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CHAPTER V
SURGERY: RESPIRATORY, CARDIOVASCULAR, HEMIC AND LYMPHATIC SYSTEMS
CPT CODES 30000-39999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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Chapter V
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems
CPT Codes 30000 - 39999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 30000-39999. 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.

Open procedures of the thorax include the approach and exploration. CPT code 32100 (thoracotomy, major; with exploration and biopsy) should not be reported separately with open thoracic procedures to describe the approach and exploration. CPT code 32100 may be separately reportable with an open thoracic procedure if: (1) it is performed on the contralateral side; (2) it is performed on the ipsilateral side through a separate skin incision; or (3) it is performed to obtain a biopsy at a different site than the other open thoracic procedure.

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. Respiratory System

1. The nose and mouth have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes that describe the procedure as an integumentary procedure (CPT codes 10000-19999), a nasal procedure (CPT codes 30000-30999), or an oral procedure (CPT codes 40000-40899). If a procedure is

performed on a lesion at or near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If the code descriptor of a CPT code from the respiratory system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) should not be reported separately.

2. A biopsy performed in conjunction with a more extensive nasal/sinus procedure is not separately reportable unless the biopsy is examined pathologically prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination.

Example: If a patient presents with nasal obstruction, sinus obstruction and multiple nasal polyps, it may be reasonable to perform a biopsy prior to, or in conjunction with, polypectomy and ethmoidectomy. A separate biopsy code (e.g., CPT code 31237 for nasal/sinus endoscopy) should not be reported with the removal nasal/sinus endoscopy code (e.g., CPT code 31255) because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic or surgical endoscopy of the respiratory system is performed, it is a standard of practice to evaluate the access regions. A separate HCPCS/CPT code should not be reported for this evaluation of the access regions. For example, if an endoscopic anterior ethmoidectomy is performed, a diagnostic nasal endoscopy should not be reported separately simply because the approach to the ethmoid sinus is transnasal. Similarly, fiberoptic bronchoscopy routinely includes an examination of the nasal cavity, pharynx, and larynx. A separate HCPCS/CPT code should not be reported with the bronchoscopy HCPCS/CPT code for this latter examination whether it is limited (“cursory”) or complete.

If medically reasonable and necessary endoscopic procedures are performed on two regions of the respiratory system with different types of endoscopes, both procedures may be separately reportable. For example, if a patient requires diagnostic bronchoscopy for a lung mass with a fiberoptic bronchoscope and a separate laryngoscopy for a laryngeal mass with a fiberoptic laryngoscope at the same patient encounter, HCPCS/CPT codes for both procedures may be reported separately. It must be medically

reasonable and necessary to utilize two separate endoscopes to report both codes.

If the findings of a diagnostic endoscopy lead to the performance of a non-endoscopic surgical procedure at the same patient encounter, the diagnostic endoscopy may be reported separately. However, if a “scout” endoscopic procedure to evaluate the surgical field (e.g., confirmation of anatomic structures, assess extent of disease, confirmation of adequacy of surgical procedure such as tracheostomy) is performed at the same patient encounter as an open surgical procedure, the endoscopic procedure is not separately reportable.

A diagnostic endoscopy is not separately reportable with a surgical endoscopy per *CPT Manual* instructions. If an endoscopic procedure fails and is converted into an open procedure, the endoscopic procedure is not separately reportable with the open procedure.

Example: A patient presents with aspiration of a foreign body. A bronchoscopy is performed identifying lobar foreign body obstruction, and an attempt is made to remove this obstruction bronchoscopically. It would be inappropriate to report CPT codes 31622 (diagnostic bronchoscopy) and 31635 (surgical bronchoscopy with removal of foreign body). Only the "surgical" endoscopy, CPT code 31635, may be reported. In this example, if the endoscopic effort fails and a thoracotomy is performed, the diagnostic bronchoscopy may be reported separately in addition to the thoracotomy. Modifier 58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. However, the CPT code for the surgical bronchoscopy to remove the foreign body is not separately reportable because the procedure was converted to an open procedure. If the surgeon decides to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, this confirmatory bronchoscopy is not separately reportable although the initial diagnostic bronchoscopy may still be reportable.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service may be reported. *CPT Manual* instructions indicate that surgical sinus endoscopy includes a sinusotomy (if appropriate) and a diagnostic sinus endoscopy. However, if the medically necessary procedure is a sinusotomy and

a sinus endoscopy is performed to evaluate adequacy of the sinusotomy and visualize the sinus cavity for disease, it may be appropriate to report the sinusotomy HCPCS/CPT code rather than the sinus endoscopy HCPCS/CPT code.

5. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. For example, control of nasal hemorrhage (CPT code 30901) is not separately reportable for control of bleeding during a nasal/sinus endoscopic procedure. However, if bleeding occurs in the postoperative period and requires return to the operating room for treatment, a HCPCS/CPT code for control of the bleeding may be reported with modifier 78 indicating that the procedure was a complication of a prior procedure requiring treatment in the operating room. However, control of postoperative bleeding not requiring return to the operating room is not separately reportable.

6. When endoscopic service(s) are performed, the most comprehensive code describing the service(s) rendered should be reported. If multiple services are performed and not adequately described by a single CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended to the secondary service CPT code(s). Additionally, only medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

7. If laryngoscopy is required for elective or emergency placement of an endotracheal tube, the laryngoscopy is not separately reportable. CPT code 31500 describes an emergency endotracheal intubation procedure and should not be reported when an elective intubation is performed. For example, if intubation is performed in a rapidly deteriorating patient who requires mechanical ventilation, a separate HCPCS/CPT code may be reported for the intubation with adequate documentation of the reasons for the intubation.

8. The descriptor for CPT code 31600 (Tracheostomy, planned (separate procedure)) includes the “separate procedure” designation. Therefore, pursuant to the CMS “separate procedure” policy, a tracheostomy is not separately reportable with laryngeal surgical procedures that frequently require tracheostomy (e.g., laryngotomy, laryngectomy, laryngoplasty).

9. If laryngoscopy is required for placement of a tracheostomy, the tracheostomy (CPT codes 31600-31610) may be reported. The laryngoscopy is not separately reportable.

10. CPT code 92511 (nasopharyngoscopy with endoscope) should not be reported separately when performed as a cursory examination with other respiratory endoscopic procedures.

11. A surgical thoracoscopy is not separately reportable with an open thoracotomy procedure, the latter being the more extensive procedure. However, if the clinical findings of a diagnostic thoracoscopy lead to the decision to perform an open thoracotomy, the diagnostic thoracoscopy may be separately reportable. A thoracoscopy to evaluate anatomic landmarks or assess extent of disease in a previously diagnosed patient is not separately reportable with an open thoracotomy.

12. A tube thoracostomy (CPT code 32020 (32551 in 2008)) may be performed for drainage of an abscess, empyema, or hemothorax. The code descriptor for CPT code 32020 (32551 in 2008) defines it as a “separate procedure”. It is not separately reportable when performed at the same patient encounter as another open procedure on the ipsilateral side of the thorax.

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

14. The procedures described by CPT codes 30801 and 30802 (cautery and/or ablation of mucosa of inferior turbinates) are performed to reduce the size of the inferior turbinates of the nose. These two codes should not be reported for access to the nose or sinuses or for control of intraoperative bleeding with other codes describing nasal or sinus endoscopy or other nasal procedures. Since the procedure described by CPT code 30802 (intramural, unilateral or bilateral) is more extensive than the procedure described by CPT code 30801 (superficial, unilateral or bilateral), both codes should not be reported for the same patient encounter.

D. Cardiovascular System

1. Coronary artery bypass procedures utilizing venous grafts (CPT codes 33510-33523) include procurement of the venous graft(s) as an integral component of the procedure. CPT codes 37700-37735 (ligation of saphenous veins) should not be reported separately for procurement of the venous grafts.

2. When a coronary artery bypass procedure is performed, the most comprehensive code describing the procedure should be reported. When venous grafting only is performed, only one code in the range of coronary artery bypass CPT codes 33510-33516 may be reported. No other bypass codes should be reported with these codes. One code in the range of CPT codes 33517-33523 (combined arterial-venous grafting) and one code in the range of CPT codes 33533-33536 (arterial grafting) may be reported together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, only one code in the range of CPT codes 33533-33536 may be reported.

3. During venous or combined arterial venous coronary artery bypass grafting procedures (CPT codes 33510-33523), it is occasionally necessary to perform epi-aortic ultrasound. This procedure may be reported with CPT code 76998 (ultrasonic guidance, intraoperative) appending modifier 59. CPT code 76998 should not be reported for ultrasound guidance utilized to procure the vascular graft.

4. Many of the code descriptors in the CPT code range 36800-36861 (hemodialysis access, intervascular cannulation, shunt insertion) include the “separate procedure” designation. Pursuant to the CMS “separate procedure” policy, these “separate procedures” are not separately reportable with vascular revision procedures at the same site/vessel.

5. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy, and/or bypass. When a thromboendarterectomy is performed at the site of an aneurysm repair or graft insertion, the thromboendarterectomy is not separately reportable. If a bypass procedure requires an endarterectomy to insert the bypass graft, only the code describing the bypass may be reported. The endarterectomy is not separately reportable. If both an aneurysm repair (e.g., after

rupture) and a bypass are performed at separate non-contiguous sites, the aneurysm repair code and the bypass code may be reported with an anatomic modifier or modifier 59. If a thromboendarterectomy is medically necessary due to vascular occlusion in a different vessel, the appropriate code may be reported with an anatomic modifier or modifier 59 indicating that the procedures were performed in non-contiguous vessels.

At a given site, only one type of bypass (venous, non-venous) code may be reported. If different vessels are bypassed with different types of grafts, separate codes may be reported. If the same vessel has multiple obstructions and requires bypass with different types of grafts in different areas, separate codes may be reported. However, it is necessary to indicate that multiple procedures were performed by using an anatomic modifier or modifier 59.

6. When an open vascular procedure (e.g., thromboendarterectomy) is performed, the repair and closure are included components of the vascular procedure. CPT codes 35201-35286 (repair of blood vessel) are not separately reportable in addition to the primary vascular procedure.

7. If a failed percutaneous vascular procedure is followed by an open procedure by the same physician at the same patient encounter (e.g., percutaneous transluminal angioplasty, thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the HCPCS/CPT code for the completed procedure, which is usually the more extensive open procedure may be reported. If a percutaneous procedure is performed on one lesion and a similar open procedure is performed on a separate lesion, the HCPCS/CPT code for the percutaneous procedure may be reported with modifier 59 only if the lesions are in distinct and separate anatomically defined vessels. If similar open and percutaneous procedures are performed on different lesions in the same anatomically defined vessel, only the open procedure may be reported.

8. The CPT codes 36000, 36406, 36410, etc. represent very common procedures performed to gain venous access for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy, hydration, transfusion, drug administration, etc. When intravenous access is routinely obtained in the course of performing other medical/diagnostic/surgical procedures or is necessary to accomplish the procedure (e.g., infusion therapy,

chemotherapy), it is inappropriate to separately report the venous access services. CPT codes 96360-96361 should not be reported for infusions to maintain patency of a vascular access site.

9. When a non-coronary percutaneous intravascular interventional procedure is performed on the same vessel at the same patient encounter as diagnostic angiography (arteriogram/venogram), only one selective catheter placement code for the vessel may be reported. If the angiogram and the percutaneous intravascular interventional procedure are not performed in immediate sequence and the catheter(s) are left in place during the interim, a second selective catheter placement or access code should not be reported. Additionally, dye injections to position the catheter should not be reported as a second angiography procedure.

10. Diagnostic angiograms performed on the same date of service as a percutaneous intravascular interventional procedure should be reported with modifier 59. If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier 59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

11. If a median sternotomy is utilized to perform a cardiothoracic procedure, the repair of the sternotomy is not separately reportable. CPT codes 21820-21825 (treatment of sternum fracture) should not be reported for repair of the sternotomy.

If a cardiothoracic procedure is performed after a prior cardiothoracic procedure with sternotomy (e.g., repeat procedure, new procedure, treatment of postoperative hemorrhage), removal of embedded wires is not separately reportable.

12. If a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure. For example, if a reoperation for coronary artery bypass or valve procedures requires removal of previously inserted sternal wires, removal of these wires is not separately reportable.

13. When existing vascular access lines or selectively placed catheters are utilized to procure arterial or venous samples, reporting the sample collection separately is inappropriate. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling. CPT code 75893 includes concomitant venography if performed. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure.

14. Peripheral vascular bypass CPT codes describe bypass procedures with venous and other grafting materials (CPT codes 35501-35683). These procedures are mutually exclusive since only one type of bypass procedure may be performed at a site of obstruction. If multiple sites of obstruction are treated with different types of bypass procedures at the same patient encounter, multiple bypass procedure codes may be reported with anatomic modifiers or modifier 59. If a physician attempts a graft with one material but completes the graft with another material, only the one code describing the completed procedure should be reported.

15. Bypass grafts (CPT codes 35500-35683) include blood vessel repair. CPT codes 35201-35286 (direct repair, repair with vein graft, and repair with graft other than vein) should not be reported with a bypass graft code for the same anatomic site.

16. Vascular obstruction may be caused by thrombosis, embolism, atherosclerosis or other conditions. Treatment may include thrombectomy, embolectomy and/or endarterectomy. CPT

codes describe embolectomy/thrombectomy (e.g., CPT codes 34001-34490), atherectomy (e.g., CPT codes 35480-35495), and thromboendarterectomy (e.g., CPT codes 35301-35390). Only the most comprehensive code describing the services performed at a given site/vessel may be reported. Therefore, for a given site/vessel, codes from more than one of the above code ranges should not be reported together. If a percutaneous interventional procedure fails (e.g., balloon thrombectomy) and the same physician performs an open procedure (e.g., thromboendarterectomy) at the same patient encounter, only the completed procedure, generally the more extensive open procedure, may be reported.

17. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the more comprehensive atherectomy that was performed (generally the open procedure) should be reported (see sequential procedure policy, Chapter I, Section M).

18. CPT codes 35800-35860 describe treatment of postoperative hemorrhage requiring return to the operating room. These codes should not be reported for the treatment of hemorrhage during the initial operative session nor treatment of postoperative hemorrhage not requiring return to the operating room. These codes should generally be reported with modifier 78 indicating that the procedure represents a return to the operating room for a related procedure in the postoperative period.

19. 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 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 33200-33249 or 93600-93662.

20. Electronic analysis (i.e., interrogation and programming) is integral to the insertion or replacement of a pacemaker or cardioverter-defibrillator pulse generator. The interrogation and programming codes should not be reported separately.

21. CPT code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type...) describes an arterial infusion directly into an artery of a non-chemotherapeutic medication to treat the artery for disease (e.g., vasospasm) other than thrombolysis. This code should not be utilized to report intravenous infusions, arterial push injections (CPT code 96373), or chemotherapy infusions. It should not be reported for infusion for systemic therapy. This code should not be reported for infusion into a blood vessel undergoing a percutaneous diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. This code may be reported separately when a catheter is inserted into a blood vessel for the purpose of the transcatheter therapy of the blood vessel. CPT code 75896 may be reported for the radiological supervision and interpretation associated with the transcatheter therapy described by CPT code 37202.

22. The *CPT Manual* defines primary and secondary percutaneous transluminal arterial mechanical thrombectomies. The *CPT Manual* contains an instruction which states: “Do not report 37184-37185 for mechanical thrombectomy performed for retrieval of short segments of thrombus or embolus evident during other percutaneous interventional procedures. See 37186 for these procedures.” Based on this CPT instruction, the NCCI contains edits bundling the primary percutaneous transluminal mechanical thrombectomy (CPT code 37184) into all percutaneous arterial interventional procedures. These edits allow use of NCCI–associated modifiers if a provider performs a primary percutaneous transluminal arterial mechanical thrombectomy rather than a secondary percutaneous transluminal arterial mechanical

thrombectomy (CPT code 37186) in conjunction with the other percutaneous arterial procedure.

23. CPT code 37215 describes a percutaneous transcatheter placement of intravascular stent(s) in the cervical carotid artery utilizing distal embolic protection. It includes all ipsilateral selective carotid arterial catheterization, all diagnostic imaging for ipsilateral cervical and cerebral carotid arteriography, and all radiological supervision and interpretation (RS&I). Physicians should not unbundle the RS&I services. For example a provider should not report CPT code 75962 (RS&I for transluminal balloon angioplasty of a peripheral artery) for angioplasty of the cervical carotid artery which is an included service in the procedure defined by CPT code 37215. Additionally since the carotid artery is not a peripheral artery, it is a misuse of CPT code 75962 to describe a carotid artery procedure. These same principles would apply to CPT code 37216, but it is currently a noncovered service code on the Medicare Physician Fee Schedule.

24. 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.

25. Operative ablation procedures (CPT codes 33250-33266) include cardioversion as an integral component of the procedures. CPT codes 92960 or 92961 (elective cardioversion) should not be reported separately with the operative ablation procedure codes unless an elective cardioversion is performed at a separate patient encounter on the same date of service. If electrophysiologic study with pacing and recording is performed during an operative ablation procedure, it is integral to the procedure and should not be reported separately as CPT code 93624 (electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy...).

26. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan Ganz)) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569 (insertion of peripherally inserted central venous catheter) for

the insertion of a single catheter. If a physician does not complete the insertion of one type of catheter and subsequently inserts another at the same patient encounter, only the completed procedure may be reported.

27. CPT codes 33203, 33265, and 33266 describe surgical endoscopic procedures (CPT code 33203 – insertion of epicardial electrodes; CPT codes 33265, 33266 – operative tissue ablation). CPT codes 32603 and 32604 describe diagnostic thoracoscopy of the pericardial sac. Since surgical endoscopy includes diagnostic endoscopy, CPT codes 32603/32604 should not be reported separately with CPT codes 33203/33265/33266 for the same patient encounter.

E. Hemic and Lymphatic Systems

When bone marrow aspiration is performed alone, the appropriate code to report is CPT code 38220. When a bone marrow biopsy is performed, the appropriate code is CPT code 38221 (bone marrow biopsy). This code cannot be reported with CPT code 20220 (bone biopsy). CPT codes 38220 and 38221 may only be reported together if the two procedures are performed at separate sites or at separate patient encounters. Separate sites include bone marrow aspiration and biopsy in different bones or two separate skin incisions over the same bone. When both a bone marrow biopsy (CPT code 38221) and bone marrow aspiration (CPT code 38220) are performed at the same site through the same skin incision, do not report the bone marrow aspiration, CPT code 38220, in addition to the bone marrow biopsy (CPT code 38221). HCPCS/CPT code G0364 may be reported to describe the bone marrow aspiration performed with bone marrow biopsy through the same skin incision on the same date of service.

F. Mediastinum

1. CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with “exploration, drainage, removal of foreign body, or biopsy”. Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 should not be reported separately for exploration of the mediastinum when performed with procedures on mediastinal structures (e.g., esophagus, bronchi, aorta, heart) or structures accessed through the mediastinum (e.g., lungs, vertebrae). These

codes may be reported separately if mediastinal drainage, removal of foreign body, or biopsy is performed.

G. 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.

H. 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. 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.

5. Open procedures of the thoracic cavity require a thoracotomy for the surgical approach. A physician should not report CPT code 32100 (thoracotomy, major; with exploration and biopsy) in addition to an open thoracic procedure CPT code.

6. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 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. HCPCS/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.

7. 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.

8. 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.

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

10. 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.

11. 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.

12. 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.

13. 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.