# CHAPTER XI

## MEDICINE
## EVALUATION AND MANAGEMENT SERVICES
## CPT CODES 90000 – 99999

## NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICAID SERVICES

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## A. Introduction

The principles of correct coding discussed in Chapter I apply to *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 shall report the HCPCS/*CPT* code that describes the procedure performed to the greatest specificity possible. A HCPCS/*CPT* code shall be reported only if all services described by the code are performed. A physician shall not report multiple HCPCS/*CPT* codes if a single HCPCS/*CPT* code exists that describes the services performed. This type of unbundling is incorrect coding.

The HCPCS/*CPT* codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician shall 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 PTP-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) shall 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 shall not be reported separately. Similarly, the fluid utilized to administer drug(s)/substance(s) is incidental hydration and shall 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 shall 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) 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 Medicaid for practitioner services.

8. The drug and chemotherapy administration *CPT* codes 96360-96375 and 96401-96425 include the services 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 shall not report drug administration services in a facility setting, a facility based evaluation and management *CPT* code (e.g., 99281-99285) shall 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 Medicaid.

Hospital outpatient facilities, 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 shall 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) shall 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 for hospital outpatient facilities, *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)) shall not be reported with HCPCS/*CPT* code C8957 (initiation of prolonged intravenous infusion (more than 8 hours)).

*CPT* codes 96521 and 96522 shall 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. With the exception of moderate conscious sedation (see below), the NCCI program does not allow separate reporting of anesthesia services for a medical or surgical service when it is provided by the physician performing the service.

Drug administration services, *CPT* codes 96360-96377 shall not be reported for anesthesia provided by the physician performing a medical or surgical service.

Separate reporting for moderate conscious sedation services (*CPT* codes 99151-99153) is allowed when it is provided by the same physician performing a medical or surgical procedure.

12. Under the NCCI program, 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 shall not report *CPT* codes 96360-96376 for these services.

Under the NCCI program postoperative pain management is not separately reportable when it is 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 PTP-associated modifier if performed in a non-facility site of service.

13. Administration of most immunizations is reported with *CPT* codes 90460-90461 or 90471-90474 depending upon the patient’s age and physician counseling of the patient/family. Some states may utilize HCPCS codes G0008, G0009, or G0010 to report administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine, respectively.

In those situations, providers shall not report both a *CPT* code and a G code for the same vaccine.

14. If one or more immunizations and a significant, separately identifiable evaluation and management (E&M) service are rendered by a physician on the same date of service, both the immunization administration code (e.g., *CPT* codes 90460-

90474) and the E&M code with modifier 25 appended may be reported. If the patient returns on another day solely to receive another immunization, only the immunization administration code shall be reported.

15. 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.

*16.* *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 shall 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 of 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.

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) shall 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) *was* not separately reportable with diagnostic or therapeutic psychiatric services (*CPT* codes 90785-90845, 90847-90880). HCPCS code M0064 require*d* face-to-face patient contact by the practitioner licensed to perform the service. Facilities may *have* report*ed* HCPCS code M0064 (pharmacologic management services) with a psychotherapy code if the two services *had been* 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 separately reportable on the same date of service as psychoanalysis (*CPT* code 90845), narcosynthesis (*CPT* code 90865), or hypnotherapy (*CPT* code 90880) only if the E&M service is separate and distinct from the psychiatric 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.

HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. If a state Medicaid program uses these codes, they shall 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 shall 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 PTP-

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. 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. Codes 99408/99409 shall not be reported in addition to codes G0396/G0397.

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 shall 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) shall 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, 90947, G0491, and G0492 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. The NCCI program 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.

Under the NCCI program, any E&M service that is related to the renal failure (e.g., hypertension, fluid overload, uremia, electrolyte imbalance) or to the dialysis procedure and that is performed on the same date of service as the dialysis procedure shall 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. Gastroenterology procedures included in *CPT* code ranges 43753-43757 and 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology when performed are integral components of an esophagogastroduodenoscopy (e.g., *CPT* code 43235). Gastric or duodenal intubation with or without aspiration (e.g., *CPT* codes 43753, 43754, 43756) shall 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 shall not report *CPT* codes 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 shall 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) shall 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.

Fundus photography (*CPT* code 92250) and scanning ophthalmic computerized diagnostic imaging (e.g., *CPT* codes 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.

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 as an elective posterior segment ophthalmic surgical procedure.

*5.* *CPT* code 92071 (fitting of contact lens for treatment of ocular surface disease) shall 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. The *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, 97530 *or G0515,* which are generally performed by physical or occupational therapists. Speech language pathologists shall not report

*HCPCS/CPT* codes 97110, 97112, 97150, 97530, 97127 *or G0515* as unbundled services included in the services coded as 92507, 92508, or 92526.*(CPT code 97532 was deleted on January 1, 2018.)*

3. A single practitioner shall 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 *HCPCS/CPT* codes 97127 (therapeutic interventions that focus on cognitive function . . .)*,* 97533 (sensory integrative techniques to enhance . . .)*, or G0515 (development of cognitive skills to improve . . .)*.

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 *HCPCS/CPT* codes 97127*,* 97533 *and/or G0515,* a provider entity that employs both types of practitioners may report both services utilizing an NCCI PTP-associated modifier. *(CPT code 97532 was deleted on January 1, 2018.)*

4. Treatment of swallowing dysfunction and/or oral function for feeding (*CPT* code 92526) may utilize electrical stimulation. The HCPCS code G0283 (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) shall not be reported with *CPT* code 92526 for electrical stimulation during the procedure. The NCCI PTP edit (92526/G0283) for practitioner service claims does not allow use of NCCI PTP-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 for outpatient hospital facility claims does allow use of NCCI PTP-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 shall 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 shall 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 PTP-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) shall 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)) shall 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 shall 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) shall not be included in critical care E&M service time.

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 shall 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 shall not be included in the critical care time.

3. 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.

4. Cardiac output measurements (*CPT* codes 93561-93562) are routinely performed during cardiac catheterization

procedures. Per *CPT* instruction, *CPT* codes 93561-93562 shall not be reported separately with cardiac catheterization codes.

*5.* *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 shall 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.

6. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (*CPT* codes 97802-97804) shall not be reported separately for the same patient encounter.

7. Under the NCCI program, 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. 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 PTP-associated modifier.

8. 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 shall 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.

9. 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 shall not be reported separately.

10. 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 shall not be reported separately for the submaximal stress test integral to MTWA testing. *CPT* codes 93015-93018 shall not be reported on the same date of service as *CPT* code 93025.

*11.* *CPT* codes 93040-93042 describe diagnostic rhythm ECG testing. They shall not be reported for cardiac rhythm monitoring in any site of service.

12. 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.

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 shall *not* 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 shall not be reported. One PCI code may be reported for each coronary artery bypass graft plus each branch off the main graft. PCI performed on a major coronary artery or coronary artery branch accessed through a bypass graft may be reported using a bypass graft PCI code. If a single lesion extends from one target vessel (major

coronary artery, coronary bypass graft, or coronary artery branch) into another target vessel and can be revascularized with a single intervention, only one PCI code shall be reported even though two target vessels are treated.

13. 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, 36140, 36160, 36200-36248, 36410, 96360-96376, 76000, 93040-93042). All these services are components of a cardiac catheterization or percutaneous coronary artery interventional procedure, or internal cardioversion and are not separately reportable. Additionally, ultrasound guidance is not separately reportable with these procedures. Physicians shall not report *CPT* codes *76937,* 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of these procedures. *(CPT code 76001 was deleted January 1, 2019.)*

14. A cardiac catheterization procedures 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.

15. 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) shall 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.

16. 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 shall 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, or others with a cardiac catheterization procedure, the angiography procedure must be as complete a procedure as it would be without concomitant cardiac catheterization. (HCPCS code G0275 was deleted January 1, 2014.)

17. 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. If it is medically necessary to perform selective renal artery catheterization and renal angiography, HCPCS code G0275 should not be additionally reported. (HCPCS code G0275 was deleted January 1, 2014.)

18. 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 *may* be reported with HCPCS code G0269. A physician shall not separately report an associated imaging code such as *CPT* code 75710 or HCPCS code G0278.

19. 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 shall 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* code 76000) 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. *(CPT code 76001 was deleted January 1, 2019.)*

Physicians shall not report *CPT* codes *76937,* 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.

*CPT* codes 93600 (Bundle of His recording), 93602 (Intra-atrial recording), 93603 (Right ventricular recording), 93610 (Intra-atrial pacing), and 93612 (Intraventricular pacing) shall 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 PTP-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.

20. Endoymocardial 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 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* code 76000) are not separately reportable for an endomyocardial biopsy. *(CPT code 76001 was deleted January 1, 2019.)*

21. 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. If the state Medicaid program uses HCPCS codes C8921-C8930, 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 shall 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.

*22.* *CPT* code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) shall 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.

*23.* *CPT* code 93503 (insertion and placement of flow directed catheter (e.g., Swan-Ganz)) shall 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.

24. 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., 71045, 71046) shall not be reported separately for this radiologic examination.

25. 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) shall not be reported separately with a cardioversion procedure (e.g., *CPT* codes 92960, 92961).

26. 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) shall not

be reported separately with electronic analysis of an antitachycardia pacemaker system (*CPT* code 93724).

*27.* *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 NCCI program 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 shall not be reported separately.

*28.* *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 shall 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.

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 shall 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.

*29.* *CPT* code 93590 describes percutaneous transcatheter closure of a mitral valve paravalvular leak. If a left heart

catheterization by transapical puncture is additionally performed, add-on *CPT* code 93462 may additionally be reported. However, if the left heart catheterization is performed by transseptal puncture, *CPT* code 93462 shall not be additionally reported. Therefore, *CPT* code 93590 is listed as a primary code for add-on *CPT* code 93462. These two codes are also bundled in a procedure-to-procedure edit that allows use of an NCCI-associated modifier to bypass it if left heart catheterization by transapical puncture is performed.

**J. Pulmonary Services**

The *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 shall 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 shall 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. Cardiopulmonary exercise testing (*CPT* code 94621) is a comprehensive exercise test with a number of component tests separately defined in the *CPT* Manual. It is inappropriate to separately report component services such as, but not limited to, venous access, ECG monitoring, spirometric parameters performed before, during and after exercise, oximetry, $O_2$ consumption, $CO_2$ production, and rebreathing cardiac output

calculations when performed during the same patient encounter as a cardiopulmonary exercise test. It is also inappropriate to report a cardiac stress test, a pulmonary stress test (*CPT* code 94618), or a component of either of these stress tests when performed during the same patient encounter as a cardiopulmonary exercise test.

5. Under the NCCI program, 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 shall not report this code when the physician orders it in a facility. This code shall 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 shall only be reported once during an 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) shall 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 the episode of care lasts more than one calendar day, only one unit of service of *CPT* code 94640 may be reported for the entire episode of care.

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" continuous treatments exceeding one hour, *CPT* codes 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) may 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 shall 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 shall 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 shall 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 shall 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" shall 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). The EEG testing shall 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 is 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) shall 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 shall not report other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860, 95870, 95907-95913, 95925-95937, 95938, 95939) since they are also included in the global package.

*6.* *CPT* code 95940 describes continuous intraoperative neurophysiology monitoring in the operating room requiring one on one monitoring and personal attendance. HCPCS code G0453 describes continuous intraoperative neurophysiology monitoring for a single patient from outside the operating room (remote or nearby). The unit of service (UOS) for each of these procedures is “each 15 minutes”. A physician shall not report both of these procedures for the same time period. If the two procedures are reported for the same date of service for the same patient, the time period for each procedure must be distinct and not overlapping with the time period for the other procedure.

*CPT* code 95941 describes continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or monitoring of more than one case while in the operating room. This code is not valid for practitioner services.

**M. Central Nervous System Assessments/Tests**

1. Neurobehavioral status exam (*CPT* code*s* 96116 *and 96121*) shall not be reported when a mini-mental status examination is performed. *CPT* code*s* 96116 *and 96121* shall not be

reported with psychiatric diagnostic examinations (*CPT* codes 90791 or 90792). *CPT* codes 96116 *and 96121* 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. The psychiatric diagnostic interview examination (*CPT* codes 90791, 90792)*,* psychological/neuropsychological testing (*CPT* codes *96136-96146), and psychological/neuropsychological evaluation services (CPT codes 96130-96133)* must be distinct services *if reported on the same date of service. CPT Manual* instructions permit physicians to integrate other sources of clinical data into the report that is generated for *CPT* codes *96130-96133*. Since the procedures described by *CPT* codes *96130-96139* are timed procedures, physicians shall not report time for duplicating information (collection or interpretation) included in the psychiatric diagnostic interview examination and*/or* psychological/neuropsychological *evaluation services or test administration and scoring*. *(CPT codes 96101 and 96118 were deleted January 1, 2019.)*

3. Central nervous system (CNS) assessment/test *CPT* codes (e.g., *96130-96133, 96136-96146, 96105, 96125, 96127*) shall 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 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. *(CPT codes 96101-96103 and 96118-96120 were deleted January 1, 2019.)*

**N. Chemotherapy Administration**

1. 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 PTP-associated modifiers.

*CPT* codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services shall 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) 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 Medicaid for practitioner services.

2. The drug and chemotherapy administration HCPCS/*CPT* codes 96360-96375, 96377 and 96401-96425 include the services 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 shall not report drug administration services in a facility setting, a facility based evaluation and management *CPT* code (e.g., 99281-99285) shall 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 Medicaid for practitioner services.

Outpatient hospital facilities 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.

3. 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.

*4.* *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 shall 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) shall 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 shall 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.

5. 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.

**O. Special Dermatological Procedures**

The NCCI program does not allow separate reporting 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.

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. An occupational therapist may report only one evaluation/re-evaluation (*CPT* codes 97165-97168) on a single date of service. A physical therapist may report only one evaluation/re-evaluation (*CPT* codes 97161-97164) on a single date of service. A physician or facility shall not report both an occupational therapy evaluation/re-evaluation service and physical therapy evaluation/re-evaluation service if performed by the same practitioner. If the two services are performed by two different practitioners on the same date of service, both procedures may be reported.

2. With one exception, providers shall 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 PTP edits do not include all possible pairs of physical medicine and rehabilitation services (excepting “supervised modality” services) even though they shall *not* be reported for the same fifteen minute time period.

Physicians are expected to code correctly even in the absence of NCCI PTP edits.

3. NCCI PTP edits include those with column one codes for physical medicine and rehabilitation therapy services and column two codes for physical therapy and occupational therapy re-

evaluation, *CPT* codes 97164 and 97168. The re-evaluation services shall 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.

4. 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.

5. 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 inappropriately 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.

6. Based on *CPT Manual* instructions debridement *CPT* codes 97597-97602 shall not be reported in conjunction with surgical debridement (*CPT* codes 11042-11047) for the same wound. Similarly, *CPT* code 97602 shall not be reported in conjunction with *CPT* codes 97597 and 97598 for the same wound

7. 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.

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 PTP-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.

*8.* *CPT* codes 97750 (physical performance test or measurement), 97755 (assistive technology assessment), and 97763 (Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes) are not separately reportable for the same date of service with a physical therapy evaluation/re-evaluation *CPT* code (e.g., 97161-97164) or occupational therapy evaluation/re-evaluation *CPT* code (e.g., 97165-97168) when the two services are performed by a single practitioner or two practitioners of the same specialty. If the two services are performed by two different practitioners of different specialties, the two services may be reported utilizing an NCCI- associated modifier. For example, if a physical therapist performs one service and an occupational therapist performs the other service, the two services may be reported separately. However, if a physical therapist performs one service and a different physical therapist performs the other service, the two services are not separately reportable.

CPT codes 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes) and CPT code 97761 (Prosthetic(s) training, upper and/or lower extremity(ies, initial prosthetic(s) encounter, each 15 minutes) are not separately reportable for the same date of service with physical therapy re-evaluation CPT code 97164 or occupational therapy re-evaluation CPT code 97168 when the two services are performed by a single practitioner or two practitioners of the same specialty. If the two services are performed by two different practitioners of different specialties, the two services may be reported utilizing an NCCI-associated modifier.

*9.* *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). The above paragraph was relocated from Chapter XII, Section C. NCCI Code 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 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. If a physician provides a state Medicaid covered medical nutrition service to a beneficiary 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 PTP-associated modifier.

Under the NCCI program, medical nutrition service codes are not separately reportable for the same patient encounter as the cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service.

**R. Osteopathic Manipulative Treatment**

Under the NCCI program, a provider performing Osteopathic Manipulative Treatment (OMT) cannot separately report anesthesia services such as nerve blocks or epidural injections for OMT. In addition, under the NCCI program, 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 shall 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**

Physical medicine and rehabilitation services described by *CPT* codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing chiropractic manipulative treatment (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, 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 shall 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 shall 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 shall 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**

The *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).

The 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).

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 shall 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. A physician shall not double count time if reporting more than one E&M service for the same date of service or same monthly period.

6. The E&M codes describing observation/inpatient care services with admission and discharge on same date (*CPT* codes 99234-99236) shall 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 shall 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.

Under the NCCI program, digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an evaluation and management code.

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 71045 and 71046), 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.

Under the NCCI program, critical and intensive care *CPT* codes include thoracic electrical bioimpedance (*CPT* code 93701) which shall 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 shall 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.

Physician services can be categorized as either major surgical procedures, minor surgical procedures, non-surgical procedures, or evaluation and management (E&M) services. This section summarizes some of the rules for reporting E&M services in relation to major surgical, minor surgical, and non-surgical procedures. Even in the absence of NCCI PTP edits, providers should bill for their services following these rules.

The Medicaid NCCI program uses the same definition of major and minor surgery procedures as the Medicare program.

- Major surgery – those codes with 090 Global Days in the "Medicare Physician Fee Schedule Database / Relative Value File"
- Minor surgery – those codes with 000 or 010 Global Days

The Medicare designation of global days can be found on the Medicare/ National Physician Fee Schedule/ PFS Relative Value Files page of the CMS Medicare website at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Select the calendar year and the file name with highest alphabetical suffix – e.g., RVUxxD – for the most recent version of the fee schedule. In the zip file, select document PPRRVU….xlsx" and refer to "Column O, Global Days".

An E&M service is separately reportable on the same date of service as a major or minor surgical procedure under limited circumstances.

If an E&M service 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 package for the procedure and are not separately reportable. There are currently no NCCI PTP edits based on this rule.

In general, E&M services performed on the same date of service as a 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 shall 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").

Many non-surgical 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 shall *not* be reported as a separate E&M code. Other non-surgical procedures are not usually performed by a physician and have no physician work associated with them. A physician shall *not* 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 non-surgical 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 non-surgical procedure but cannot include any work inherent in the non-surgical procedure, supervision of others performing the non-surgical procedure, or time for interpreting the result of the non-surgical procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as a non-surgical procedure is correct coding. 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 shall 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).

*7.* *CPT* codes 99238 and 99239 describe hospital discharge day management. These codes shall 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 shall 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 shall 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.

8. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services.

If a state Medicaid program uses these codes, they shall 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 shall 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 PTP-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. 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. Codes 99408/99409 shall not be reported in addition to codes G0396/G0397.

9. 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 shall 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.

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.

## V. Medically Unlikely Edits (MUEs)

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

2. Providers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. The MUEs were set so that such occurrences should be uncommon. If a provider does this frequently for any HCPCS/*CPT* code, the provider may be coding units of service incorrectly. The provider should consider contacting his/her national health care organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national health care organization, provider, or other interested third party may request a reconsideration of the MUE value. *Written requests for reconsideration of an MUE may be sent to the entity and address identified on the CMS Medicaid NCCI website at*

*https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html*

3. For purposes of reporting units of service (UOS) for antigen preparation (i.e., *CPT* codes 95145-95170), the physician reports "number of doses". The NCCI program 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.

*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 shall 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. If permitted by a state Medicaid program, group therapy services provided in a partial hospitalization program (PHP) may be reported with HCPCS codes G0410 or G0411 which are timed codes.

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.

*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). The NCCI program 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 shall 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 shall 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 shall 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 shall 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. MUE values for surgical procedures that may be performed bilaterally are based on the NCCI coding principle that a bilateral surgical procedure should be reported on one line of a claim with modifier 50 and one (1) unit of service*. If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50.* This coding principle does not apply to non-surgical diagnostic and therapeutic procedures.

18. Some allergy testing *CPT* codes (e.g., 95004, 95017-95052) are reported based on the number of individual tests performed. NCCI 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* codes97165-97167) shall 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) shall 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 only 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 shall not be reported with *CPT* code 92941, but with other *CPT* codes such as 92920, 92924, and/or 92943.

**W. General Policy Statements**

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, or providers, 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 Medicaid 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.

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 shall 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 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 Medicaid 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*.

3. 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. 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*.

4. With the exception of moderate conscious sedation (see below) the NCCI program does not allow separate reporting of anesthesia for a medical or surgical procedure when it is provided by the physician performing the procedure. The physician shall not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure.

Additionally, the physician shall 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) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

The NCCI program allows separate reporting for moderate conscious sedation services (*CPT* codes 99151-99153) when it is provided by the same physician performing a medical or surgical procedure.

Under the NCCI program, 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.

For outpatient hospital facilities 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 shall not report *CPT* codes 96360-96377 for these services.

Under the NCCI program, postoperative pain management is not separately reportable when it is 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 PTP-associated modifier if performed in a non-facility site of service.

5. The global surgery package includes insertion of urinary catheters. *CPT* codes 51701-51703 (insertion of bladder catheters) shall not be reported with a surgical procedure.

6. Repair of a surgical incision (*CPT* codes 12001-13153) is generally included in the global surgical package. These codes shall not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable.

NCCI PTP edits do not bundle *CPT* codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI PTP edits. Wound repair *CPT* codes 12001-13153 shall not be reported separately to describe closure of incisions for surgical procedures. Closure/repair of a surgical incision is included in the global surgical package.

7. 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.

8. 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. The NCCI program 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.

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.

The biopsy is not separately reportable if *utilized* for the purpose of assessing margins of resection or verifying resectability.

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 PTP-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 PTP-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 PTP-associated modifiers should generally not be utilized.

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.

11. If the code descriptor for a HCPCS/*CPT* code, *CPT* Manual instruction for a code, or Medicaid NCCI policy for a code indicates that the procedure includes radiologic guidance, a physician shall 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 PTP-associated modifier if appropriate.

*12.* *CPT* code 36591 describes “collection of blood specimen from a completely implantable venous access device”. *CPT* code 36592 describes “collection of blood specimen using an established central or peripheral venous catheter, not otherwise specified”. These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

*13.* *CPT* code 96523 describes “irrigation of implanted venous access device for drug delivery system”. This code may be reported only if no other service is reported for the patient encounter.