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CHAPTER XI
MEDICINE
EVALUATION AND MANAGEMENT SERVICES
CPT CODES 90000 - 99999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter XI
Medicine
Evaluation and Management Services
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A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 90000-99999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

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

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

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

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

1. CPT codes 96360-96379 and C8957 describe hydration and therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs. CPT codes 96401-96549 describe administration of chemotherapy or other highly complex drug or biologic agents. Issues related to chemotherapy administration are discussed in this section as well as Section N. (Chemotherapy Administration).

2. CPT codes 96360, 96365, 96374, 96409, and 96413 describe “initial” service codes. For a patient encounter only one “initial” service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To

report two different “initial” service codes use NCCI-associated modifiers.

3. Because the placement of peripheral vascular access devices is integral to intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 96360-96368, 96374-96379, 96409-96417) should not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, this service may be reported separately. Since intra-arterial infusion often involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes may be reported separately.

4. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D_5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and should not be reported separately. Similarly, the fluid utilized to administer drug(s)/substance(s) is incidental hydration and should not be reported separately.

Transfusion of blood or blood products includes the insertion of a peripheral intravenous line (e.g., CPT codes 36000, 36410) which is not separately reportable. Administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is incidental hydration and is not separately reportable.

If therapeutic fluid administration is medically necessary (e.g., correction of dehydration, prevention of nephrotoxicity) before or after transfusion or chemotherapy, it may be reported separately.

5. Hydration concurrent with other drug administration services is not separately reportable.

6. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services should not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

7. The drug and chemotherapy administration CPT codes 96360-96375 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility based evaluation and management CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians should not report drug administration services in a facility setting, a facility based evaluation and management CPT code (e.g., 99281-99285) should not be reported by a physician with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the evaluation and management code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

Under OPPS, hospitals may report drug administration services (CPT codes 96360-96376) 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.

8. 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.

9. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir for systemic drug delivery) and CPT code 96521 (refilling and maintenance of portable pump) should not be reported with CPT code 96416(initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump. Similarly under the OPPS, CPT codes 96521 (refilling and maintenance of portable pump) and 96522 (refilling and maintenance of implantable pump or reservoir for systemic drug delivery (e.g., intravenous, intra-arterial)) should not be reported with HCPCS/CPT code C8957 (initiation of prolonged intravenous infusion (more than 8 hours)).

CPT codes 96521 and 96522 should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

10. Medicare Anesthesia Rules prevent separate payment for anesthesia services for a medical or surgical service when provided by the physician performing the service. Drug administration services, CPT codes 96360-96376 should not be reported for anesthesia provided by the physician performing a medical or surgical service.

11. 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.

12. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported with HCPCS codes G0008, G0009, or G0010 respectively. Administration of other immunization(s) not excluded by law is reported with CPT codes 90465-90468 or 90471-90474 depending upon the patient’s age and physician counseling of the patient/family. Based on CPT instructions a physician should report administration of all immunizations other than influenza, pneumococcal, or hepatitis B vaccines on a single date of service from either of these two code ranges and should not report a combination of CPT codes from the two code ranges.

13. 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 90465-90474, G0008-G0010.

14. CPT codes 96361 and 96366 are utilized to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes may be reported only if the infusion is medically reasonable and necessary for the patient’s treatment or diagnosis. They should not be reported for “keep open” infusions as often occur in the emergency department or observation unit.

C. Psychiatric Services

CPT codes for psychiatric services include diagnostic (CPT codes 90801, 90802) and therapeutic (individual, group, other) procedures. Since psychotherapy includes continuing psychiatric evaluation, CPT codes 90801 and 90802 are not separately reportable with individual psychotherapy codes. CPT code 90801 or 90802 is separately reportable with a group psychotherapy code if the diagnostic interview and group psychotherapy service occur during separate time intervals on the same date of service. Diagnostic services performed during the group therapy session are not separately reportable.

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...". Non-interactive services are not performed at the same patient encounter as interactive services and are not separately reportable with interactive services.

Drug management is included in diagnostic and therapeutic psychiatric services (e.g., CPT codes 90801-90829, 90845, 90847-90853, 90865-90880). CPT code 90862 and HCPCS code M0064 (pharmacologic management) are not separately reportable with these codes. Both CPT code 90862 and HCPCS code M0064 require face-to-face patient contact by the practitioner licensed to perform the service. Facilities may report CPT code 90862 or HCPCS code M0064 (pharmacologic management services) with a psychotherapy code if the two services are performed at separate patient encounters on the same date of service.

Based on CMS payment policy for practitioner services evaluation and management (E&M) codes are not separately reportable with psychiatric diagnostic evaluation codes (CPT codes 90801 or 90802). Facilities may separately report E&M codes and psychiatric diagnostic evaluation codes if the services are performed at separate patient encounters on the same date of service.

Individual psychotherapy codes (CPT code 90804-90829) include separate codes for psychotherapy with medical evaluation and management (E&M) services as well as codes for psychotherapy without E&M services. For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes on the same date of service. Facilities may separately report E&M codes and individual psychotherapy codes if the services are performed at separate patient encounters on the same date of service.

For practitioner services E&M codes are not separately reportable on the same date of service as psychoanalysis (CPT code 90845), narcosynthesis (CPT code 90865), or hypnotherapy (CPT code 90880). These psychiatric services include E& M services provided on the same date of service. Facilities may separately report E&M codes and psychoanalysis, narcosynthesis, or hypnotherapy if the services are performed at separate patient encounters on the same date of service.

D. Biofeedback

Biofeedback services utilize electromyographic techniques to detect and record muscle activity. CPT codes 95860-95872 (EMG) should not be reported separately with biofeedback services based on the use of electromyography during a biofeedback session. If an EMG is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate EMG code(s) (e.g., CPT codes 95860-95872) may be reported separately. Modifier 59 should be appended to the EMG code to indicate that the service was a separately identifiable diagnostic service. Recording an objective electromyographic response to biofeedback is not sufficient to separately report a diagnostic EMG CPT code.

E. Dialysis

Renal dialysis procedures coded as CPT codes 90935, 90937, 90945, and 90947 include evaluation and management (E&M) services related to the dialysis procedure and the renal failure. If the physician additionally performs on the same date of service medically reasonable and necessary E&M services unrelated to the dialysis procedure or renal failure that are significant and separately identifiable, these services may be separately reportable. CMS allows physicians to additionally report if appropriate CPT codes 99201-99215, 99221-99223, 99238—99239, 99241-99245, 99251-99255, and 99291-99292. These codes must be reported with modifier 25 if performed on the same date of service as the dialysis procedure.

Per CMS payment policy any E&M service related to the renal failure (e.g., hypertension, fluid overload, uremia, electrolyte imbalance) or dialysis procedure performed on the same date of service as the dialysis procedure should not be reported separately even if performed at a separate patient encounter. E&M services for conditions unrelated to the dialysis procedure or renal failure even if performed at the same patient encounter as the dialysis procedure may be reported separately with modifier 25.

F. Gastroenterology

1. Gastroenterological (GI) tests included in the CPT code range 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology, if performed, are included in an upper endoscopy (e.g., CPT code 43235). CPT codes 91000 (esophageal intubation) and 91055 (gastric intubation) are not separately reportable when performed as part of an upper GI endoscopy. Provocative testing with procurement of gastric specimens (CPT code 91052) is expedited during upper GI endoscopy. When performed at the same patient encounter as upper GI endoscopy, CPT code 91052 should be reported with modifier 52 to indicate that a reduced level of service was performed.

2. The gastroesophageal reflux test described by CPT code 91035 requires attachment of a telemetry pH electrode to the esophageal mucosa. If a physician uses endoscopic guidance to attach the electrode, the physician should not report CPT codes

43234 (upper gastrointestinal endoscopy, simple primary examination...) or 43235 (upper gastrointestinal endoscopy...; diagnostic...) for the guidance procedure. The guidance is not separately reportable. Additionally it would be a misuse of CPT codes 43234 or 43235 since these codes do not describe guidance, but a more extensive diagnostic endoscopy.

G. Ophthalmology

1. General ophthalmological services (CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management (E&M) codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-92014) should not be reported separately. The E&M service includes the general ophthalmological services.

2. Special ophthalmologic services represent specific services not included in a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services and may be reported separately.

3. For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are integral to the procedure and are not separately reportable. Therefore, CPT codes 36000 (introduction of a needle or catheter), 36410 (venipuncture), 96360-96368 (IV infusion), 96374-96376 (IV push injection), and selective vascular catheterization codes are not separately reportable with services requiring intravenous injection (e.g., CPT codes 92230, 92235, 92240, 92287).

4. CPT codes 92230 and 92235 (fluorescein angioscopy and angiography) include selective catheterization and injection procedures for angiography.

5. Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92135) 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.

H. Otorhinolaryngologic Services

1. CPT coding for otorhinolaryngologic services includes codes for diagnostic tests that may be performed qualitatively during physical examination or quantitatively with electrical recording equipment. The procedures described by CPT codes 92552-92557, 92561-92588, and 92597 may be reported only if calibrated electronic equipment is utilized. Qualitative assessment of these tests by the physician is included in the evaluation and management service.

2. Speech language pathologists may perform services coded as CPT codes 92507, 92508, or 92526. They do not perform services coded as CPT codes 97110, 97112, 97150, 97530, or 97532 which are generally performed by physical or occupational therapists. Speech language pathologists should not report CPT codes 97110, 97112, 97150, 97530, or 97532 as unbundled services included in the services coded as 92507, 92508, or 92526.

3. Treatment of swallowing dysfunction and/or oral function for feeding (CPT code 92526) may utilize electrical stimulation. HCPCS code G0283 (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code 92526 for electrical stimulation during the procedure. The NCCI edit (92526/G0283) for Medicare Carriers (A/B MACs processing practitioner service claims) does not allow use of NCCI-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit in OCE for Fiscal Intermediaries does allow use of NCCI-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different patient encounters on the same date of service.

4. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

I. Cardiovascular Services

Cardiovascular medicine services include non-invasive and invasive diagnostic testing including intracardiac testing as well as therapeutic services (e.g., electrophysiological procedures).

1. If cardiopulmonary resuscitation (CPR) is performed without other evaluation and management (E&M) services, only CPT code 92950 (Cardiopulmonary resuscitation (e.g., in cardiac arrest)) should be reported. For example, if a physician directs cardiopulmonary resuscitation and the patient's attending physician resumes the care of the patient after the patient has been revived, the first physician may report CPT code 92950 but not an E&M code.

2. Critical care E&M services (CPT codes 99291 and 99292) and prolonged physician E&M services (CPT codes 99354-99357) are reported based on time. Providers should not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged physician E&M service time. For example, the time devoted to performing cardiopulmonary resuscitation (CPT code 92950) should not be included in critical care E&M service time.

3. A number of diagnostic and therapeutic cardiovascular procedures (e.g., CPT codes 92950-92998, 93501-93545, 93600-93624, 93640-93652) 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 should 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 should not be reported separately unless a significant, separately identifiable E&M service is performed and documented in the medical record. The physician should report the E&M service with modifier 25 to indicate that it was significant and separately identifiable.

6. If a physician in attendance for a cardiac stress test obtains a history and performs a limited physical examination related to the cardiac stress test, a separate evaluation and management (E&M) code should not be reported separately unless a significant, separately identifiable E&M service is performed unrelated to the performance of the cardiac stress test. The E&M code should be reported with modifier 25 to indicate that it is a significant, separately identifiable E&M service.

7. Cardiovascular stress tests include insertion of needle and/or catheter, infusion/injection (pharmacologic stress tests) and ECG strips (e.g., CPT codes 36000, 36410, 96360-96376, 93000-93010, 93040-93042). These services should not be reported separately.

8. Microvolt T-wave alternans (MTWA) (CPT code 93025) testing requires a submaximal stress test that differs from the traditional exercise stress test (CPT codes 93015-93018) which utilizes a standard exercise protocol. CPT codes 93015-93018 should not be reported separately for the submaximal stress test integral to MTWA testing. If a physician performs an MTWA with submaximal stress test followed by a traditional stress test on the same date of service, CMS payment policy allows separate payment of MTWA (CPT code 93025) and the interpretation and report for the traditional stress test (CPT code 93018). The practice expense component of the traditional stress test is not separately payable, and a physician should not report CPT codes 93015-93017 on the same date of service as CPT code 93025.

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

10. 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.

11. Percutaneous coronary artery interventions include stent placement, atherectomy, and balloon angioplasty. For reimbursement purposes, Medicare recognizes three coronary arteries: right coronary artery (modifier RC), left circumflex coronary artery (modifier LC) and left anterior descending coronary artery (modifier LD). For a given coronary artery and its branches, the physician should report only one intervention, the most complex, regardless of the number of stent placements, atherectomies, or balloon angioplasties performed in that coronary artery and its branches. From a coding perspective, stent placement is considered more complex than an atherectomy which is considered more complex than a balloon angioplasty. These interventions should be reported with the appropriate modifier (RC, LC, LD) indicating in which coronary artery (including its branches) the procedure(s) was(were) performed. Since Medicare recognizes three coronary arteries (including their branches) for reimbursement purposes, it is possible that a physician may report up to three percutaneous interventions if an intervention is performed in each of the three coronary arteries or their branches. The first reported procedure must utilize a primary code (CPT codes 92980, 92982, 92995) corresponding to the most complex procedure performed. The procedure(s) performed in the other one or two coronary arteries (including their branches) are reported with the CPT add-on codes (CPT codes 92981, 92984, 92996). Modifier 59 should not be utilized to report percutaneous coronary artery stent placement, atherectomy, or balloon angioplasty.

12. Cardiac catheterization and percutaneous coronary artery interventional procedures such as angioplasty, atherectomy, or stenting include insertion of a needle and/or catheter, infusion, fluoroscopy and ECG rhythm strips (e.g., CPT codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 96360-96376, 71034, 76000-76001, 93040-93042). All these services are components of a cardiac catheterization or percutaneous coronary artery interventional procedure and are not separately reportable.

13. A cardiac catheterization procedure~~s~~ 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.

14. 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., 93508, 93539, 93540, 93545, 76000) should not be reported separately. If medically reasonable and necessary diagnostic coronary angiography precedes the percutaneous coronary artery intervention, a coronary artery or cardiac catheterization and associated radiopaque dye injections may be reported separately. However, fluoroscopy is not separately reportable with diagnostic coronary angiography or cardiac catheterization.

15. While withdrawing the catheter during a cardiac catheterization procedure, physicians often inject a small amount of dye to examine the renal arteries and/or iliac arteries. These services when medically reasonable and necessary may be reported with HCPCS codes G0275 or G0278. A physician should not report CPT codes 75722 or 75724 (renal angiography) unless the renal artery(s) is (are) catheterized and a complete renal angiogram including the venous phase is performed and interpreted. A physician should not report CPT codes 75625 (abdominal aortography) or 75630 (abdominal aortography with bilateral iliofemoral lower extremity angiography) unless a complete study including venous phase is performed and interpreted. In order to report angiography CPT codes 75625, 75630, 75722, 75724, or others with a cardiac catheterization procedure, the angiography procedure must be as complete a

procedure as it would be without concomitant cardiac catheterization.

16. Renal artery angiography at the time of cardiac catheterization should be reported as HCPCS code G0275 if selective catheterization of the renal artery is not performed. HCPCS code G0275 should not be reported with CPT code 36245 for selective renal artery catheterization or CPT codes 75722 or 75724 for renal angiography. If it is medically necessary to perform selective renal artery catheterization and renal angiography, HCPCS code G0275 should not be additionally reported.

17. Placement of an occlusive device such as an angio seal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported with HCPCS code G0269. A physician should not separately report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

18. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (CPT codes 33202-33249) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes (e.g., CPT codes 76000, 76001) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures (e.g., CPT code 71090 for fluoroscopy during insertion of a pacemaker) may be reported separately. Additionally, ultrasound guidance is not separately reportable with these HCPCS/CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by CPT codes 33202-33249 or 93600-93662.

19. Occasionally it is medically reasonable and necessary to perform echocardiography (CPT codes 93303-93318) utilizing intravenous push injections of contrast. The injection of contrast (e.g., CPT codes 96365, 96374, 96375, 96376) is not separately reportable.

HCPCS codes C8921-C8930 describe echocardiography procedures with contrast and include echocardiography without contrast if performed at the same patient encounter. Under OPPS, hospitals should report the appropriate code from the HCPCS code range C8921-C8930 when echocardiography is performed with contrast rather than the corresponding CPT code in the code range 93303-93350. Since the HCPCS codes C8921-C8930 include echocardiography without contrast if performed at the same patient encounter as echocardiography with contrast, a code from the HCPCS code range C8921-C8930 and the corresponding code from the CPT code range 93303-93352 should not be reported separately for the same patient encounter for echocardiography.

CPT code 93352 is an add-on code that describes use of echocardiographic contrast during stress echocardiography. It may be reported by physicians with CPT codes 93350 or 93351 in the appropriate site of service. CPT code 93352 is not separately payable under OPPS.

20. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

21. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan Ganz)) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569 (insertion of peripherally inserted central venous catheter) for the insertion of a single catheter. If a physician does not complete the insertion of one type of catheter and subsequently inserts another at the same patient encounter, only the completed procedure may be reported.

22. Since cardioversion includes interrogation and programming of a cardioverter-defibrillator if performed, interrogation and programming of a cardioverter-defibrillator system (e.g., CPT codes 93282-93284, 93289, 93292, and 93295) should not be reported separately with a cardioversion procedure (e.g., CPT codes 92960, 92961).

23. Since electronic analysis of an antitachycardia pacemaker system includes interrogation and programming of the pacemaker system, interrogation and programming of a pacemaker system (e.g., CPT codes 93279-93281, 93286, and 93288) should not be reported separately with electronic analysis of an antitachycardia pacemaker system (CPT code 93724).

J. Pulmonary Services

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories.

1. Alternate methods of reporting data obtained during a spirometry or other pulmonary function session should not be reported separately. For example, the flow volume loop is an alternative method of calculating a standard spirometric parameter. CPT code 94375 is included in standard spirometry (rest and exercise) studies.

2. If a physician in attendance for a pulmonary function study obtains a limited history and performs a limited physical examination related to the pulmonary function testing, 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 function test, an E&M service may be reported with modifier 25.

3. If multiple spirometric determinations are necessary to complete the service described by a CPT code, only one unit of service should be reported. For example, CPT code 94070 describes bronchospasm provocation with an administered agent and utilizes multiple spirometric determinations as in CPT code 94010. A single unit of service includes all the necessary spirometric determinations.

4. Complex pulmonary stress testing (CPT code 94621) is a comprehensive stress test with a number of component tests separately defined in the *CPT Manual*. It is inappropriate to separately code venous access, ECG monitoring, spirometric parameters performed before, during and after exercise, oximetry, O_2 consumption, CO_2 production, rebreathing cardiac output calculations, etc., when performed as part of a complex pulmonary stress test. It is also inappropriate to report a cardiac stress test and the component codes used to perform a simple pulmonary stress test (CPT code 94620) when a complex pulmonary stress test is performed. If using a standard exercise protocol, serial electrocardiograms are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, the professional components for both a cardiac and pulmonary stress test may be reported. Modifier 59 should be reported with the secondary procedure. Both tests must satisfy the requirement for medical necessity. (Since a complex pulmonary stress test includes electrocardiographic recordings, the technical components for both the cardiac stress test and the pulmonary stress test should not be reported separately.)

5. Pursuant to the *Federal Register* (Volume 58, Number 230, 12/2/1993, pages 63640-63641), ventilation management CPT codes (94002-94004 and 94660-94662) are not separately reportable with evaluation and management (E&M) CPT codes. If an E&M code and a ventilation management code are reported, only the E&M code is payable.

6. The procedure described by CPT code 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour) does not include any physician work RVUs. When performed in a facility, the procedure utilizes facility staff and supplies, and the physician does not have any practice expenses related to the procedure. Thus, a physician should not report this code when the physician orders it in a facility. This code should not be reported with CPT codes 99217-99239, 99251-99255, 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 94640 (pressurized or nonpressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) should not be reported for the same patient encounter. If performed at separate patient encounters on the same date of service, the two services may be reported separately.

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 95010, 95015, or 95027) are performed on the same date of service, both the "sequential and incremental" test and single test codes may be reported if the tests are for different allergens or different dilutions of the same allergen. The unit of service to report is the number of separate tests. A single test and a “sequential and incremental” test for the same dilution of an allergen should not be reported separately on the same date of service. For example, if the single test for an antigen is positive and the physician proceeds to “sequential and incremental” tests with three additional *different* dilutions of the same antigen, the physician may report one unit of service for the single test code and three units of service for the “sequential and incremental” test code.

2. Photo patch tests (CPT code 95052) consist of applying a patch(s) containing allergenic substance(s) to the skin and exposing the skin to light. Physicians should not unbundle this service by reporting both CPT code 95044 (patch or application tests) plus CPT code 95056 (photo tests) rather than CPT code 95052.

3. Evaluation and management (E&M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. Obtaining informed consent is included in the immunotherapy service and should not be reported with an E&M code. If E&M services are reported, modifier 25 should be utilized.

4. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. These codes should not be reported together for the same date of service. Additionally, testing is an integral component of rapid desensitization kits (CPT code 95180) and is not separately reportable.

L. Neurology and Neuromuscular Procedures

The *CPT Manual* defines codes for neuromuscular diagnostic and therapeutic services. Sleep testing, nerve and muscle testing, and electroencephalographic procedures are included. The *CPT Manual* guidelines for sleep testing are very precise and should be followed carefully when reporting these services.

1. Sleep testing differs from polysomnography in that the latter requires sleep staging. Sleep staging includes a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. A "sleep study" and "polysomnography" should not be reported separately for the same patient encounter.

2. Polysomnography requires at least one central and usually several other EEG electrodes. EEG procurement for polysomnography (sleep staging) differs greatly from that required for diagnostic EEG testing (e.g., speed of paper, number of channels). EEG testing should not be reported separately with polysomnography unless a complete diagnostic EEG is performed separately in the usual manner at a separate patient encounter on the same date of service. If a complete diagnostic EEG is performed at a separate patient encounter on the same date of service as a polysomnography, modifier 59 should be appended to the EEG code.

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) describe different services than those provided during sleep testing or polysomnography. These procedures may be reported separately with sleep testing only if they are performed as significant, separately identifiable services distinct from EEG testing included in sleep testing or polysomnography. In the latter situation, the EEG codes must be reported with modifier 59 to indicate that a different service was performed.

4. If nerve testing (e.g., EMG, nerve conduction velocity) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the range of CPT codes 95851-95937 are not separately reportable. These codes describe significant, separately identifiable diagnostic services requiring a formal report in the medical record. Electrical stimulation used to identify or locate nerves during a procedure involving treatment of a cranial or peripheral nerve (e.g., nerve block, nerve destruction, neuroplasty, transection, excision, repair) is integral to the procedure and is not separately reportable.

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

6. The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters.

M. Central Nervous System Assessments/Tests

1. Neurobehavioral status exam (CPT code 96116) should not be reported when a mini-mental status examination is performed. CPT code 96116 should never be reported with psychiatric diagnostic examinations (CPT codes 90801 or 90802). CPT code 96116 may be reported with other psychiatric services or evaluation and management services only if a complete neurobehavioral status exam is performed. If a mini-mental status examination is performed by a physician, it is included in the evaluation and management service.

2. CPT codes 96101-96103 describe psychological testing differing by method of performance and interpretation. Two or more codes from this code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different psychological tests. Similarly, CPT codes 96118-96120 describe neuropsychological testing differing by method of performance and interpretation. Two or more codes from this latter code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different neuropsychological tests.

3. The psychiatric diagnostic interview examination (CPT codes 90801, 90802) and psychological/neuropsychological testing (CPT codes 96101, 96118) must be distinct services. *CPT Manual* instructions permit physicians "to integrate other sources of clinical data" into the report that is generated for CPT codes 96101 or 96118. Since the procedures described by CPT codes 96101 and 96118 are timed procedures, physicians should be careful to avoid reporting time for duplicating information included in the psychiatric diagnostic interview examination and report.

4. A physician may report CPT codes 96101 (psychological testing...) or 96118 (neuropsychological testing...) only if the physician personally administers at least one test to the patient.

N. Chemotherapy Administration

1. The CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report two different "initial" service codes use NCCI-associated modifiers.

2. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services should not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved

ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term “physician” refers to M.D.’s, D.O.’s, and other practitioners who bill Medicare claims processing contractors for services payable on the “Medicare Physician Fee Schedule”.

3. The drug and chemotherapy administration HCPCS/CPT codes 90760-90775 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility based evaluation and management CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians should not report drug administration services in a facility setting, a facility based evaluation and management CPT code (e.g., 99281-99285) should not be reported with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the evaluation and management code should be reported with modifier 25. For purposes of this paragraph, the term “physician” refers to M.D.’s, D.O.’s, and other practitioners who bill Medicare claims processing contractors for services payable on the “Medicare Physician Fee Schedule”.

Under OPPS, hospitals may report drug administration services and facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

4. Flushing or irrigation of an implanted vascular access port or device prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Under these circumstances, do not report CPT code 96523.

5. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir) and CPT code 96521(refilling and maintenance of portable pump) should not be reported with CPT code 96416(initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump.

CPT codes 96521 and 96522 should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

6. A concurrent intravenous infusion of an antiemetic or other non-chemotherapeutic drug with intravenous infusion of chemotherapeutic agents may be reported separately as CPT code 96368 (concurrent intravenous infusion). CPT code 96368 may be reported with a maximum of one unit of service per patient encounter regardless of the number of concurrently infused drugs or the length of time for the concurrent infusion(s). Hydration concurrent with chemotherapy is not separately reportable.

7. Prior to January 1, 2005, the NCCI edits with column one CPT codes 96408 (Intravenous chemotherapy administration by push technique) and 96410 (Intravenous chemotherapy administration by infusion technique, up to one hour) each with column two CPT code 90780 (Therapeutic or diagnostic intravenous infusion up to one hour) were often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 90780 of these NCCI edits was only appropriate if the 90780 procedure was for hydration, antiemetic, or other non-

chemotherapy drug administered before, after, or at different patient encounters than the chemotherapy. Modifier 59 should not have been used for “keep open” infusion for the chemotherapy.

O. Special Dermatological Procedures

Medicare does not allow separate payment of E&M CPT code 99211 with photochemotherapy procedures (CPT codes 96910-96913) for services performed by a nurse or technician such as examining a patient prior to a subsequent procedure for burns or reactions to the prior treatment. If a physician performs a significant separately identifiable medically reasonable and necessary E&M service on the same date of service, it may be reported with modifier 25.

P. Physical Medicine and Rehabilitation

1. With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. (The only exception involves a “supervised modality” defined by CPT codes 97010-97028 which may be reported for the same fifteen minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI edits pair a “timed” CPT code with another “timed” CPT code or a non-timed CPT code. These edits may be bypassed with modifier 59 if the two procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter. NCCI does not include all edits pairing two physical medicine and rehabilitation services (excepting “supervised modality” services) even though they should never be reported for the same fifteen minute time period.

2. NCCI contains edits with column one codes of the physical medicine and rehabilitation therapy services and column two codes of the physical therapy and occupational therapy re-evaluation CPT codes of 97002 and 97004 respectively. The re-evaluation services should not be routinely reported during a planned course of physical or occupational therapy. However, if the patient’s status should change and a re-evaluation is medically reasonable and necessary, it may be reported with modifier 59 appended to CPT code 97002 or 97004 as appropriate.

3. The procedure coded as CPT code 97755 (assistive technology assessment...direct one-on-one contact by provider, with written report, each 15 minutes) is intended for use on severely impaired patients requiring adaptive technology. For example, a patient with the use of only one or no limbs might require the use of high level adaptive technology.

4. The NCCI edit with column one CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column two CPT code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 97530 of this NCCI edit is appropriate only if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.

5. Based on *CPT Manual* instructions selective debridement (CPT codes 97597, 97598) should not be reported in conjunction with surgical debridement (CPT codes 11040-11044). Physicians cannot report these codes separately on the same date of service. However, under OPPS a facility may report these codes separately if the selective debridement and surgical debridement are performed on two separate and distinct wounds. The two procedures may be performed by the same practitioner or two separate practitioners and may be performed at the same or separate patient encounters on the same date of service. The same principle applies to CPT code 97602 which is payable under OPPS.

Q. Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is subject to Global Surgery Rules. Per Medicare Anesthesia Rules a provider performing OMT cannot separately report anesthesia services such as nerve blocks or epidural injections for OMT. In addition, per Medicare Global Surgery Rules, postoperative pain management after OMT (e.g., nerve block, epidural injection) is not separately reportable. Epidural or nerve block injections performed on the same date of service as OMT and unrelated to the OMT may be reported with OMT using modifier 59.

R. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier 59.

S. Miscellaneous Services

1. When CPT code 99175 (Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison) is reported, observation time provided predominantly to monitor the patient for a response to an emetogenic agent should not be included in other timed codes (e.g., critical care, prolonged services).

2. If hypothermia (e.g., CPT code 99185) is accomplished by regional infusion techniques, chemotherapy administration CPT codes should not be reported unless chemotherapeutic agents are also administered at the same patient encounter.

3. Therapeutic phlebotomy (CPT code 99195) is not separately reportable with autologous blood collection (CPT codes 86890, 86891), plasmapheresis, or exchange transfusion. Services integral to performing the phlebotomy (e.g., CPT codes 36000, 36410, 96360-96376) are not separately reportable.

T. Evaluation and Management (E&M) Services

CPT codes for evaluation and management (E&M) services are principally included in the CPT code range 99201-99499. The codes describe the site of service (e.g., office, hospital, home, nursing facility, emergency department, critical care), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter, consultation), and various miscellaneous services (e.g., prolonged physician service, care plan oversight service). E&M services are further classified by the complexity of the relevant clinical history, physical examination, and

medical decision making. Some E&M codes are based on the duration of the encounter (e.g., critical care services).

Rules governing the reporting of more than one E&M code for a patient on the same date of service are very complex and are not described herein. However, the NCCI contains numerous edits based on several principles including, but not limited to:

1. A physician may report only one “new patient” code on a single date of service.

2. A physician may report only one code from a range of codes describing an initial E&M service on a single date of service.

3. A physician may report only one “per diem” E&M service from a range of per diem codes on a single date of service.

4. A physician should not report an “initial” per diem E&M service with the same type of “subsequent” per diem service on the same date of service.

5. E&M codes describing observation/inpatient care services with admission and discharge on same date (CPT codes 99234-99236) should not be reported on the same date of service as initial hospital care per diem codes (99221-99223), subsequent hospital care per diem codes (99231-99233), or hospital discharge day management codes (99238-99239).

The prolonged physician 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 physician E&M services (CPT codes 99354-99357) are reported based on time, providers should not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged physician E&M service time.

Evaluation and management services, in general, are cognitive services, and significant procedural services are not included in evaluation and management services. Certain procedural services

that arise directly from the evaluation and management service are included as part of the evaluation and management service. For example, cleansing of traumatic lesions, closure of lacerations with adhesive strips, application of dressings, counseling and educational services are included in evaluation and management services.

Digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an evaluation and management code. CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

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

Because of the intensive nature of caring for critically ill patients, certain services in addition to patient history, examination, and medical decision making are included in the overall evaluation and management associated with critical and intensive care. Per CPT instructions, services including, but not limited to, the interpretation of cardiac output measurements (CPT codes 93561 and 93562), chest X-rays (CPT codes 71010 and 71020), blood gases, and data stored in computers (ECGs, blood pressures, hematologic data), gastric intubation (CPT code 91105), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94002-94004, 94660, 94662), and vascular access procedures (CPT codes 36000, 36410, 36600) are included in critical and intensive care services and should not be reported separately. Under the OPPS the same services are not separately reportable with critical care CPT code 99291. The hospital resources necessary to generate the information for interpretation by a physician are included in CPT code 99291.

Per Medicare rules critical and intensive care CPT codes include thoracic electrical bioimpedance (CPT code 93701) which should not be reported separately.

Certain sections of CPT codes include codes describing specialty-specific services which primarily involve evaluation and management services. When codes for these services are reported, a separate evaluation and management service from the range of CPT codes 99201-99499 should not be reported on the same date of service. Examples of these codes include general and special ophthalmologic services and general and special diagnostic and therapeutic psychiatric services.

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

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

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 and A/B MACs processing practitioner service claims have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) 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 and A/B MACs processing practitioner service claims have separate edits. The NCCI, Carriers, and A/B MACs processing practitioner service claims do not 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. Examples of XXX procedures include allergy testing and immunotherapy, physical therapy services, and neurologic and vascular diagnostic testing procedures.

Pediatric and neonatal critical and intensive care CPT codes (99468-99480) are per diem codes that can be reported by one physician on each day of service. These codes are reported by the physician directing the inpatient critical or intensive care of the patient. These codes should not be reported by other physicians performing critical care services on the same date of service. Critical care services provided by a second physician of a different specialty may be reported with CPT codes 99291 and 99292.

U. Medically Unlikely Edits (MUEs)

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

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

3. For purposes of reporting units of service (UOS) for antigen preparation (i.e., CPT codes 95145-95170), the physician reports “number of doses”. Medicare defines a dose for reporting purposes as 1 milliliter (ml). Thus, if a physician prepares a 10 ml vial of antigen, the physician may only report a maximum of

10 UOS for that vial even if the number of actual administered doses is greater than 10. Medicare payment amounts for these codes were determined by dividing the practice expenses for a 10 ml vial into ten doses. (See Internet Only *Claims Processing Manual*, Publication 100-04, Chapter 12, Section 200 (B)(7)).

4. CPT code 94681 (oxygen uptake, expired gas analysis; including CO_2 output, percentage oxygen extracted) may be reported one time per day. It includes rest and exercise determinations.

5. The unit of service for CPT code 90853 (Group psychotherapy (other than of a multiple family group)) is the patient encounter with completed therapy session even if it lasts longer than one hour. 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 therapy session provided by a different practitioner. Effective January 1, 2009, group therapy services provided in a PHP (partial hospitalization program) should be reported with HCPCS codes G0410 or G0411 which are timed codes. Prior to January 1, 2009, CMS permitted PHPs to report group therapy services utilizing CPT code 90853 with a unit of service corresponding to forty five to sixty minutes of therapy.

V. 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 96360-96375 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

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

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. 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.

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

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

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

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

10. Most NCCI 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.