G0269 has payment status indicator "N" indicating that payment is packaged into the payment for other services paid. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

17. HCPCS code V2790 (amniotic membrane for surgical reconstruction, per procedure) should not be reported separately with CPT codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since Medicare payment for these two CPT codes includes the amniotic membrane.

D. Medically Unlikely Edits (MUEs)

1 MUEs are described in Chapter I, Section V.

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

3. MUE values of HCPCS codes for discontinued drug*s* are zero (0).

4. The MUE value of HCPCS codes describing compounded inhalation drugs is zero (0) because compounded drugs are not FDA approved. The CMS *Internet-Only Manual, Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.1 requires that claims

processing contractors only pay for FDA approved drugs unless CMS issues other instructions.

5. In 2011 new HCPCS code J0171 (injection, adrenalin, epinephrine, 0.1 mg) replaced deleted HCPCS code J0170 (injection, adrenalin, epinephrine, up to 1 ml ampule). HCPCS code J0170 was often reported incorrectly. A 1 ml ampule of adrenalin/epinephrine contains 1.0 mg of adrenalin/epinephrine in a 1:1,000 solution. However, a 10 ml prefilled syringe with a 1:10,000 solution of adrenalin/epinephrine also contains only 1.0 mg of adrenalin/epinephrine. Thus a physician must recognize that ten (10) units of service for HCPCS code J0171 correspond to a 1 ml ampule or 10 ml of a prefilled syringe (1:10,000 (0.1 mg/ml) solution).

6. There are two HCPCS codes describing injectable dexamethasone. HCPCS code J1094 (injection, dexamethasone acetate, 1 mg) is no longer manufactured and has an MUE value of zero(0). HCPCS code J1100 (injection, dexamethasone sodium phosphate, 1 mg) is currently available. When billing for dexamethasone, physicians should be careful to report the correct formulation with the correct HCPCS code.

7. Based on the code descriptor, HCPCS code J3471 (injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 units)) should not be reported with more than 999 units of service. Per the CMS ASP (Average Sale Price) NDC (National Drug Code) HCPCS Crosswalk table, HCPCS code J3472 (injection, hyaluronidase, ovine, preservative free, per 1000 USP units) should be reported for a product that is no longer available. Therefore, if a physician utilizes more than 999 USP units of the product described by J3471, the physician may report HCPCS code J3471 on more than one line of a claim appending modifier 59 to additional claim lines and should report no more than 999 units of service on any one claim line.

8. The Medically Unlikely Edit (MUE) values for practitioner services for oral immunosuppressive, oral anti-cancer, and oral anti-emetic drugs are set at zero (0). Practitioners providing these medications to patients must bill the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), rather than the Part A/Part B Medicare Administrative Contractors (A/B MACs), using the National Drug Codes(NDC). A/B MACs do not pay codes for these oral medications when submitted on practitioner claims. The MUE values for outpatient hospital services are based on the amount of drug that might be

administered to a patient on a single date of service. Facilities may not report to the A/B MAC more than a one day supply of any of these drugs for a single date of service. Outpatient hospital facilities may submit claims to DME MACs for a multiple day supply of these drugs provided on a single date of service.

9. The MUE values for HCPCS codes G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) are one (1) since the UOS for each code is defined as “per patient encounter” and the likelihood that a patient needs this type of testing at more than one encounter on a single date of service is very small. These codes include all drug screening at the patient encounter and should not be reported with multiple UOS at the same patient encounter.

10. HCPCS codes Q9951 and Q9965-Q9967 describe low osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered. The MUE value for HCPCS code Q9951 (Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml) is zero (0). When this MUE value was established, no low osmolar contrast material products with iodine concentration of 400 mg iodine or greater per ml were identified. HCPCS code Q9951 is often incorrectly reported for low osmolar contrast material products with lower iodine concentrations. Similarly HCPCS codes Q9958-Q9964 describe high osmolar contrast material with different iodine concentrations. The appropriate code to report is based on the iodine concentration in the contrast material administered.

11. Generally only one unit of service for an item of durable medical equipment (DME) (e.g., oxygen concentrator, wheelchair base) may be paid on a single date of service. Medicare does not allow payment for backup or duplicate durable medical equipment. More than one unit of service may be paid on a single date of service for accessories and supplies related to DME when appropriate. Prosthetics and orthotics may also be paid with more than one unit of service on a single date of service when appropriate.

12. 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.

13. HCPCS codes G0406-G0408 describe follow-up inpatient consultation services via telehealth and HCPCS codes G0425-G0427 describe emergency or initial inpatient telehealth consultation services via telehealth. These codes should not be reported by a practitioner on the same date of service that the practitioner reports a face-to-face evaluation and management code. These codes are utilized to report telehealth services that, if performed with the patient physically present, would be reported with corresponding CPT codes.

Since follow-up inpatient consultation services with a patient present are reported utilizing per diem CPT codes 99231-99233, HCPCS codes G0406-G0408 may only be reported with a single unit of service per day.

Since initial inpatient consultation services with a patient present are reported utilizing per diem CPT codes 99231-99233, HCPCS codes G0425-G0427 may only be reported with a single unit of service per day when reporting inpatient telehealth consultation services. However, if HCPCS codes G0425-G0427 are utilized to report emergency department services, reporting rules are comparable to CPT codes 99281-99285.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some

sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules *[e.g., CMS Internet-Only Manual, Publication 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS Internet-Only Manual, Publication 100-04 (Medicare Claims Processing Manual), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)]* do not apply to hospitals.

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

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

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

5. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical

procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

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

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

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

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62310-62319, 64400-6448*9*, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

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

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

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

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

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

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

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

modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

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

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

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