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CHAPTER VIII
SURGERY: ENDOCRINE, NERVOUS, EYE AND OCULAR ADNEXA, AND AUDITORY SYSTEMS
CPT CODES 60000 - 69999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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Chapter VIII
Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems
CPT Codes 60000 - 69999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 60000-69999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

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

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

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

B. Evaluation and Management (E&M) Services

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

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

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

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

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

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have 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.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually

performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

C. Nervous System

1. A burr hole is often necessary for intracranial surgery (e.g., craniotomy, craniectomy) to access intracranial contents, to alleviate pressure, or to place an intracranial pressure monitoring device. When this service is integral to the performance of other services, CPT codes describing this service~~s~~ are not separately reportable if performed at the same patient encounter. A burr hole is separately reportable with another cranial procedure only if performed at a separate site unrelated to the other cranial procedure or at a separate patient encounter on the same date of service.

In addition, taps, punctures, or burr holes accompanied by drainage procedures (e.g., hematoma, abscess, cyst, etc.) followed by other procedures are not separately reportable unless performed as staged procedures. Modifier 58 may be reported to indicate staged or planned services. Many intracranial procedures include bone grafts by CPT definition, and these grafts should not be reported separately.

2. Biopsies performed in the course of Central Nervous System (CNS) surgery should not be reported as separate procedures.

3. Craniotomies and craniectomies always include a general exploration of the accessible field. An exploratory craniectomy or craniotomy (CPT code 61304 or 61305) should not be reported separately with another craniectomy/craniotomy procedure performed at the same anatomic site and same patient encounter.

4. A craniotomy is performed through a skull defect resulting from reflection of a skull flap. Replacing the skull flap during the same procedure is an integral component of a craniotomy procedure and should not be reported separately utilizing the cranioplasty CPT codes 62140 and 62141. A cranioplasty may be separately reportable with a craniotomy procedure if the cranioplasty is performed to replace a skull bone flap removed during a procedure at a prior patient encounter or if the cranioplasty is performed to repair a skull defect larger than that created by the bone flap.

5. If two procedures are performed at the same anatomic site and same patient encounter, one procedure may be bundled into the other. (e.g., one procedure may be integral to the other.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters, they may be separately reportable. Modifier 59 may be reported to indicate that the two procedures are distinct and separately reportable services under these circumstances.

Example: A patient with an open head injury and a contre-coup subdural hematoma requires an exploratory craniectomy for the open head injury and a burr hole drainage on the contralateral side for a subdural hematoma. The creation of a burr hole at the site of the exploratory craniectomy would be considered integral to the craniectomy. However, the contralateral burr hole drainage is a separate service not integral to the exploratory craniectomy. To correctly report the burr hole drainage for the contralateral subdural hematoma and the exploratory craniectomy, the burr hole should be reported with the appropriate modifier (e.g., 59, RT, LT). In this example the correct coding would be CPT codes 61304 (exploratory craniectomy) with one unit of service and 61154-59 (burr hole with drainage of subdural hematoma) with one unit of service.

6. The use of general intravascular access devices (e.g., intravenous lines), cardiac monitoring, oximetry, laboratory sample procurement, and other routine monitoring for patient safety during general anesthesia, monitored anesthesia care (MAC), or other anesthesia are included in the anesthesia service and are not separately reportable. For example, if a physician performing a spinal puncture for intrathecal injection administers an anxiolytic agent, the vascular access and any appropriate monitoring is considered part of the spinal puncture procedure and is not separately reportable.

7. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure. The reporting of nerve block or facet block CPT codes for anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate.

8. If cerebrospinal fluid is withdrawn during a nerve block procedure, the withdrawal is not separately reportable (e.g., diagnostic lumbar puncture). It is integral to the nerve block procedure.

9. If a dural (cerebrospinal fluid) leak occurs during a spinal procedure, repair of the dural leak is integral to the spinal procedure. CPT code 63707 or 63709 (repair of dural/cerebrospinal fluid leak) should not be reported separately for the repair.

10. CPT code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. The procedure coded as CPT code 64721 includes the procedure coded as CPT code 29848 when performed on the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported.

11. Nerve repairs by suture (neurorrhaphies) (CPT codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury or anastomosis of nerves which are proximally associated (e.g., facial-spinal accessory, facial-hypoglossal, etc.). When neurorrhaphy is performed with a nerve graft (CPT codes 64885-64911), neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., the neurorrhaphy is integral to the procedure and is not separately reportable.

12. Implantation of neurostimulator electrodes in an area of the cerebral cortex may not be reported with two codes describing different approaches. CPT code 61860 describes implantation by craniectomy or craniotomy. CPT code 61850 describes implantation by twist drill or burr hole(s).

13. Because procedures necessary to perform a column one coded procedure are included in the column one coded procedure, column two CPT codes such as 62310-62311, 62318-62319 (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive spinal/back procedures.

14. A laminectomy includes excision of all the posterior vertebral components, and a laminotomy includes partial excision of posterior vertebral components. Since a laminectomy is a more extensive procedure than a laminotomy, a laminotomy code should not be reported with a laminectomy code for the same vertebra. CPT codes 22100-22103 (partial excision of posterior vertebral component (e.g., spinous process, lamina, or facet) for intrinsic bony lesion) are not separately reportable with laminectomy or laminotomy procedures for the same vertebra.

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

16. Since the code descriptor for CPT code 61576 (transoral approach to skull base... (including tracheostomy)) includes a tracheostomy in the code descriptor, a CPT code describing a tracheostomy should not be reported separately.

17. For reporting CPT code 69990 (operating microscope), the reader is referred to Chapter VIII, Section F (Operating Microscope).

18. CPT code 61623 (endovascular temporary balloon arterial occlusion... concomitant neurological monitoring,...) describes a procedure that includes prolonged neurologic assessment. This code should not be utilized to report the temporary arterial occlusion that is an inherent component of CPT code 61624 (transcatheter permanent occlusion or embolization...; central nervous system (intracranial, spinal cord)).

19. Muscle chemodenervation procedures coded as CPT codes 64612-64614 occasionally require needle electromyographic (EMG) guidance. From January 1 through December 31, 2005, CMS allowed CPT code 95870 to be reported for such guidance when medically reasonable and necessary. Effective January 1, 2006, needle EMG guidance for muscle chemodenervation procedures coded as CPT codes 64612-64614 may be reported with CPT code 95874.

20. Some procedures (e.g., intracranial, spinal) utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. The physician performing an operative procedure should not report other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package. However, when performed by a different physician during the procedure, intraoperative neurophysiology testing is separately reportable by the second physician.

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

D. Ophthalmology

1. When a subconjunctival injection (e.g., CPT code 68200) with local anesthetic is performed as part of a more extensive anesthetic procedure (e.g., peribulbar or retrobulbar block), the subconjunctival injection is not separately reportable. It is part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy and/or anterior vitrectomy may be performed in conjunction with cataract extraction. If an iridectomy is performed in order to complete a cataract extraction, it is an integral part of the procedure and is not separately reportable. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable. If an iridectomy or vitrectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitrectomy may be reported separately with an NCCI-associated modifier. The medical record must document the distinct medical necessity for each procedure.

A trabeculectomy is separately reportable with a cataract extraction if performed for a purpose unrelated to the cataract extraction. For example, if a patient with glaucoma requires a cataract extraction and a trabeculectomy is the appropriate treatment for the glaucoma, the trabeculectomy may be separately reportable. However, performance of a trabeculectomy as a preventative service for an expected transient increase in

intraocular pressure postoperatively, without other evidence for glaucoma, is not separately reportable.

3. CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye.

4. There are numerous CPT codes describing repair of retinal detachment (e.g., 67101-67113). These procedures are mutually exclusive and should not be reported separately for the ipsilateral eye on the same date of service. Some retinal detachment repair procedures include some vitreous procedures which are not separately reportable. For example, the procedure described by CPT code 67108 includes the procedures described by CPT codes 67015, 67025, 67028, 67031, 67036, 67039, and 67040.

5. The procedures described by CPT codes 68020-68200 (incision, drainage, biopsy, excision, or destruction of the conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362). CPT codes 68020-68200 should not be reported separately with CPT codes 68320-68362 for the ipsilateral eye.

6. CPT code 67950 (canthoplasty) is included in repair procedures such as blepharoplasties (e.g., CPT codes 67917, 67924, 67961, 67966).

7. Correction of lid retraction (CPT code 67911) includes a full thickness graft (e.g., CPT code 15260) as part of the procedure. A full thickness graft code such as CPT code 15260 should not be reported separately with CPT code 67911 for the ipsilateral eye.

8. If it is medically reasonable and necessary to inject anti-sclerosing agents at the same patient encounter as surgery to correct glaucoma, the injection is included in the glaucoma procedure. CPT codes such as 67500, 67515, and 68200 for injection of anti-sclerosing agents (e.g., 5-FU, HCPCS code J9190) should not be reported separately with other pressure-reducing or glaucoma procedures.

9. Since visual field examination (CPT codes 92081-92083) would be performed prior to scheduling a patient for a blepharoplasty (CPT codes 15820-15823) or blepharoptosis (CPT codes 67901-67908) procedure, the visual field examination CPT codes should not be reported separately with the blepharoplasty or blepharoptosis procedure codes for the same date of service.

10. The CPT code descriptors for CPT code 67108 (repair of retinal detachment...) and 67113 (repair of complex retinal detachment...) include removal of lens if performed. CPT codes for removal of lens or cataract extraction (e.g., 66830-66984) should not be reported separately.

11. Medicare Anesthesia Rules prohibit the physician performing an operative procedure from separately reporting anesthesia for that procedure except for moderate conscious sedation for some procedures. CPT codes describing ophthalmic injections (e.g., CPT codes 67500, 67515, 68200) should not be reported separately with other ophthalmic procedure codes when the injected substance is an anesthetic agent. Since Medicare Global Surgery Rules prohibit the separate reporting of postoperative pain management by the physician performing the procedure, the same CPT codes should not be reported separately by the physician performing the procedure for postoperative pain management.

12. CMS payment policy does not allow separate payment for a blepharoptosis procedure (CPT code 67901-67908) and blepharoplasty procedure (CPT codes 15822, 15823) on the ipsilateral upper eyelid.

13. CPT codes 65420 and 65426 describe excision of pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT codes 65780-65782 should not be reported separately with either of these codes for the ipsilateral eye.

14. CPT codes 92018 and 92019 (ophthalmological examination and evaluation, under general anesthesia . . .) are generally not separately reportable with ophthalmological surgical procedures. The examination and evaluation of an eye while a patient is under general anesthesia for another ophthalmological procedure is integral to the procedure. However, there are unusual circumstances when an adequate ophthalmological examination cannot be completed without anesthesia (e.g., uncooperative pediatric patient, severe eye trauma). In such situations CPT codes 92018 or 92019 may be separately reportable with appropriate documentation.

E. Auditory System

1. If the code descriptor for a procedure of the auditory system includes a mastoidectomy (e.g., CPT codes 69530, 69802, 69910), an additional code describing a mastoidectomy (e.g., 69502-69511) is not separately reportable for the ipsilateral mastoid.

2. A myringotomy (e.g., CPT codes 69420, 69421) is included in a tympanoplasty or tympanostomy procedure and is not separately reportable.

F. Operating Microscope

1. The *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 20.4.5 (Allowable Adjustments) limits the reporting of use of an operating microscope (CPT code 69990) to procedures described by CPT codes 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64891 and 64905-64907. CPT code 69990 should not be reported with other procedures even if an operating microscope is utilized. CMS guidelines for payment of CPT code 69990 differ from *CPT Manual* instructions following CPT code 69990. The NCCI bundles CPT code 69990 into all surgical procedures other than those listed in the *Medicare Claims Processing Manual*. Most edits do not allow use of NCCI-associated modifiers.

2. If a physician performs two procedures utilizing the operating microscope but only one of the procedures is on the CMS list of procedures for which CPT code 69990 is separately payable, payment for CPT code 69990 may be denied because of an edit bundling CPT code 69990 into the other procedure not on the CMS list. (Claims processing systems do not identify which procedure is linked to CPT code 69990.) In these cases, physicians may submit the claim to the local carrier (A/B MAC processing practitioner service claims) appending modifier 22 to the CPT code for the procedure on which the operating microscope was used and a letter of explanation. Although the carrier (A/B MAC processing practitioner service claims) cannot override an NCCI edit that does not allow use of NCCI-associated modifiers, the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

G. Laparoscopy

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

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

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported.

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

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

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

H. Medically Unlikely Edits (MUEs)

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

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

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

I. General Policy Statements

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

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 Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

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. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with

the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

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

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

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

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

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62310-62319, 64400-64484, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

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

96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

5. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

6. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should 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 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 edits.

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

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

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

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

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

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

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