

**CHAPTER III  
SURGERY: INTEGUMENTARY SYSTEM  
CPT CODES 10000-19999  
FOR  
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL**

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## **Chapter III**

### **Surgery: Integumentary System**

#### **CPT Codes 10000 - 19999**

#### **A. Introduction**

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 10000-19999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Providers/suppliers shall report the Healthcare Common Procedure Coding System/Current Procedural Technology (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 provider/supplier shall 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 provider/supplier shall not separately report these services simply because HCPCS/CPT codes exist for them.

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

#### **B. Evaluation & 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

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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 Medicare Administrative Contractors (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 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), unless related to a complication of surgery.

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.

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### **C. Anesthesia**

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 (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.

Local anesthesia including local infiltration, regional blocks, mild sedation, and all other anesthesia services except moderate conscious sedation reportable as CPT codes 99151-97153 are not separately reportable by a physician performing a medical or surgical procedure.

Billing for "anesthesia" services rendered by a nurse or other office personnel (unless the nurse is an independent certified nurse anesthetist, CRNA, etc.) is inappropriate as these services are "incident to" the physician's services.

It is a misuse of therapeutic injection or aspiration CPT codes to report administration of local anesthesia for a procedure. For example, it is a misuse of CPT codes 10160 (Puncture aspiration), 20500-20501 (Injection of sinus tract), 20526-20553 (Injection of carpal tunnel, tendon sheath, ligament, trigger points, etc.), 20600-20611 (Arthrocentesis) to report administration of local anesthetic for another procedure.

CPT codes 64450 (Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch) and 64455 (Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)) shall not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately. In the postoperative period, patients treated with epidural or subarachnoid continuous drug administration may require daily hospital adjustment/management of the catheter, dosage, etc. (CPT code 01996). This service may be reported by the anesthesia practitioner. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global period services associated with the operative procedure. If the only surgery performed is placement of an epidural or subarachnoid catheter for continuous drug administration, CPT code 01996 may be reported on subsequent days by the managing physician.

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## **D. Incision and Drainage**

Incision and drainage services, as related to the integumentary system, generally involve cutaneous or subcutaneous drainage of cysts, pustules, infections, hematomas, abscesses, seromas, or fluid collections.

If it is necessary to incise and/or drain a lesion as part of another procedure or to gain access to an area for another procedure, the incision and/or drainage is not separately reportable if performed at the same patient encounter.

For example, a physician excising pilonidal cysts and/or sinuses (CPT codes 11770-11772) may incise and drain one or more of the cysts. It is inappropriate to report CPT codes 10080 or 10081 separately for the incision and drainage of the pilonidal cyst(s).

HCPCS/CPT codes for incision and drainage shall not be reported separately with other procedures such as excision, repair, destruction, removal, etc., when performed at the same anatomic site at the same patient encounter.

HCPCS/CPT codes describing complications of a procedure may or may not be separately reportable at the same patient encounter as the procedure causing the complication. (See Chapter I, Section C, Subsection 14).

CPT code 10180 (Incision and drainage, complex, postoperative wound infection) would never be reportable for the same patient encounter as the procedure causing the postoperative infection. It may be separately reportable with a subsequent procedure, depending upon the circumstances. If it is performed to gain access to an anatomic region for another procedure, CPT code 10180 is not separately reportable. However, if the procedure described by CPT code 10180 is performed at an anatomic site unrelated to another procedure, it may be reported separately with the procedure.

## **E. Lesion Removal**

1. HCPCS/CPT codes define different types of removal codes such as destruction (e.g., laser, freezing), debridement, paring/cutting, shaving, or excision. Only 1 removal HCPCS/CPT code may be reported for a lesion. If multiple lesions are included in a single removal procedure (e.g., single excision of skin containing 3 nevi), only 1 removal HCPCS/CPT code may be reported for the procedure. If a removal procedure is begun by one method but is converted to another method to complete the procedure, only the HCPCS/CPT code describing the completed procedure may be reported. If it is medically necessary to remove multiple lesions separately, it may be appropriate (depending upon the code descriptors) for the procedures to report multiple HCPCS/CPT codes using anatomic modifiers or modifier 59 or XS to indicate different sites or lesions.
2. The HCPCS/CPT codes for lesion removal include the procurement of tissue from the

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same lesion by biopsy at the same patient encounter. CPT codes 11102-11107 (biopsy of skin) shall not be reported separately. CPT codes 11102-11107 may be separately reportable with lesion removal HCPCS/CPT codes if the biopsy is performed on a different lesion than the removal procedure.

3. The NCCI program has a PTP edit with Column One CPT code 11055 (Paring or cutting of benign hyperkeratotic lesion ...) and Column Two CPT code 11720 (Debridement of nail(s) by any method(s); 1 to 5). Modifier 59 or **XE, XP, XS, XU** shall not be used to bypass the edit if these 2 procedures are performed on the same distal phalanx, including the skin overlying the distal interphalangeal joint.
4. Removed tissue is often submitted for surgical pathology evaluation, which is generally reported with CPT codes 88300-88309. If multiple lesions are submitted for pathological examination as a single specimen, only one CPT code may be reported for examination of all the lesions (even if each lesion is processed separately). However, if it is medically reasonable and necessary to submit multiple lesions separately identifying the precise location of each lesion, a separate surgical pathology CPT code may be reported for each lesion.
  5. If a physician reviews pathology slides from previously removed lesion(s) in association with an E&M service to determine whether additional surgery is required, the review of the pathology slides is included in the E&M service. The provider/supplier shall not report CPT codes 88321-88325 (Surgical pathology consultation) in addition to the E&M code.
6. Lesion removal may require closure (simple, intermediate, or complex), adjacent tissue transfer, or grafts. If the lesion removal requires dressings, strip closure, or simple closure, these services are not separately reportable. Thus, CPT codes 12001-12021 (Simple repairs) are integral to the lesion removal codes. Intermediate or complex repairs, adjacent tissue transfer, and grafts may be separately reportable if medically reasonable and necessary. However, excision of benign lesions with excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440) includes simple, intermediate, or complex repairs which shall not be reported separately. If more than one lesion is removed and one of those lesions is larger than 0.5 cm, an intermediate or complex repair may be reported, if performed, for a lesion larger than 0.5 cm. Removal of one lesion smaller than 0.5 cm does not preclude also reporting an intermediate or complex repair for a larger lesion.
7. If lesion removal, incision, or repair requires debridement of non-viable tissue surrounding a lesion, incision, or injury to complete the procedure, the debridement is not separately reportable.
8. Reflectance confocal microscopy (CPT codes 96931-96936) is performed to determine whether a skin lesion is malignant. The PTP edits allow providers/suppliers to report on the same date of service excision of the lesion if malignant, but not biopsy or excision of

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the lesion if benign.

## **F. Mohs Micrographic Surgery**

Mohs micrographic surgery (CPT codes 17311-17315) is performed to remove complex or ill-defined cutaneous malignancy. A single physician performs both the surgery and pathologic examination of the specimen(s). The Mohs micrographic surgery CPT codes include skin biopsy and excision services (CPT codes 11102-11107, 11600-11646, and 17260-17286) and pathology services (88300-88309, 88329-88332). Reporting these latter codes in addition to the Mohs micrographic surgery CPT codes is inappropriate. However, if a suspected skin cancer is biopsied for pathologic diagnosis before proceeding to Mohs micrographic surgery, the biopsy (e.g., CPT codes 11102-11107) and frozen section pathology (CPT code 88331) may be reported separately using modifier 59 or **XS or XU**, or 58 to distinguish the diagnostic biopsy from the definitive Mohs surgery. Although the *CPT Professional* indicates that modifier 59 should be used, it is also acceptable to use modifier 58 to indicate that the diagnostic skin biopsy and Mohs micrographic surgery were staged or planned procedures. Repairs, grafts, and flaps are separately reportable with the Mohs micrographic surgery CPT codes.

## **G. Intralesional Injections**

CPT codes 11900-11901 describe intralesional injections of non-chemotherapeutic agents. CPT codes 96405-96406 describe intralesional injections of chemotherapeutic agents. Two intralesional injection codes shall not be reported together unless separate lesions are injected with different agents, in which case modifier 59 or XS may be used. It is a misuse of CPT codes 11900, 11901, 96405, or 96406 to report injection of local anesthetic prior to another procedure on the lesion(s). Some of the procedures with which CPT codes 11900, 11901, 96405, and 96406 are not separately reportable if the intralesional injection is a local anesthetic include:

- 11200 - 11201 (Removal of skin tags)
- 11300 - 11313 (Shaving of lesions)
- 11400 - 11471 (Excision of benign lesions)
- 11600 - 11646 (Excision of malignant lesions)
- 12001 - 12018 (Repair - simple)
- 12020 - 12021 (Treatment of wound dehiscence)
- 12031 - 12057 (Repair - intermediate)
- 13100 - 13160 (Repair - complex)
- 11719 - 11762 (Trimming, debridement and excision of nails)
- 11765 (Wedge excision)
- 11770 - 11772 (Excision of pilonidal cysts)

This list is not an exhaustive listing of the procedures, since the administration of local anesthesia by the physician performing a procedure is not separately reportable for any procedure.

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## H. Repair and Tissue Transfer

1. The *CPT Professional* classifies repairs (closure) (CPT codes 12001-13160) as simple, intermediate, or complex. If closure cannot be completed by one of these procedures, adjacent tissue transfer or rearrangement (CPT codes 14000-14350) may be used. Adjacent tissue transfer or rearrangement procedures include excision (CPT codes 11400-11646) and repair (12001-13160). Thus, CPT codes 11400-11646 and 12001-13160 shall not be reported separately with CPT codes 14000-14350 for the same lesion or injury. Additionally, debridement necessary to perform a tissue transfer procedure is included in the procedure. It is inappropriate to report debridement (e.g., CPT codes 11000-11001, 11004-11006, 11042-11047, 97597, 97598, 97602) with adjacent tissue transfer (e.g., CPT codes 14000-14350) for the same lesion/injury.
2. Extensively undermining of adjacent tissue to achieve closure of a wound or defect may constitute complex repair, not tissue transfer and rearrangement. Tissue transfer and rearrangement requires that adjacent tissue be incised and carried over to close a wound or defect.
3. Skin grafting in conjunction with a repair or adjacent tissue transfer is separately reportable if the grafting is not included in the code descriptor of the adjacent tissue transfer code.
4. Adjacent tissue transfer codes shall not be reported with the closure of a traumatic wound if the laceration is coincidentally approximated using a tissue transfer type closure (e.g., Z-plasty, W-plasty). The closure should be reported with repair codes. However, if the surgeon develops a specific tissue transfer to close a traumatic wound, a tissue transfer code may be reported.
5. Procurement of cultures or tissue samples during a closure is included in the repair or adjacent tissue transfer codes and is not separately reportable.

## I. Grafts and Flaps

CPT codes describing skin grafts and skin substitutes are classified by size, location of recipient area defect, and type of graft or skin substitute. For most combinations of location and type of graft/skin substitute, there are 2 or 3 CPT codes including a primary code and 1 or 2 Add-on Codes (AOCs). The primary code describes one size of graft/skin substitute and shall not be reported with more than one unit of service. Larger size grafts or skin substitutes are reported with AOCs.

1. The primary graft/skin substitute codes (e.g., 15100, 15120, 15200, 15220) are mutually exclusive, since only one type of graft/skin substitute can be used at an anatomic site. If multiple sites require different types of grafts/skin substitutes, the different graft/skin

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substitute CPT codes should be reported with anatomic modifiers or modifier 59 or XS to indicate the different sites.

2. Debridement of a skin wound (e.g., CPT codes 11000, 11042-11047, 97597, 97598) before a graft/skin substitute is included in the skin graft/skin substitute procedure (CPT codes 15050-15278) and shall not be reported separately. If the recipient site requires excision of open wounds, burn eschar, or scar or incisional release of scar contracture, CPT codes 15002-15005 may be separately reportable for certain types of skin grafts/skin substitutes.
3. Debridement (e.g., CPT codes 11000, 11042-11047, 97597, 97598) of the site of a tissue transfer is included in the tissue transfer procedure and is not separately reportable.
4. A *CPT Professional* instruction following CPT code 67911 (Correction of lid retraction) states that autogenous graft CPT codes (15769, 20920, 20922) may be reported separately. All other services necessary to complete the procedure are included. (CPT code 20926 was deleted January 1, 2020).

#### **J. Breast (Incision, Excision, Introduction, Repair and Reconstruction)**

1. Since a mastectomy (CPT codes 19300-19307) describes removal of breast tissue including all lesions within the breast tissue, breast excision codes (19110-19126) generally are not separately reportable unless performed at a site unrelated to the mastectomy. However, if the breast excision procedure precedes the mastectomy for the purpose of obtaining tissue for pathologic examination which determines the need for the mastectomy, the breast excision and mastectomy codes are separately reportable. (Modifier 58 may be used to indicate that the procedures were staged.) If a diagnosis was established preoperatively, an excision procedure for the purpose of obtaining additional pathologic material is not separately reportable.

Similarly, diagnostic biopsies (e.g., fine needle aspiration, core, incisional) to procure tissue for diagnostic purposes to determine whether an excision or mastectomy is necessary at the same patient encounter may be reported with modifier 58 appended to the excision or mastectomy code. However, biopsies (e.g., fine needle aspiration, core, incisional) are not separately reportable if a preoperative diagnosis exists.

2. The breast procedure codes include incision and closure. Some codes describe mastectomy procedures with lymphadenectomy and/or removal of muscle tissue. The latter procedures are not separately reportable. Except for sentinel lymph node biopsies, ipsilateral lymph node excisions are not separately reportable. Contralateral lymph node excisions may be separately reportable with appropriate modifiers (i.e., LT, RT).
3. Sentinel lymph node biopsy is separately reportable when performed before a localized excision of breast or a mastectomy without lymphadenectomy. However, sentinel lymph

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node biopsy is not separately reportable with a mastectomy procedure that includes lymphadenectomy in the anatomic area of the sentinel lymph node biopsy. Open biopsy or excision of sentinel lymph node(s) should be reported as follows: axillary (CPT codes 38500 or 38525), deep cervical (CPT code 38510), internal mammary (CPT code 38530). CPT code 38740 (Axillary lymphadenectomy; superficial) should not be reported for a sentinel lymph node biopsy. Sentinel lymph node biopsy of superficial axillary lymph node(s) is correctly reported as CPT code 38500 (Biopsy or excision of lymph node(s), open, superficial) which includes the removal of one or more discretely identified superficial lymph nodes. By contrast, a superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue.

4. Breast reconstruction codes that include the insertion of a prosthetic implant shall not be reported with codes that separately describe the insertion of a breast prosthesis.
5. CPT codes for breast procedures generally describe unilateral procedures.
6. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the provider/supplier shall not separately report a post procedure mammography code (e.g., 77065-77067) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.
7. CPT code 15734 (Muscle, myocutaneous, or fasciocutaneous flap; trunk) shall not be reported with breast reconstruction CPT codes 19357-19364 and 19367-19369 or breast prosthesis CPT codes 19340 and 19342 since a flap, if performed, is included in the reconstruction or prosthesis procedure.
8. Breast reconstruction procedures (CPT codes 19357-19369) include adjacent tissue transfer or rearrangement procedures (e.g., CPT codes 14000, 14001) if performed. An adjacent tissue transfer or rearrangement procedure may be reported on the same day as a breast reconstruction procedure if the adjacent tissue transfer or rearrangement is performed at a different site unrelated to the breast reconstruction procedure.

#### **K. Medically Unlikely Edits (MUEs)**

1. Chapter I, Section V describes Medically Unlikely Edits (MUEs).
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

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national medical or surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

3. The unit of service for fine needle aspiration biopsy (CPT codes 10004-10012 and 10021) is the separately identifiable lesion. If a physician performs multiple “passes” into the same lesion to obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for a separate aspiration biopsy of a distinct separately identifiable lesion.
4. If a Mohs surgeon removes a tumor specimen and divides it into multiple pieces of tissue, creates a block from each piece of tissue, and stains one or more blocks from that specimen with an initial single antibody immunohistochemistry stain, the Mohs surgeon shall report only one unit of service of CPT code 88342 (Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure). Only one unit of service of CPT code 88342 may be reported per specimen. If the Mohs surgeon additionally stains one or more blocks from that specimen with an additional different single antibody immunohistochemistry (immunocytochemistry) stain, CPT code 88341 (Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)) may be reported with one unit of service per different antibody stain procedure. The unit of service for these codes is not each block derived from a single specimen.
5. The Centers for Medicare & Medicaid Services (CMS) *Internet-Only Manual (IOM)* Publication 100-04 *Medicare Claims Processing Manual (MCPM)* Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital including Inpatient Hospital Part B and OPSS), 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.
6. CPT code 15852 describes a dressing change, other than for burns, under anesthesia (other than local). The unit of service for this code is each encounter for a dressing change. The unit of service is not each separate dressing.

#### **L. General Policy Statements**

1. The MUE values and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians shall not

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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* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Professional* 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*.
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*.
6. CPT codes 15851 and 15852 describe suture removal and dressing change, respectively, under anesthesia other than local anesthesia. These codes shall not be reported when a patient requires anesthesia for a related procedure (e.g., return to the operating room for treatment of complications where an incision is reopened necessitating removal of sutures

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and redressing). Additionally, CPT code 15852 shall not be reported with a primary procedure.

7. 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. (See Section C, (Anesthesia)).

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, 64400-64489, and 96360-96379 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.

8. 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.
9. 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) shall not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

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10. 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.
11. For more information regarding biopsies, see Chapter I, Section A, Introduction.
12. Fine needle aspiration (FNA) biopsies (CPT codes 10004-10012, and 10021) shall not be reported with a biopsy procedure code for the same lesion. For example, a 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 provider/supplier shall report only one code, either the biopsy code or the FNA code.
13. Reserved for future use.
14. The NCCI PTP edits pairing CPT codes 11102, 11104, and 11106 (Tangential, punch, or incisional biopsy of single skin lesion) each with CPT codes 17000 and 17004 (Destruction of benign or premalignant lesions) are often bypassed by using modifier 59 or **XE or XS**. Use of modifier 59 or **XE or XS** with these NCCI PTP edits is only appropriate if the 2 procedures of a code pair edit are performed on separate lesions or at separate patient encounters. Refer to the *CPT Professional* instructions preceding CPT codes 11102, 11104, and 11106 for additional clarification about the CPT codes 11102-11107.
15. The NCCI PTP edit with Column One CPT code 11719 (Trimming of nondystrophic nails, any number) and Column Two CPT code 11720 (Debridement of nail(s) by any method(s); 1 to 5) is often bypassed by using modifier 59 or **XE, XP, XS, XU**. Use of modifier 59 or **XE or XS** with the Column Two CPT code 11720 of this NCCI PTP edit is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the 2 procedures are performed at separate patient encounters.
16. If the code descriptor of a HCPCS/CPT code includes the phrase “separate procedure,” the procedure is subject to NCCI PTP 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.
17. 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-associated modifiers, and have a **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

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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 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-associated modifiers should generally not be used.

18. 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.
19. If the code descriptor for a HCPCS/CPT code, *CPT Professional* instruction for a code, or 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-associated modifier if appropriate.
20. 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. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.
21. 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.

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