Chapter XI
Medicine
Evaluation and Management
CPT-4 90000 - 99999

A. Introduction

The Medicine section of the CPT-4 manual includes codes for non-invasive or minimally invasive (primarily percutaneous access) services that would not be considered surgical procedures or evaluation and management services. In keeping with the general principles of proper CPT-4 coding, the services required to accomplish an evaluation or procedure as described by a medicine code are included in the code and cannot be separately billed even if other specific CPT-4 codes exist to describe these supplemental services. These principles are described in depth in the general policies of Chapter I.

B. Therapeutic or Diagnostic Infusions/Injections

The CPT-4 codes 90780-90799 describe services involving therapeutic or diagnostic injections and infusions. The CPT-4 codes 96400-96549 describe administration of chemotherapeutic (primarily antineoplastic) agents; issues referable to chemotherapy administration will be discussed in this section due to the frequent similarities in administration.

Because the placement of peripheral vascular access devices is integral to vascular (intravenous, intra-arterial) infusions and injections, the CPT-4 codes for placement of these devices are not to be separately billed. Accordingly, routine insertion of an intravenous catheter (e.g., CPT-4 codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT-4 codes 90780, 90781, 90784, 96408-96412) would be inappropriate. Insertion of central venous access is not routinely necessary to accomplish these services and therefore, could be separately billed. Because intraarterial infusion usually involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions, and therefore, these services could be separately billed.

When the sole purpose of fluid administration (e.g. saline, D_5W, etc.) is to maintain patency of the access device, the infusion is neither diagnostic or therapeutic; therefore, the injection, infusion or chemotherapy administration codes are not to be separately billed. In the case of transfusion of blood or blood products, the insertion of a peripheral IV (e.g., CPT-4 codes 36000, 36410) is routinely necessary and is not separately billed. Administration of fluid in the course of transfusions to maintain line patency or between units of blood products is, likewise, not to be separately billed. In the case of chemotherapy administration, fluids such as saline or dextrose solutions may be necessary to maintain line patency or flush lines between different agents given at the same session; infusion of these fluids should not be separately billed. If fluid administration is medically necessary for therapeutic reasons (e.g., hydration or preservation of renal function) in the course of a transfusion or chemotherapy, this could be separately billed with the "DS" modifier as this is being administered as medically necessary.

When the sole purpose of a visit is for the administration of fluids, chemotherapy or other medications, a separate evaluation and management service is not to be billed, even if a physician interacts with the patient to oversee the injection/infusion. If a significant, separately identifiable, patient encounter is performed and documented which involves medical decision making, distinct from the injection/infusion oversight, an evaluation and management service could appropriately be billed. The medical record must reflect the appropriate documentation to support the evaluation and management billing.

Because the injection/infusion and chemotherapy codes are broadly encompassing and administration of intracavitary agents have separate CPT-4 codes, CPT-4 code 90799 is not separately billed on a routine basis; accordingly, this code is bundled into other infusion/injection codes.

C. Psychiatric Services

CPT-4 codes for psychiatric services include general and special diagnostic services as well as a variety of therapeutic services. By CPT-4 manual definition, therapeutic services (e.g., CPT-4 codes 90842-90844) include psychotherapy and continuing medical

diagnostic evaluation; therefore, CPT-4 code 90801 is not billed with these services.

Interactive services (diagnostic or therapeutic) are distinct forms of 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...". Accordingly, non-interactive services would not be possible at the same session and are not to be billed together.

Drug management is included in some therapeutic services (e.g. CPT-4 codes 90842-90844, 90847, 90853) and therefore CPT-4 code 90862 (Pharmacologic management) is not to be billed with these codes.

When medical services, other than psychiatric services, are provided in addition to psychiatric services, separate evaluation and management codes cannot be billed. The psychiatric service includes the evaluation and management services provided.

D. Biofeedback

Biofeedback services involve the use of electromyographic techniques to detect and record muscle activity. The CPT-4 codes 95860-95872 (EMG) should not be billed 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 codes (e.g., CPT-4 codes 95860-95872) may be billed but the "DS" modifier should be added to indicate that the service performed was a separately identifiable diagnostic service. Reporting only an objective electromyographic response to biofeedback is not sufficient to bill the codes referable to EMG.

E. Gastroenterology

Gastroenterologic tests included in CPT-4 codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as part of upper endoscopy (e.g., CPT-4 code 43235); therefore, CPT-4 codes 91000 (esophageal intubation) and 91055 (gastric intubation) are not separately billed when performed during upper endoscopy. Provocative testing (CPT-4 code 91052) can be expedited during GI endoscopy (procurement of gastric specimens). When performed at

the same time as GI endoscopy, CPT-4 code 91052 is billed with the "52" modifier indicating that a reduced level of service was performed.

If gastric lavage for treatment (e.g., ingested poisons) is accomplished during endoscopy, the CPT-4 code 91105 (gastric intubation) is not to be separately billed. When this service is performed on the same date as endoscopy but is not performed endoscopically, the "DS" modifier should be added indicating that this service was performed during a different session.

F. Ophthalmology

General ophthalmological services (e.g., CPT-4 codes 92002-92014) describe components of the ophthalmologic examination which would also be described by single organ evaluation and management guidelines. When evaluation and management codes are billed, satisfying the single specialty examination guidelines, these general ophthalmological service codes (e.g., CPT-4 codes 92002-92014) are not to be billed; the same services would be represented by both series of codes.

Special ophthalmologic services represent specific services not described as part of a general or routine ophthalmological examination. When these services are provided, documented as a separately identifiable service in the medical record, and billed along with evaluation and management services, they represent services over and above those necessary to satisfy the single specialty criteria used to define the level of evaluation and management service billed. While special ophthalmological services are recognized as significant, separately identifiable services, the performance of these services may require modification of the evaluation and management service billed.

For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are necessary to accomplish the procedure and are included in the procedure. Accordingly, HCPCS/CPT-4 codes 36000, 36410, G0001, 90780, and 90784 (introduction of a needle and catheter) are not to be separately billed with services requiring intravenous injection (e.g., CPT-4 codes 92230, 92235, 92287, 92499 for indocyanine green angiography, among others).

G. Otorhinolaryngologic Services

CPT-4 coding for otorhinolaryngologic services involve a number of tests that can be performed qualitatively or quantitatively by confrontation during physical examination. CPT-4 definition specifies which is the case for each code. Specifically, CPT-4 codes 92531-92534 involve evaluation by physician observation and are, therefore, not to be billed with an evaluation and management service. CPT-4 codes 92552-92589 can be performed qualitatively or quantitatively but according to CPT-4 definition these can be billed only if calibrated electronic equipment is used. Confrontational estimation of these tests by the physician is part of the evaluation and management service.

H. Cardiovascular Services

Cardiovascular medicine services include non-invasive and invasive diagnostic testing (including intracardiac testing) as well as therapeutic services (e.g., electrophysiological procedures). Several unique issues arise due to the spectrum of cardiovascular codes included in this section.

1. When cardiopulmonary resuscitation is performed without other evaluation and management services (e.g., a physician responds to a "code blue" and directs a successful code with the patient's attending physician then resuming the care of the patient), only the CPT-4 code 92950 for CPR should be billed. Levels of critical care services and prolonged management services are determined by time; when CPT-4 code 92950 is billed, the time required to perform CPR is not included in critical care or other timed evaluation and management services.

2. In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately billed. A number of therapeutic and diagnostic cardiovascular procedures (e.g., CPT-4 codes 92950-92996, 93501-93545, 93600-93624, 93640-93652) routinely utilize intravenous or intraarterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques; accordingly, separate services for routine access, monitoring,

injection or infusion are not to be billed. Fluoroscopic guidance procedures are routinely used during invasive intravascular procedures and are included in those services. In unique circumstances, where these services are performed, not as an integral part of the procedure, the appropriate code can be separately billed with the "DS" modifier (different situation). When supervision and interpretation codes are identified in the CPT-4 manual for a given procedure, these can also be billed separately.

3. Cardiac output measurement (e.g. CPT-4 codes 93561-93562) is routinely performed during cardiac catheterization procedures per CPT-4 definition and, therefore, CPT-4 codes 93561-93562 are not to be billed with cardiac catheterization codes.

4. Electrophysiological studies routinely require vascular access, injections/infusions, continuous monitoring, etc. Additionally, in the course of an electrophysiological study, an advanced pacing device is routinely used to stimulate and record intracardiac electrical activities. Accordingly, it is inappropriate to bill a separate service for insertion of a temporary pacemaker. If, at the same session as a electrophysiological study, a permanent pacemaker is placed, it can be billed as a separate service.

5. CPT-4 codes 93797 and 93798 describe comprehensive services provided by a physician for cardiac rehabilitation. As this includes all services referable to cardiac rehabilitation, it would be inappropriate to bill a separate evaluation and management service code unless an unrelated, separately identifiable, service is performed and documented in the medical record.

6. When a physician who is in attendance for a cardiac stress test obtains a history, and performs a limited examination referable specifically to the cardiac stress test, a separate evaluation and management service is not billed unless a significant, separately identifiable service is performed unrelated to the performance of the cardiac stress test. The evaluation and management service would be billed with the "DS" modifier.

7. Routine monitoring of EKG rhythm and review of daily hemodynamics, including cardiac outputs, is a part of critical care evaluation and management. Separate billing for review of EKG

rhythm strips (e.g., CPT-4 codes 93014, 93040-93042, 93561, 93562) and critical care services is inappropriate. An exception to this may include a sudden change in patient status associated with a change in cardiac rhythm requiring a return to the ICU or telephonic transmission to review a rhythm strip. Time included for this service is not included in the critical care time calculated for the critical care service.

I. Pulmonary Services

CPT-4 coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories. As a result of these code combinations, several issues are addressed in this policy section.

1. Alternate methods of reporting data obtained during a spirometry or other pulmonary function session cannot be separately billed. Specifically, the flow-volume loop is an alternative method of calculating a standard spirometric parameter. The CPT-4 code 94375 is included in standard spirometry (rest and exercise) studies.

2. When a physician who is in attendance for a pulmonary function study, obtains a history, and performs a limited examination referable specifically to the pulmonary function testing, separately coding for an evaluation and management service is not appropriate. If a significant, separately identifiable service is performed unrelated to the technical performance of the pulmonary function test, an evaluation and management service may be billed.

3. When multiple spirometric determinations are necessary to be performed (e.g., CPT-4 code 94070) to complete the service described in the CPT-4 code, only one unit of service is billed.

4. Pulmonary stress testing (e.g., CPT-4 code 94620) is a comprehensive stress test with a number of component tests separately defined in the CPT-4 manual. It is inappropriate to separately code venous access, EKG 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 progressive

pulmonary exercise test. It is also inappropriate to bill for a cardiac stress test and the component codes used to perform a routine pulmonary stress test, when the comprehensive pulmonary stress test was 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, both a cardiac and pulmonary stress test could be billed. The "51" modifier should be billed with the secondary procedure. In addition, if both tests are billed, both tests must satisfy the requirement for medical necessity.

J. Allergy Testing and Immunotherapy

The CPT-4 manual divides allergy into testing and immunotherapy. Immunotherapy is divided into codes that include preparation of the antigen when it is administered at the same session and when it is prepared but delivered for immunotherapy by a different physician. Several specific issues are identified regarding allergy testing and immunotherapy. Most issues regarding allergy therapy are addressed by national or local medical review policy.

1. If a local carrier provides coverage for skin end point titration, and standard testing is performed on the same day for the same allergen, only the code for skin end point titration is billed. Additionally, the relative value unit of this test has been determined on the basis of one unit of service for one titration/one allergen. Accordingly this code should be routinely billed as one unit of service for each antigen, regardless of the number of injections necessary to complete the titration.

2. When photo patch tests (e.g. CPT-4 code 95052) are performed (same antigen/same session) with patch or application tests, only the photo patch testing should be billed. Additionally, if photo testing is performed including application or patch testing, the code for photo patch testing (CPT-4 code 95052) is to be billed, not CPT-4 code 95044 and CPT-4 code 95056.

3. Evaluation and management codes billed with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is administered. Obtaining informed consent, is included in the immunotherapy. If E & M services are billed, medical documentation of the separately identifiable service should be in the charted documentation.

5. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. These codes should, therefore, not be billed together. Additionally, the testing becomes an integral part to the rapid desensitization (CPT-4 code 95180) and would therefore not be billed separately.

K. Neurology and Neuromuscular Procedures

The CPT-4 manual defines codes for diagnostic/therapeutic services not requiring neurosurgical intervention. Sleep testing, nerve and muscle testing and electroencephalographic procedures are included. The CPT-4 manual guidelines regarding sleep testing are very precise and should be reviewed carefully before billing for these services.

1. Sleep testing differs from polysomnography in that the latter requires the presence of sleep staging. This includes, in the record, a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. Accordingly, at the same session, a "sleep study" and "polysomnography" are not to be billed together.

2. Polysomnography requires at least one central and usually several EEG electrodes. EEG procurement for polysomnography (sleep staging) differs greatly from that required for diagnostic EEG testing (i.e., speed of paper, number of channels, etc). Accordingly, EEG testing is not to be billed with polysomnography unless performed separately; the EEG tests, if rendered with a separate report, are to be billed with the "DS" modifier, indicating that this represents a different session from the sleep study.

3. Because of the nature of CPT-4 definition for EEG testing, multiple component tests are defined and, when performed at the same session, should be billed with the "51" modifier, indicating that multiple procedures were performed at the same session.

4. Continuous electroencephalographic monitoring services (CPT-4 codes 95950-95962) represent different services than those provided during sleep testing; accordingly these codes are only to be billed when a separately identifiable service can be identified and recorded. Additionally, billing standard EEG services would only be appropriate if a significant separately identifiable

service is provided. These codes are to be billed with the "DS" modifier to indicate that a different service is clearly documented.

5. When nerve testing (EMG, nerve conduction velocity, etc.) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the series of CPT-4 codes 95851-95937 are not to be separately billed; these codes reflect significant, separately identifiable services requiring a formal report in the medical record. Additionally, electrical stimulation used to identify or locate nerves as part of a procedure involving treatment of a cranial or peripheral nerve (e.g., nerve block, nerve destruction, neuroplasty, transection, excision, repair, etc.) is part of the procedure.

L. Chemotherapy Administration

1. Chemotherapy administration codes include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. For a given agent, only one intravenous route (push or infusion) is appropriate at a given session. It is recognized that frequently combination chemotherapy is provided by different routes at the same session; when this is the case using the CPT-4 codes 96408, 96410, 96412, 96414 the "DS" modifier (different substance) should be attached to the lesser valued technique indicating that separate agents were administered by different techniques.

2. When hydration is required subsequent to or in combination with the administration of chemotherapeutic agents, the CPT-4 codes 90780-90781 should be used rather than the chemotherapy administration codes. Administration of fluids for keep open purposes between courses of chemotherapy at the same session is essential for the chemotherapy administration service and is not to be separately billed; only when the fluid administration is medically necessary should it be billed with the chemotherapy codes (e.g., to correct dehydration, to prevent nephrotoxicity, etc.).

M. Miscellaneous Services

1. When CPT-4 code 99175 is billed, observation time provided exclusively to monitor the patient for a response to emetogenic

agent, it is not to be included into other timed codes (e.g., critical care, office visits, prolonged services, etc.).

2. If hypothermia (e.g., CPT-4 code 99185) is accomplished by regional infusion techniques, separate services for chemotherapy administration should not be billed unless chemotherapeutic agents are also administered at the same session.

3. Therapeutic phlebotomy services (e.g., CPT-4 code 99195) are not to be billed with transfusion service codes (e.g., CPT-4 code 86890, 86891), plasmapheresis codes, or exchange transfusion codes. Services necessary to perform the phlebotomy (e.g., HCPCS/CPT-4 codes 36000, 36410, G0001, 90780, 90781) are included in the procedure. Blood banking by a patient for future surgical services is part of the anticipated surgery and is not to be separately billed.

4. CPT-4 code 99178 is included in all evaluation and management services.

N. Evaluation and Management

CPT-4 codes for evaluation and management services are principally included in the group of CPT-4 codes, 99201-99499. The codes are divided to describe the place of service (e.g., office, hospital, home, nursing facility, emergency department, critical care, etc.), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter, consultation, etc.), and various miscellaneous services (e.g., prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision-making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be billed per day. The prolonged physician service (with direct face-to-face patient contact), CPT-4 codes 99354 and 99355 represent an exception and may be used in conjunction with another evaluation and management code. Other services that are described by codes based on the duration of the encounter, such as critical care services, must be reported alone and not with the prolonged service codes.

Evaluation and management services, in general, are cognitive services and significant procedural services are not included in the 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. Cleansing of traumatic lesions, closure of lacerations with adhesive strips, dressings, casting and wrapping of musculoskeletal injuries (not requiring a more extensive procedure), counselling and educational services, among other services are included in evaluation and management services.

Because of the intensive nature of caring for critically ill patients, certain services beyond patient history, examination and medical decision making are included in the overall evaluation and management associated with critical care. By CPT-4 definition, services including the interpretation of cardiac output measurements (e.g., CPT-4 codes 93561 and 93562), chest X-Rays (e.g., CPT-4 codes 71010 and 71020), blood gases, and data stored in computers (e.g., EKGs, blood pressures, hematologic data), gastric intubation (e.g., CPT-4 code 91105), temporary transcutaneous monitoring (e.g., CPT-4 code 92953), ventilator management (e.g., CPT-4 codes 94656, 94657, 94660, 94662), and vascular access procedures (e.g., HCPCS/CPT-4 codes 36000, 36410, G0001, 36600) are included in critical care services.

Certain sections of CPT-4 have incorporated codes describing specialty-specific services which primarily involve evaluation and management. When codes for these services are billed, a separate evaluation and management service described by the series of CPT-4 codes 99201-99499 are not to be billed on the same date. Examples of these codes include general and special ophthalmologic services, general and special diagnostic and therapeutic psychiatric services, among others. Procedural services involve some degree of physician involvement or supervision which is integral to the service; separate evaluation and management services are not billed unless a significant, separately identifiable service is provided. Examples of such procedures include infusion therapy, chemotherapy administration, allergy testing and immunotherapy, osteopathic manipulative treatment, physical therapy services, neurologic and vascular testing procedures.

O. General Policy Statement

1. CPT-4 codes 92230 and 92235 (angioplasty) include injection procedures for angiography.

2. Angioplasties include insertion of the needle and/or catheter, infusion, fluoroscopy and EKG strips (e.g., CPT-4 codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 90780-90784, 76000-76001, 93000-93010, 93040-93042). All are components of performing an angioplasty.

3. Cardiovascular stress tests include insertion of needle and/or catheter, infusion and EKG strips (e.g., CPT-4 codes 36000, 36410, 90780-90784, 93010, 93040-93042).

4. All echocardiographic codes also include rhythm strips (e.g., CPT-4 codes 93040-93042, 93012, 93014). CPT-4 code 93350 (echocardiography) includes CPT-4 codes 36000, 36410 (insertion of the needle and/or catheter) and 90780-90784 (infusion).

5. Ventilation management and continuous positive airway pressure ventilation (CPAP) are mutually exclusive of evaluation and management services.

6. Cardiac catheterization procedures may require procurement of EKG tracings during the procedure to assess chest pain during catheterization and angioplasty; when performed in this fashion, these are not separately billable.

7. CPT-4 codes 93539-93545 (cardiac catheterization) include CPT-4 codes 71034, 76000, and 76001 (fluoroscopy).

8. CPT-4 code 95070 (inhalation testing) includes CPT-4 codes 94760, 94761 (oximetry).

9. HCPCS codes M0005-M0008 (office visits - including modalities) include CPT-4 codes 97010-97546 (physical medicine modalities).

10. HCPCS codes M0005-M0008 (office visits with modalities) and M0064 (office visit) are mutually exclusive of the evaluation and management codes.