CHAPTER XII
SUPPLEMENTAL SERVICES
HCPCS LEVEL II CODES A0000 – V9999
FOR
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

Revision Date (Medicare): 1/1/2026

Table of Contents

Chapter XII
Supplemental Services
HCPCS Level II Codes A0000-V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to Healthcare Common Procedure Coding System (HCPCS) Level II codes. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians shall report the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code shall be reported only if all services described by the code are performed. A physician shall not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services performed. This type of unbundling is incorrect coding.

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

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

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

B. Evaluation & Management (E&M) Services

This section summarizes some of the Medicare Global Surgery Rules for reporting Evaluation & Management (E&M) services in the global period.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the MAC. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider/supplier to the same beneficiary, certain Global Surgery Rules are applicable to the NCCI program. 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 days 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 service is performed on the same date of service as a major surgical procedure to decide whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. The NCCI program does not contain edits based on this rule because MACs have separate edits.

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

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

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not 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 provider/supplier shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure 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 a "XXX" procedure may be appropriate in some instances.

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

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

2. HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with E&M services under certain circumstances. If a Medicare covered reasonable and medically necessary E&M service requires breast and/or pelvic examination, HCPCS code G0101 shall not be additionally reported.

   However, if the Medicare covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

3. HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an E&M code (e.g., CPT/HCPCS codes 99202-99499, G0463, G0466-G0470, G0438, G0439). 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."

4. Subsection deleted, January 1, 2024.

5. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic, per millicurie) describes a radiopharmaceutical used for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. HCPCS code A9512 shall not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if 2 separate nuclear medicine studies are performed on the same date of service, 1 with the radiopharmaceutical described by HCPCS code A9512 and 1 with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both

codes may be reported using an NCCI PTP-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be used for separate nuclear medicine studies on the same date of service as a nuclear medicine study using the radiopharmaceutical described by HCPCS code A9512.

6. The NCCI program contains PTP edits that bundle some radiopharmaceutical codes into nuclear medicine procedure codes. In some situations where a patient has 2 nuclear medicine procedures performed on the same date of service, the radiopharmaceutical used for 1 nuclear medicine procedure may be incompatible with the second nuclear medicine procedure. In this circumstance, it may be appropriate to report the radiopharmaceutical with modifiers 59 or XE or XS.

7. HCPCS code A4220 describes a refill kit for an implantable pump. It shall not be reported separately with CPT codes 95990 (Refilling and maintenance of implantable pump..., spinal... or brain...when performed) or 95991 (Refilling and maintenance of implantable pump, spinal... or brain... requiring skill of physician or other qualified health care professional) since Medicare payment for these 2 CPT codes includes the refill kit.

   Similarly, HCPCS code A4220 shall not be reported separately with CPT codes 62369 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill) or 62370 (Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)) since Medicare payment for these 2 CPT codes includes the refill kit.

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

9. HCPCS codes G0422 and G0423 (Intensive cardiac rehabilitation...per session) include the same services as the cardiac rehabilitation CPT codes 93797 and 93798, but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as 6 hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) shall not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately. The Medicare covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation service.

   Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services are included in the cardiac rehabilitation benefit and are not separately reportable. (CMS Final Rule (*Federal Register*, Vol. 74, No. 226,

November 25, 2009, pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable, and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier.

10. Pulmonary rehabilitation (HCPCS/CPT codes G0424, 94625, 94626) includes therapeutic services and all related monitoring services to improve respiratory function. It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT code 94618), cardiopulmonary exercise testing (CPT code 94621)). Pulmonary rehabilitation shall not be reported with HCPCS codes G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles... (includes monitoring)), G0238 (Therapeutic procedures to improve respiratory function... (includes monitoring)), or G0239 (Therapeutic procedures to improve respiratory function or increase strength... (includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT code 94618), cardiopulmonary exercise testing (CPT code 94621)). (HCPCS code G0424 was deleted January 1, 2022.)

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

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

11. Presumptive drug testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. HCPCS code G0659 defining a different type of definitive drug testing was added. Only one definitive drug testing HCPCS code may be reported per date of service.

12. In accordance with code descriptor changes for HCPCS codes G0416 effective January 1, 2015, CMS requires that surgical pathology, including gross and microscopic examination, of any and all submitted prostate needle biopsy specimens from a single patient be reported with one unit of service of HCPCS code G0416 rather than CPT code 88305.

13. Blood products are described by HCPCS Level II P codes. If a P code describes an irradiated blood product, CPT code 86945 (Irradiation of blood product, each unit) shall not be reported separately since the P code includes irradiation of the blood product. If a P code describes a CMV negative blood product, CPT codes 86644 and/or 86645 (CMV antibody) shall not be reported separately for that blood product since the P code includes the CMV antibody testing. If a P code describes a deglycerolized blood product, CPT codes 86930 (Frozen blood, each unit; freezing (includes preparation)), 86931 (Frozen blood, each unit; thawing), and/or 86932 (Frozen blood, each unit; freezing (includes preparation) and thawing) shall not be reported separately since the P code includes the freezing and thawing processes.

    If a P code describes a pooled blood product, CPT code 86965 (Pooling of platelets or other blood products) shall not be reported separately since the P code includes the pooling of the blood products. If the P code describes a "frozen" plasma product, CPT code 86927 (Fresh frozen plasma, thawing, each unit) shall not be reported separately since the P code includes the thawing process.

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

    HCPCS codes G0396 and G0397 describe services that are similar to those described by CPT codes 99408 and 99409. The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS Level II codes (e.g., G0442 (Annual alcohol misuse screening, 5 to 15 minutes), G0443 (Brief face-to-

face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (Annual depression screening, 5 to 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS Level II code, the HCPCS Level II code is not separately reportable.

For example, if a patient presents with symptoms suggestive of depression, the provider/supplier shall not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

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

16. HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) shall not be reported separately with CPT codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since Medicare payment for these 2 CPT codes includes the amniotic membrane.

17. Subsection deleted, January 1, 2025.

D. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are 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 (UOS) incorrectly. The provider/supplier may consider contacting their national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

3. The MUE values of HCPCS Level II codes for discontinued drugs are generally "0."

4. The MUE value of HCPCS Level II codes describing compounded inhalation drugs is "0," because compounded drugs are generally not FDA approved. The CMS IOM

Medicare Benefit Policy Manual (MCPM), Chapter 15, Section 50.4.1 requires that claims processing contractors only pay for FDA-approved drugs unless CMS issues other instructions.

5. HCPCS code J0171 (Injection, adrenalin, epinephrine, 0.1 mg) may be reported incorrectly. A 1 ml ampule of adrenalin/epinephrine contains 1.0 mg of adrenalin/epinephrine in a 1:1,000 solution. However, a 10 ml prefilled syringe with a 1:10,000 solution of adrenalin/epinephrine also contains only 1.0 mg of adrenalin/epinephrine. Thus, a physician must recognize that 10 UOS for HCPCS code J0171 corresponds to a 1 ml ampule or 10 ml of a prefilled syringe (1:10,000 (0.1 mg/ml) solution). (HCPCS code J0171 was deleted July 1, 2025.)

6. There may be multiple HCPCS Level II codes describing certain drugs. For example, HCPCS code J1094 (Injection, dexamethasone acetate, 1 mg) is no longer manufactured and has an MUE value of "0." HCPCS code J1100 (Injection, dexamethasone sodium phosphate, 1 mg) is available and has an MUE of 120. When billing for drugs, providers/suppliers should be careful to report the correct formulation with the correct HCPCS code. (HCPCS code J1094 was deleted April 1, 2025.)

7. If a physician uses more than 999 USP units of the product described by J3471 (Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units)), the provider/supplier may report HCPCS code J3471 on more than 1 line of a claim appending modifier 59 or XU to additional claim lines.

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

   The MUE values for outpatient hospital services are generally based on the amount of drug that might be administered to a patient on a single date of service. Facilities may not report to the A/B MAC more than a one-day supply of any of these drugs for a single date of service. Outpatient hospital facilities may submit claims to DME MACs for a multiple-day supply of these drugs provided on a single date of service.

9. If a HCPCS Level II drug code descriptor defines the unit of service as "per dose," only one unit of service may be reported per drug administration procedure even if more than the usual amount of drug is administered. For example, HCPCS code J7321 (Hyaluronan or derivative Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose) describes a drug that may be injected into the knee joint. Only one unit of service may be reported for injection of the drug into each knee joint, even if the amount of injected drug exceeds the usual amount of drug injected.

10. Presumptive drug testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

    Definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes are reported "per day" and shall not be reported with more than one unit of service per day. Definitive drug testing HCPCS code G0659 is reported "per day" and shall not be reported with more than one unit of service per day. Only one definitive drug testing HCPCS code may be reported per date of service.

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

12. HCPCS code K0462 (Temporary replacement for patient owned equipment being repaired, any type) may be reported with one unit of service for each item of patient-owned equipment that is being repaired. Component parts of a patient-owned piece of equipment being repaired shall not be reported separately. For example, if a patient-owned CPAP (continuous positive airway pressure) blower requires repair, the provider/supplier may report one unit of service for K0462. The provider/supplier shall not report an additional unit of service for an integral humidifier even if it also requires repair. Additionally, the provider/supplier shall not report an additional unit of service for a detachable humidifier unless it also requires repair at the same time.

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

14. HCPCS code P9604 describes a prorated, one-way travel allowance for collection of medically necessary laboratory specimen(s) drawn from a home bound or nursing home bound patient. A round trip should be reported with modifier LR and 1 unit of service rather than 2 UOS. The reported UOS shall be prorated for multiple patients drawn at the same address and for stops at the homes of Medicare and non-Medicare patients, as described in the Medicare IOM Publication 100-04 MCPM, Chapter 16 (Laboratory Services), Section 60.2.

15. The CMS IOM Publication 100-04 MCPM, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one unit of service on a single claim line unless the code descriptor defines the procedure as "bilateral." If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50. The MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on 2 claim lines, each with 1 unit of service using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

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

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

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

17. HCPCS code G9157 (Transesophageal doppler measurement of cardiac output (including probe placement, image acquisition, and interpretation per course of treatment) for monitoring purposes) describes a diagnostic procedure reportable only for ventilated patients in the Intensive Care Unit or operative patients with a need for intra-operative fluid optimization. Reporting this code is limited to an inpatient hospital place of service. HCPCS code G9157 shall be reported no more than once per course of treatment.

E. General Policy Statements

1. The MUE values and NCCI PTP edits are based on services provided by the same provider/supplier to the same beneficiary on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.
2. In this manual, many policies are described using the term "physician." Unless indicated differently the use 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, CMS IOM Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services) and Global Surgery Rules, CMS IOM Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery) do not apply to hospitals.

3. Providers/suppliers reporting services under Medicare's hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare IOM instructions.

4. In 2010, the *CPT Professional* codebook modified the numbering of codes so that the sequence of codes as they appear in the *CPT Professional* codebook does not necessarily correspond to a sequential numbering of codes. In the *Medicare NCCI Policy Manual*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Professional* codebook.

5. 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 using 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 using tissue adhesive may be reported separately. If a practitioner uses 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 uses 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 the OPPS, HCPCS code G0168 is not recognized and paid. Facilities may report wound closure using sutures, staples, or tissue adhesives, singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Professional* codebook.

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 provider/supplier shall not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the provider/supplier shall not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (e.g., CPT codes 96360-96379) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

   Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or

surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

Under Medicare Global Surgery Rules, drug administration services (e.g., CPT codes 96360-96379) 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/suppliers shall not report CPT codes 96360-96379 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, 62320-62327, 64400-64450 describe some services that may be used for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if 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 (e.g., CPT codes 96360-96379) unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (e.g., CPT codes 96360-96379) may be reported with an NCCI PTP-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) shall not be reported with any procedure with a global period of 000, 010, or 090 days, nor with some procedures with a global period of MMM.

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

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 using modifier 78.

10. For more information regarding biopsies, see Chapter I, Section A, Introduction.

11. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI PTP-associated modifiers (Correct Coding Modifier Indicator (CCMI) of "1") because the 2 codes of the code pair edit may be reported if the 2 procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the 2 codes generally should not be reported together unless the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI PTP-associated modifiers should generally not be used.

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

13. If the code descriptor for a HCPCS/CPT code, *CPT Professional* codebook instruction for a code, or the CMS instruction for a code indicates that the procedure includes radiologic guidance, a provider/supplier shall not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI PTP-associated modifier if appropriate.

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

15. CPT code 96523 describes "irrigation of implanted venous access…" This code may be reported only if no other service is reported for the patient encounter.