CHAPTER I
GENERAL CORRECT CODING POLICIES
FOR
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

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

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Table of Contents

Chapter I
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A. Introduction

Healthcare providers/suppliers use Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes to report medical and surgical services performed on patients to Medicare Administrative Contractors (MACs). Healthcare Common Procedure Coding System (HCPCS) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA's) *CPT Professional*, which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare & Medicaid Services (CMS) and are updated throughout the year as necessary. Changes in CPT codes are approved by the AMA CPT Editorial Panel, which meets 3 times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific in defining a single service (e.g., CPT code 93000 (electrocardiogram)), while other codes define procedures consisting of many services (e.g., CPT code 58263 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s), with repair of enterocele)). Because many procedures can be performed via different approaches, different methods, or in combination with other procedures, there are often multiple HCPCS/CPT codes defining similar or related procedures.

CPT and HCPCS Level II code descriptors usually do not define all services included in a procedure. There are often services inherent in a procedure or group of procedures. For example, anesthesia services include certain preparation and monitoring services.

CMS developed the National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. Prior to April 1, 2012, NCCI Procedure-to-Procedure (PTP) edits were placed into either the "Column One/Column Two Correct Coding Edit Table" or the "Mutually Exclusive Edit Table." However, on April 1, 2012, the edits in the "Mutually Exclusive Edit Table" were moved to the "Column One/Column Two Correct Coding Edit Table" so that all NCCI PTP edits are currently contained in this single table. Combining the 2 tables simplifies researching NCCI PTP edits and online use of the NCCI tables.

Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider/supplier reports the 2 codes of an edit pair, the Column One code is eligible for payment and the Column Two code is denied. However, if it is clinically appropriate to use an NCCI PTP-associated modifier, both the Column One and Column Two codes are eligible for payment. (NCCI PTP-associated modifiers and their appropriate use are discussed elsewhere in this chapter.)

When the NCCI program was first established and during its early years, the "Column One/Column Two Correct Coding Edit Table" was termed the "Comprehensive/Component Edit Table." This latter terminology was a misnomer. Although the Column Two code is often a component of a more comprehensive Column One code, this relationship is not true for many edits. In the latter type of edit, the code pair edit simply represents 2 codes that should not be reported together. For example, a provider/supplier shall not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

In this chapter, Sections B – Q address various issues relating to NCCI PTP edits.

Medically Unlikely Edits (MUEs) prevent payment for a potentially inappropriate number/quantity of the same service on a single day. An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. For more information concerning MUEs, see Section V of this chapter.

In this manual, many policies are described using the term "physician." Unless otherwise indicated, the use of this term does not restrict the application of policies to physicians only. Rather, the policies apply 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 *Internet-Only Manual* (IOM), Publication 100-04 *Medicare Claims Processing Manual* (MCPM) Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services) and Global Surgery Rules, e.g., CMS IOM, Publication 100-04 MCPM Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery) do not apply to hospitals.

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

Providers/suppliers must report services correctly. This manual discusses general coding principles in Chapter I, and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. There are certain types of improper coding that providers/suppliers must avoid.

Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Providers/suppliers must not unbundle the services described by a HCPCS/CPT code. Some examples follow:

- A provider/supplier shall not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example, if a physician

performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the provider/supplier shall report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The provider/supplier shall not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less;) plus CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral, or bilateral (separate procedure)).

- A physician shall not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the provider/supplier shall report CPT code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code 46600 (Anoscopy; diagnostic...) plus CPT code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be used with an endoscopic procedure code.

- A provider/supplier shall not unbundle a bilateral procedure code into 2 unilateral procedure codes. For example, if a physician performs bilateral mammography, the provider/supplier shall report CPT code 77066 (Diagnostic mammography... bilateral). The provider/supplier shall not report CPT code 77065 (Diagnostic mammography... unilateral) with 2 UOS or 77065 LT plus 77065 RT.

- A provider/supplier shall not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A provider/supplier shall not report CPT code 49000 (Exploratory laparotomy...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

- Providers/suppliers shall only report a biopsy separately when pathologic examination results in a decision to immediately proceed with a more extensive procedure (e.g., excision, destruction, removal) on the same lesion; or when performed on a separate lesion.

- Providers/suppliers shall not report a biopsy separately when it is to assess resection margins or to verify resectability; or when performed and submitted for pathologic evaluation completed after performing the more extensive procedure.

Providers/suppliers must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the providers/suppliers must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. For example, if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider/supplier shall report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A provider/supplier shall not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Providers/suppliers must avoid upcoding. A HCPCS/CPT code may be reported only if all

services described by that code have been performed. For example, if a physician performs a superficial axillary lymphadenectomy (CPT code 38740), the provider/supplier shall not report CPT code 38745 (Axillary lymphadenectomy; complete).

Providers/suppliers must report UOS correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A provider/supplier shall not report UOS for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. For example, some therapy codes are reported in fifteen-minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A provider/supplier shall not report a per session code using fifteen-minute increments. CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.

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 inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

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*.

This chapter addresses general coding principles, issues, and policies. Many of these principles, issues, and policies are addressed further in subsequent chapters dealing with specific groups of HCPCS/CPT codes. In this chapter, examples are often used to clarify principles, issues, or policies. The examples do not represent the only codes to which the principles, issues, or policies apply.

B. Coding Based on Standards of Medical/Surgical Practice

Most HCPCS/CPT code defined procedures include services that are integral to them. Some of these integral services have specific CPT codes for reporting the service when not performed as an integral part of another procedure. (For example, CPT code 36000 (Introduction of needle or intracatheter, vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein. Other integral services do not have specific CPT codes. (For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.) Services integral to HCPCS/CPT code defined procedures are included in those procedures based upon the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

Many NCCI PTP edits are based upon the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. When integral component services have their own HCPCS/CPT codes, NCCI PTP edits place the comprehensive service in Column One and the component service in Column Two. Since a component service integral to a comprehensive service is not separately reportable, the Column Two code is not separately reportable with the Column One code.

Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration;
- Insertion of urinary catheter
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia Services)
- Local, topical or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS unit
- Institution of Patient Controlled Anesthesia
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Imaging and/or ultrasound guidance
- Surgical supplies, except for specific situations where CMS policy permits separate payment.

Although other chapters in this manual further address issues related to standards of medical/surgical practice, it is not possible to discuss all NCCI PTP edits based upon the principle of the standards of medical/surgical practice due to space limitations. However, there are several general principles that can be applied to the edits, as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.

2. The component service is usually necessary to complete the comprehensive service.

3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Specific examples of services that are not separately reportable because they are components of more comprehensive services follow:

Medical Examples

1. Because interpretation of cardiac rhythm is an integral component of the interpretation of an electrocardiogram, a rhythm strip is not separately reportable.

2. Because determination of ankle/brachial indices requires both upper and lower extremity Doppler studies, an upper extremity Doppler study is not separately reportable.

3. Because a cardiac stress test includes multiple electrocardiograms, an electrocardiogram is not separately reportable.

Surgical Examples

1. Because a myringotomy requires access to the tympanic membrane through the external auditory canal, removal of impacted cerumen from the external auditory canal is not separately reportable.

2. A bronchoscopy to assess the surgical field, anatomic landmarks, extent of disease, etc., is not separately reportable with an open pulmonary procedure such as a pulmonary lobectomy. By contrast, an initial diagnostic bronchoscopy is separately reportable. If the diagnostic bronchoscopy is performed at the same patient encounter as the open pulmonary procedure and does not duplicate an earlier diagnostic bronchoscopy by the same or another physician, the diagnostic bronchoscopy may be reported with modifier 58 appended to the open pulmonary procedure code to indicate a staged procedure. A cursory examination of the upper airway during a bronchoscopy with the bronchoscope shall not be reported separately as a laryngoscopy. However, separate endoscopies of anatomically distinct areas with different endoscopes may be reported separately (e.g., thoracoscopy and mediastinoscopy).

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Because a colectomy requires exposure of the colon, the laparotomy and adhesiolysis to expose the colon are not separately reportable.

C. Medical/Surgical Package

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work.

The component elements of the pre-procedure and post-procedure work for each procedure are included component services of that procedure as a standard of medical/surgical practice. Some general guidelines follow:

1. Many invasive procedures require vascular and/or airway access. The work associated with obtaining the required access is included in the pre-procedure or intra-procedure work. The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work.

   Airway access is necessary for general anesthesia and is not separately reportable. There is no CPT code for elective endotracheal intubation. CPT code 31500 describes an emergency endotracheal intubation and shall not be reported for elective endotracheal intubation. Visualization of the airway is a component part of an endotracheal intubation, and CPT codes describing procedures that visualize the airway (e.g., nasal endoscopy, laryngoscopy, bronchoscopy) shall not be reported with an endotracheal intubation. These CPT codes describe diagnostic and therapeutic endoscopies, and it is a misuse of these codes to report visualization of the airway for endotracheal intubation.

   Intravenous access (e.g., CPT codes 36000, 36400, 36410) is not separately reportable when performed with many types of procedures (e.g., surgical procedures, anesthesia procedures, radiological procedures requiring intravenous contrast, nuclear medicine procedures requiring intravenous radiopharmaceutical).

   After vascular access is achieved, the access must be maintained by a slow infusion (e.g., saline) or injection of heparin or saline into a “lock.” Since these services are necessary for maintenance of the vascular access, they are not separately reportable with the vascular access CPT codes or procedures requiring vascular access as a standard of medical/surgical practice. CPT codes 37211-37214 (Transcatheter therapy with infusion for thrombolysis) shall not be reported for use of an anticoagulant to maintain vascular access.

   The global surgical package includes the administration of fluids and drugs during the operative procedure. CPT codes 96360-96379 shall not be reported separately for that

operative procedure. Under OPPS, the administration of fluids and drugs during or for an operative procedure are included services and are not separately reportable (e.g., CPT codes 96360-96379).

When a procedure requires more invasive vascular access services (e.g., central venous access, pulmonary artery access), the more invasive vascular service is separately reportable if it is not typical of the procedure and the work of the more invasive vascular service has not been included in the valuation of the procedure.

Insertion of a central venous access device (e.g., central venous catheter, pulmonary artery catheter) requires passage of a catheter through central venous vessels and, in the case of a pulmonary artery catheter, through the right atrium and ventricle. These services often require the use of fluoroscopic guidance. Separate reporting of CPT codes for right heart catheterization, selective venous catheterization, or pulmonary artery catheterization is not appropriate when reporting a CPT code for insertion of a central venous access device. Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 77002) shall not be reported separately.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia services by the same physician performing a surgical or medical procedure. The physician performing a surgical or medical procedure shall not report CPT codes 96360-96379 for the administration of anesthetic agents during the procedure. If it is medically reasonable and necessary that a separate provider/supplier (anesthesia practitioner) perform anesthesia services (e.g., monitored anesthesia care) for a surgical or medical procedure, a separate anesthesia service may be reported by the second provider/supplier.

   Under the OPPS, anesthesia for a surgical procedure is an included service and is not separately reportable. For example, a provider/supplier shall not report CPT codes 96360-96379 for anesthesia services.

   When anesthesia services are not separately reportable, providers/suppliers shall not unbundle components of anesthesia and report them in lieu of an anesthesia code.

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure that no intraoperative injury occurred or to verify that the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Many procedures require cardiopulmonary monitoring, either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable. Examples of these services include cardiac monitoring, pulse oximetry, and ventilation management (e.g., 93000-93010, 93040-93042, 94760, 94761).

5. For more information regarding biopsies, see Section A, Introduction.

6. Exposure and exploration of the surgical field is integral to an operative procedure and is not separately reportable. For example, an exploratory laparotomy (CPT code 49000) is not separately reportable with an intra-abdominal procedure. If exploration of the surgical field results in additional procedures other than the primary procedure, the additional procedures may generally be reported separately. However, a procedure designated by the CPT code descriptor as a "separate procedure" is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

7. If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement, incision, and drainage) is not separately reportable. Types of procedures to which this principle applies include, but are not limited to, -ectomy, -otomy, excision, resection, -plasty, insertion, revision, replacement, relocation, removal, or closure. For example, debridement of skin and subcutaneous tissue at the site of an abdominal incision made to perform an intra-abdominal procedure is not separately reportable. (See Chapter IV, Section I (General Policy Statements), Subsection 11 for guidance on reporting debridement with open fractures and dislocations.)

8. If removal, destruction, or other form of elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure may be reported. For example, if an area of pilonidal disease contains an abscess, incision, and drainage of the abscess during the procedure to excise the area of pilonidal disease is not separately reportable.

9. An excision and removal (-ectomy) includes the incision and opening (-otomy) of the organ. A HCPCS/CPT code for an –otomy procedure shall not be reported with an –ectomy code for the same organ.

10. Multiple approaches to the same procedure are mutually exclusive of one another and shall not be reported separately. For example, both a vaginal hysterectomy and abdominal hysterectomy shall not be reported separately.

11. If a procedure using one approach fails and is converted to a procedure using a different approach, only the completed procedure may be reported. For example, if a laparoscopic hysterectomy is converted to an open hysterectomy, only the open hysterectomy procedure code may be reported.

12. If a laparoscopic procedure fails and is converted to an open procedure, the physician shall not report a diagnostic laparoscopy in lieu of the failed laparoscopic procedure. For example, if a laparoscopic cholecystectomy is converted to an open cholecystectomy, the

physician shall not report the failed laparoscopic cholecystectomy nor a diagnostic laparoscopy.

13. If a diagnostic endoscopy is the basis for and precedes an open procedure, the diagnostic endoscopy may be reported with modifier 58 appended to the open procedure code. However, the medical record must document the medical reasonableness and necessity for the diagnostic endoscopy. An endoscopy to assess anatomic landmarks and extent of disease is not separately reportable with an open procedure. When an endoscopic procedure fails and is converted to another surgical procedure, only the completed surgical procedure may be reported. The endoscopic procedure is not separately reportable with the completed surgical procedure.

14. Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable:

    (1) if it represents usual and necessary care in the operating room during the procedure;

    or

    (2) if it occurs postoperatively and does not require return to the operating room. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.

D. 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 NCCI 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 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. NCCI 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 performed on the same date of service as a 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. NCCI 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 physician 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 on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for

interpreting the result of the "XXX" procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

E. Modifiers and Modifier Indicators

The AMA *CPT Professional* and CMS define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of 2 alphanumeric characters.

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicare restrictions are fulfilled. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

Anatomic modifiers : E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU

Modifiers 76 ("Repeat Procedure or Service by Same Physician") and 77 ("Repeat Procedure by Another Physician") are not NCCI PTP-associated modifiers. Use of either of these modifiers does not bypass an NCCI PTP edit.

Each NCCI PTP edit has an assigned Correct Coding Modifier Indicator (CCMI). A CCMI of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A CCMI of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. A CCMI of "9" indicates that the use of NCCI PTP-associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator prevents blank spaces from appearing in the indicator field.

It is very important that NCCI PTP-associated modifiers only be used when appropriate. In general, these circumstances relate to separate patient encounters, separate anatomic sites, or separate specimens. (See subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have NCCI PTP modifier indicators of "1" because the 2 codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when 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 cannot be reported together unless the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic locations. However, if the 2 corresponding procedures are performed at the same patient encounter and in contiguous structures in the same organ or anatomic region, NCCI PTP-associated modifiers generally should not be used.

The appropriate use of most of these modifiers is straightforward. However, further explanation is provided regarding modifiers 25, 58, and 59. Although modifier 22 is not a modifier that bypasses an NCCI PTP edit, its use is occasionally relevant to an NCCI PTP edit and is discussed below.

a. **Modifier 22**: Modifier 22 is defined by the *CPT Professional* as "Increased Procedural Services." This modifier shall not be reported unless the service(s) performed is (are) substantially more extensive than the usual service(s) included in the procedure described by the HCPCS/CPT code reported.

When an NCCI PTP edit allows use of NCCI PTP-associated modifiers to bypass the edit and the clinical circumstances justify use of one of these modifiers, both services may be reported with the NCCI PTP-associated modifier. However, if the NCCI PTP edit does not allow use of NCCI PTP-associated modifiers to bypass it and the procedure qualifies as an unusual procedural service, the physician may report the Column One HCPCS/CPT code of the NCCI PTP edit with modifier 22. The MAC may then evaluate the unusual procedural service to determine whether additional payment is justified.

For example, CMS limits payment for CPT code 69990 (Microsurgical techniques, requiring use of operating microscope...) to procedures listed in the IOM Publication 100-04 MCPM Chapter 12 Section 20.4.5. If a physician reports CPT code 69990 with 2 other CPT codes and 1 of the codes is not on this list, an NCCI PTP edit with the code not on the list will prevent payment for CPT code 69990. Claims processing systems do not determine which procedure is linked with CPT code 69990. In situations such as this, the physician may submit their claim to the local MAC for readjudication appending modifier 22 to the CPT code. Although MAC cannot override an NCCI PTP edit that does not allow use of NCCI PTP-associated modifiers, the MAC has discretion to adjust payment to include use of the operating microscope based on modifier 22.

b. **Modifier 25**: The *CPT Professional* defines modifier 25 as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

Modifier 25 may be appended to E&M services reported with minor surgical procedures (with global periods of 000 or 010 days) or procedures not covered by Global Surgery Rules (with a global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider/supplier shall not report an E&M service for this work. Furthermore, Medicare Global Surgery Rules prevent the reporting of a separate E&M

service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient.

c. **Modifier 58**: Modifier 58 is defined by the *CPT Professional* as a "Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period." It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI PTP-associated modifiers.

If a diagnostic endoscopic procedure results in the decision to perform an open procedure, both procedures may be reported with modifier 58 appended to the HCPCS/CPT code for the open procedure. However, if the endoscopic procedure preceding an open procedure is a procedure to assess anatomic landmarks and/or extent of disease, it is not separately reportable.

Diagnostic endoscopy is never separately reportable with another endoscopic procedure of the same organ(s)or anatomic region when performed at the same patient encounter. Similarly, diagnostic laparoscopy is never separately reportable with a surgical laparoscopic procedure of the same body cavity when performed at the same patient encounter.

If a planned laparoscopic procedure fails and is converted to an open procedure, only the open procedure may be reported. The failed laparoscopic procedure is not separately reportable. The NCCI program contains many, but not all, edits bundling laparoscopic procedures into open procedures. Since the number of possible code combinations bundling a laparoscopic procedure into an open procedure is much greater than the number of such edits in the NCCI program, the principle stated in this paragraph is applicable regardless of whether the selected code pair combination is included in the NCCI tables. A provider/supplier shall not select laparoscopic and open HCPCS/CPT codes to report because the combination is not included in the NCCI tables.

d. **Modifier 59:** Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. For the NCCI program, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services, except in those instances where the services are "separate and distinct." Modifier 59 shall only be used if no other modifier more appropriately describes the relationships of the 2 or more procedure codes (see Section E for modifiers XE, XP, XS, XU. The *CPT Professional* defines modifier 59 as follows:

Modifier 59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Modifier 59 and other NCCI-associated modifiers should **NOT** be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used. Modifier 59 shall not be used with code 77427 (Radiation treatment management, 5 treatments).

NCCI PTP edits define when 2 procedure HCPCS/CPT codes may not be reported together, except under special circumstances. If an edit allows use of NCCI PTP-associated modifiers, the 2 procedure codes may be reported together when the 2 procedures are performed at 2 different patient encounters or 2 different anatomic sites. MAC processing systems use NCCI PTP-associated modifiers to allow payment of both codes of an edit. Modifiers 59 or XE, XP, XS, XU, and other NCCI PTP-associated modifiers shall NOT be used to bypass an NCCI PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI PTP-associated modifier used. Some examples of the appropriate use of modifiers 59 or XE, XP, XS, XU, are contained in the individual chapter policies.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe "different procedure or surgery." The code descriptors of the 2 codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the 2 procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider/supplier cannot use modifier 59 for such an edit based on the 2 codes being different procedures/surgeries. However, if the 2 procedures/surgeries are performed at separate patient encounters or at separate anatomic sites on the same date of service, modifiers 59 or XE or XS may be appended to indicate that they are different procedures/surgeries on that date of service.

Modifier 59 or XS is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

There are several exceptions to this general principle about misuse of modifiers 59 or XE, XP, XS, XU that apply to some code pair edits for procedures performed at the same patient encounter.

1. When a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure, it shall not be reported separately.

2. When a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it shall not be reported separately.

3. There is an appropriate use for modifiers 59 or XE or XS that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If 2 separate and distinct timed services are provided in separate and distinct time blocks, modifier 59 may be used to identify the services. The separate and distinct time blocks for the 2 services may be sequential to one another or split. When the 2 services are split, the time block for 1 service may be followed by a time block for the second service followed by another time block for the first service. All Medicare rules for reporting timed services are applicable. For example, the total time is calculated for all related timed services performed. The number of reportable UOS is based on the total time, and these UOS are allocated between the HCPCS/CPT codes for the individual services performed. The practitioner is not permitted to perform multiple services, each for the minimal reportable time, and report each of these as separate UOS.

Use of modifiers 59 or XE or XS to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifiers 59 or XE, XP, XS, XU. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI program perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. It does not include treatment of contiguous structures in the same organ or anatomic region. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site.

If the same procedure is performed at different anatomic sites, it does not necessarily imply that a HCPCS/CPT code may be reported with more than one unit of service for the procedure. Determining whether additional UOS may be reported depends in part upon the HCPCS/CPT code descriptor including the definition of the code's unit of service when present.

Example 1

The Column One/Column Two code edit with Column One CPT code 38221 (Diagnostic bone marrow biopsy(ies)) and Column Two CPT code 38220 (Diagnostic bone marrow, aspiration(s)) includes two distinct procedures when performed at separate anatomic sites (e.g., contralateral iliac bones) or separate patient encounters. In these circumstances, it would be acceptable to use modifier 59. However, if both 38221 and 38220 are performed on the same iliac bone at the same patient encounter which is the usual practice, modifier 59 shall NOT be used. Although CMS does not allow separate payment for CPT code 38220 with CPT code 38221 when bone marrow aspiration and biopsy are performed on the same iliac bone at a single patient encounter, a physician may report CPT code 38222 (Diagnostic bone marrow; biopsy(ies) and aspiration(s)).

Example 2

The Column One/Column Two code edit with Column One CPT code 11055 (Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion) and Column Two CPT code 11720 (Debridement of nail(s) by any method(s); 1 to 5) should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifiers 59 or XE, XP, XS, XU should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifiers 59 or XS may be reported with code 11720 if 1 to 5 nails are debrided, and a hyperkeratotic lesion is pared on a toe other than 1 with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

e. **Modifiers XE, XS, XP, XU:** These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be used in lieu of modifier 59 whenever possible. The modifiers are defined as follows:

XE – "Separate Encounter, A service that is distinct because it occurred during a separate encounter." This modifier shall only be used to describe separate encounters on the same date of service.

XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"

XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"

XU – "Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service"

F. Standard Preparation/Monitoring Services for Anesthesia

With few exceptions, anesthesia HCPCS/CPT codes do not specify the mode of anesthesia for a particular procedure. Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service HCPCS/CPT codes when performed in association with the anesthesia service. However, if the provider/supplier of the anesthesia service performs 1 or more of these services prior to and unrelated to the anticipated anesthesia service or after the patient is released from the anesthesia practitioner's postoperative care, the service may be separately reportable with modifiers 59 or XE or XU.

G. Anesthesia Service Included in the Surgical Procedure

Under CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical procedure. Likewise, under OPPS, payment for the anesthesia service is generally included in the payment for the medical or surgical procedure. For example, separate payment is not allowed for the physician's performance of local**,** regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. 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.

CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia shall not be reported in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician. Examples of improperly reported services that are bundled into the anesthesia service when anesthesia is provided by the physician performing the medical or surgical procedure include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), intravenous infusion/injection (CPT codes 96360-96368, 96374-96379) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042). However, if these services are not related to the delivery of an anesthetic agent or are not an inherent component of the procedure or global service, they may be reported separately.

The physician performing a surgical or medical procedure shall not report an epidural/subarachnoid injection (CPT codes 62320-62327) or nerve block (CPT codes 64400-64530) for anesthesia for that procedure.

H. HCPCS/CPT Procedure Code Definition

The HCPCS/CPT code descriptors of 2 codes are often the basis of an NCCI PTP edit. If 2 HCPCS/CPT codes describe redundant services, they shall not be reported separately. Several general principles follow:

1. A family of CPT codes may include a CPT code followed by one or more indented CPT codes. The first CPT code descriptor includes a semicolon. The portion of the descriptor of the first code in the family preceding the semicolon is a common part of the descriptor for each subsequent code of the family. For example:

CPT code 70120	Radiologic examination, mastoids; less than 3 views per side
CPT code 70130	Radiologic examination, mastoids; complete, minimum of 3 views per side

   The portion of the descriptor preceding the semicolon (“Radiologic examination, mastoids”) is common to both CPT codes 70120 and 70130. The difference between the 2 codes is the portion of the descriptors following the semicolon. Often, as in this case, 2 codes from a family may not be reported separately. A physician cannot report CPT codes 70120 and 70130 for a procedure performed on ipsilateral mastoids at the same patient encounter. It is important to recognize, however, that there are numerous circumstances when it may be appropriate to report more than one code from a family of codes. For example, CPT codes 70120 and 70130 may be reported separately if the 2 procedures are performed on contralateral mastoids or at 2 separate patient encounters on the same date of service.

2. If a HCPCS/CPT code is reported, it includes all components of the procedure defined by the descriptor. For example, CPT code 58291 includes a vaginal hysterectomy with “removal of tube(s) and/or ovary(s).” A physician cannot report a salpingo-oophorectomy (CPT code 58720) separately with CPT code 58291.

3. CPT code descriptors often define correct coding relationships where 2 codes may not be reported separately with one another at the same anatomic site and/or same patient encounter. A few examples follow:

   a. A "partial" procedure is not separately reportable with a "complete" procedure.

   b. A "partial" procedure is not separately reportable with a "total" procedure.

   c. A "unilateral" procedure is not separately reportable with a "bilateral" procedure.

   d. A "single" procedure is not separately reportable with a "multiple" procedure.

   e. A "with" procedure is not separately reportable with a "without" procedure.

   f. An "initial" procedure is not separately reportable with a "subsequent" procedure.

I. *CPT Professional* and CMS Coding Manual Instructions

CMS often publishes coding instructions in its rules, manuals, and notices. Physicians must use these instructions when reporting services rendered to Medicare patients.

The *CPT Professional* also includes coding instructions which may be found in the Introduction, individual chapters, and appendices. In individual chapters, the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow *CPT Professional* instructions unless CMS has provided different coding or reporting instructions.

The American Medical Association publishes *CPT Assistant* which contains coding guidelines. CMS does not review nor approve the information in this publication. In the development of NCCI PTP edits, CMS occasionally disagrees with the information in this publication. If a physician uses information from *CPT Assistant* to report services rendered to Medicare patients, it is possible that MACs may use different criteria to process claims.

J. CPT "Separate Procedure" Definition

If a CPT code descriptor includes the term "separate procedure," the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifiers 59 or XE or XS (or a more specific modifier, e.g.,

anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service.

K. Family of Codes

The *CPT Professional* often contains a group of codes that describe related procedures that may be performed in various combinations. Some codes describe limited component services, and other codes describe various combinations of component services. Physicians must use several principles in selecting the correct code to report:

1. A HCPCS/CPT code may be reported if and only if all services described by the code are performed.

2. The HCPCS/CPT code describing the services performed shall be reported. A physician shall not report multiple codes corresponding to component services if a single comprehensive code describes the services performed. There are limited exceptions to this rule which are specifically identified in this manual.

3. HCPCS/CPT code(s) corresponding to component service(s) of other more comprehensive HCPCS/CPT code(s) shall not be reported separately with the more comprehensive HCPCS/CPT code(s) that include the component service(s).

4. If the HCPCS/CPT codes do not correctly describe the procedure(s) performed, the physician shall report a "not otherwise specified" CPT code rather than a HCPCS/CPT code that most closely describes the procedure(s) performed.

L. More Extensive Procedure

The *CPT Professional* often describes groups of similar codes differing in the complexity of the service. Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable. Several examples of this principle follow:

1. If 2 procedures only differ in that 1 is described as a "simple" procedure and the other as a "complex" procedure, the "simple" procedure is included in the "complex" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

2. If 2 procedures only differ in that 1 is described as a "simple" procedure and the other as a "complicated" procedure, the "simple" procedure is included in the "complicated" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

3. If 2 procedures only differ in that 1 is described as a "limited" procedure and the other as a "complete" procedure, the "limited" procedure is included in the "complete" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

4. If 2 procedures only differ in that 1 is described as an "intermediate" procedure and the other as a "comprehensive" procedure, the "intermediate" procedure is included in the "comprehensive" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

5. If 2 procedures only differ in that 1 is described as a "superficial" procedure and the other as a "deep" procedure, the "superficial" procedure is included in the "deep" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

6. If 2 procedures only differ in that 1 is described as an "incomplete" procedure and the other as a "complete" procedure, the "incomplete" procedure is included in the "complete" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

7. If 2 procedures only differ in that 1 is described as an "external" procedure and the other as an "internal" procedure, the "external" procedure is included in the "internal" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

M. Sequential Procedure

Some surgical procedures may be performed by different surgical approaches. If an initial surgical approach to a procedure fails and a second surgical approach is used at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. If there are different HCPCS/CPT codes for the 2 different surgical approaches, the 2 procedures are considered "sequential," and only the HCPCS/CPT code corresponding to the second surgical approach may be reported. For example, a physician may begin a cholecystectomy procedure using a laparoscopic approach and have to convert the procedure to an open abdominal approach. Only the CPT code for the open cholecystectomy may be reported. The CPT code for the failed laparoscopic cholecystectomy is not separately reportable.

N. Laboratory Panel

The *CPT Professional* defines organ and disease specific panels of laboratory tests. If a laboratory performs all tests included in one of these panels, the laboratory shall report the CPT code for the panel. If the laboratory repeats 1 of these component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended (See Chapter X, Section C (Organ or

Disease Oriented Panels).

O. Misuse of Column Two Code with Column One Code (Misuse of Code Edit Rationale)

The CMS manuals and instructions often describe groups of HCPCS/CPT codes that should not be reported together for the Medicare program. Edits based on these instructions are often included as misuse of a Column Two code with a Column One code.

A HCPCS/CPT code descriptor does not include exhaustive information about the code. Physicians who are not familiar with a HCPCS/CPT code may incorrectly report the code in a context different than intended. The NCCI program has identified HCPCS/CPT codes that are incorrectly reported with other HCPCS/CPT codes as a result of the misuse of the Column Two code with the Column One code. If these edits allow use of NCCI PTP-associated modifiers (modifier indicator of "1"), there are limited circumstances when the Column Two code may be reported on the same date of service as the Column One code. Two examples follow:

1. Three or more HCPCS/CPT codes may be reported on the same date of service. Although the Column Two code is misused if reported as a service associated with the Column One code, the Column Two code may be appropriately reported with a third HCPCS/CPT code reported on the same date of service. For example, CMS limits separate payment for use of the operating microscope for microsurgical techniques (CPT code 69990) to a group of procedures listed in the online MCPM Chapter 12, Section 20.4.5 (Allowable Adjustments). The NCCI program has edits with Column One codes of surgical procedures not listed in this section of the manual and Column Two CPT code of 69990. Some of these edits allow use of NCCI PTP-associated modifiers because the 2 services listed in the edit may be performed at the same patient encounter as a third procedure for which CPT code 69990 is separately reportable.

2. There may be limited circumstances when the Column Two code is separately reportable with the Column One code. For example, the NCCI program has an edit with Column One CPT code of 47600 (Cholecystectomy) and Column Two CPT code of 12035 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm). If the patient has an abdominal wound in addition to and separate from the cholecystectomy surgical incision, then it may be separately reportable with CPT code 12035 using an NCCI PTP-associated modifier to bypass the edit. 47600 includes repair of the cholecystectomy surgical incision.

Misuse of code as an edit rationale may be applied to PTP edits where the Column Two code is not separately reportable with the Column One code based on the nature of the Column One coded procedure. This edit rationale may also be applied to code pairs where use of the Column Two code with the Column One code is deemed to be a coding error.

P. Mutually Exclusive Procedures

Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. An example of a mutually exclusive situation is the repair of an organ that can be performed by 2 different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an "initial" service or a "subsequent" service.

Q. Gender-Specific Procedures

Some HCPCS/CPT codes includes a sex assignment descriptor. HCPCS/CPT codes specific for patients assigned female at birth should generally not be reported with HCPCS/CPT codes for patients assigned male at birth or vice versa. For example, CPT code 53210 describes a total urethrectomy including cystostomy in a patient assigned female at birth, and CPT code 53215 describes the same procedure in a patient assigned male at birth.

R. Add-on Codes

Some codes in the *CPT Professional* are identified as "Add-on" Codes (AOCs), which describe a service that can only be reported in addition to a primary procedure. *CPT Professional* instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) is (are) not specified**.** When the *CPT Professional* identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code.

AOCs permit the reporting of significant supplemental services commonly performed in addition to the primary procedure. By contrast, incidental services that are necessary to accomplish the primary procedure (e.g., lysis of adhesions in the course of an open cholecystectomy) are not separately reportable with an AOC. Similarly, complications inherent in an invasive procedure occurring during the procedure are not separately reportable. For example, control of bleeding during an invasive procedure is considered part of the procedure and is not separately reportable.

In general, NCCI PTP edits do not include edits with most AOCs because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure (i.e., if an edit prevents payment of the primary procedure code, the AOC shall not be paid). However, the NCCI program does include edits for some AOCs when coding edits related to the primary procedures must be supplemented. Examples include edits with add-on HCPCS/CPT codes 69990 (Microsurgical techniques requiring use of operating microscope) and 95940/95941/G0453 (Intraoperative neurophysiology testing).

HCPCS/CPT codes that are not designated as AOCs shall not be misused as an AOC to report a supplemental service. A HCPCS/CPT code may be reported if and only if all services described by the CPT code are performed. A HCPCS/CPT code shall not be reported with another service

because a portion of the service described by the HCPCS/CPT code was performed with the other procedure. For example, if an ejection fraction is estimated from an echocardiogram study, it would be inappropriate to additionally report CPT code 78472 (Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing) with the echocardiography (e.g., CPT code 93307). Although the procedure described by CPT code 78472 includes an ejection fraction, it is measured by gated equilibrium with a radionuclide which is not used in echocardiography.

S. Excluded Service

The NCCI program does not generally address issues related to HCPCS/CPT codes describing services that are excluded from Medicare coverage or are not otherwise recognized for payment under the Medicare program.

T. Unlisted Procedure Codes

The *CPT Professional* includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes and are located at the end of each section or subsection of the manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service shall be reported using an unlisted procedure code. A physician shall not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI program generally does not include edits with these codes.

U. Reserved for future use

V. Medically Unlikely Edits (MUEs)

To lower the Medicare Fee-For-Service Paid Claims Error Rate, CMS has established units of service edits referred to as Medically Unlikely Edit(s)(MUEs).

An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service.

All claims submitted to MACs and Durable Medical Equipment (DME) MACs, and outpatient facility services claims (e.g., Type of Bill 13X, 14X, 85X, 87X) are tested against MUEs.

Prior to April 1, 2013, each line of a claim was adjudicated separately against the MUE value for the HCPCS/CPT code reported on that claim line. If the UOS on that claim line exceeded the MUE value, the entire claim line was denied.

In the April 1, 2013, version of MUEs, CMS began introducing date of service (DOS) MUEs. Over time CMS will convert many, but not all, MUEs to DOS MUEs. Since April 1, 2013, MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the UOS on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS MUE, all UOS on each claim line for the same date of service for the same HCPCS/CPT code are summed, and the sum is compared to the MUE value. If the summed UOS exceed the MUE value, all UOS for the HCPCS/CPT code for that date of service are denied. Denials due to claim line MUEs or DOS MUEs may be appealed to the local claims processing contractor. DOS MUEs are used for HCPCS/CPT codes where it would be extremely unlikely that more UOS than the MUE value would ever be performed on the same date of service for the same patient.

The MUE files on the CMS NCCI website display an MUE Adjudication Indicator (MAI) for each HCPCS/CPT code. An MAI of "1" indicates that the edit is a claim line MUE. An MAI of "2" or "3" indicates that the edit is a DOS MUE.

If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, (i.e., MAI equal to "1") appropriate use of CPT modifiers (i.e., 59 or XE, XP, XS, XU; 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.

MUEs for HCPCS codes with an MAI of "2" are absolute date of service edits. These are "per day edits based on policy." HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers/suppliers and CMS claims processing contractors. Limitations created by anatomical, or coding limitations are incorporated in correct coding policy, both in the HIPAA mandated coding descriptors and CMS-approved coding guidance as well as specific guidance in the CMS and NCCI manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for CPT 94002 (Ventilation assist and management . . . initial day) because such use could not accurately describe 2 initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of "2" denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy.

MUEs for HCPCS codes with an MAI of "3" are "per day edits based on clinical benchmarks." MUEs assigned an MAI of "3" are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If contractors have evidence (e.g., medical review) that UOS in excess of the MUE value were actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher-level appeal.

An MUE or the lack of an MUE, does not necessarily indicate coverage status of a HCPCS/CPT code. The NCCI program does not establish medical necessity or payment policy.

Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

1. Anatomic considerations may limit UOS based on anatomic structures. For example:
    a. The MUE value for an appendectomy is "1" since there is only 1 appendix.
    b. The MUE for a knee brace is "2" because there are 2 knees and Medicare policy does not cover back-up equipment.
    c. The MUE value for a lumbar spine procedure reported per lumbar vertebra or per lumbar interspace cannot exceed "5" since there are only 5 lumbar vertebrae or interspaces.
    d. The MUE value for a procedure reported per lung lobe cannot exceed "5" since there are only 5 lung lobes (3 in right lung and 2 in left lung).

2. CPT code descriptors/CPT coding instructions in the *CPT Professional* may limit UOS. For example:
    a. A procedure described as the "initial 30 minutes" would have an MUE value of "1" because of the use of the term "initial." A different code may be reported for additional time.
    b. If a code descriptor uses the plural form of the procedure, it must not be reported with multiple UOS. For example, if the code descriptor states "biopsies," the code is reported with "1" unit of service regardless of the number of biopsies performed.
    c. The MUE value for a procedure with "per day," "per week," or "per month" in its code descriptor is "1" because MUEs are based on number of services per day of service.
    d. The MUE value of a code for a procedure described as "unilateral" is "1" if there is a different code for the procedure described as "bilateral."
    e. The code descriptors of a family of codes may define different levels of service, each having an MUE of "1." For example, CPT codes 78102-78104 describe bone marrow imaging. CPT code 78102 is reported for imaging a "limited area." CPT code 78103 is reported for imaging "multiple areas." CPT

code 78104 is reported for imaging the "whole body."

f. The MUE value for CPT code 86021 (Antibody identification; leukocyte antibodies) is "1" because the code descriptor is plural including testing for any and all leukocyte antibodies. On a single date of service only one specimen from a patient would be tested for leukocyte antibodies.
g. When reporting codes, it is important to assure the accuracy of coding and the correct UOS by selecting a code that accurately identifies the service performed based on factors including but not limited to, the route of administration. For example, for intravitreal injection of bevacizumab, select an intravitreal code (e.g., C9257) rather than an intravenous code (e.g., J9035).

3. Edits based on established CMS policies may limit UOS. For example:
    a. The MUE value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB).
        i. If the bilateral surgery indicator is "0," a bilateral procedure must be reported with "1" unit of service. There is no additional payment for the code if reported as a unilateral or bilateral procedure because of anatomy or physiology. Alternatively, the code descriptor may specifically state that the procedure is a unilateral procedure, and there is a separate code for a bilateral procedure.
        ii. If the bilateral surgery indicator is "1," a bilateral surgical procedure must be reported with "1" unit of service and modifier 50 (bilateral modifier). A bilateral diagnostic procedure may be reported with "1" unit of service and modifier 50 on 1 claim line, or "1" unit of service with modifier RT on 1 claim line plus "1" unit of service and modifier LT on a second claim line.
        iii. If the bilateral surgery indicator is "2," a bilateral procedure must be reported with "1" unit of service. The procedure is priced as a bilateral procedure because (1) the code descriptor defines the procedure as bilateral; (2) the code descriptor states that the procedure is performed unilaterally or bilaterally; or (3) the procedure is usually performed as a bilateral procedure.
        iv. If the bilateral surgery indicator is "3," a bilateral surgical procedure must be reported with "1" unit of service and modifier 50 (bilateral modifier). A bilateral diagnostic procedure may be reported with "2" UOS on 1 claim line, "1" unit of service and modifier 50 on 1 claim line, or 1 unit of service with modifier RT on 1 claim line plus "1" unit of service and modifier LT on a second claim line.
    b. The MUE value for a code may be "1" where the code descriptor does not specify a unit of service and CMS considers the default UOS to be "per day."
    c. The MUE value for a code may be "0" because the code is listed as invalid, not covered, bundled, not separately payable, statutorily excluded, not

reasonable and necessary, etc. based on:

i. The Medicare Physician Fee Schedule Database
ii. OPPS Addendum B
iii. Alpha-Numeric HCPCS Code File
iv. DMEPOS Jurisdiction List
v. Medicare *Internet-Only Manual* (IOM)

4. The nature of an analyte may limit UOS and is in general determined by:
    a. The nature of the specimen may limit the UOS. For example, CPT code 82575 describes a creatinine clearance test and has an MUE of "1" because the test requires a twenty-four-hour urine collection; or
    b. The physiology, pathophysiology, or clinical application of the analyte is such that a maximum unit of service for a single date of service can be determined. For example, the MUE for CPT code 82747 (RBC folic acid) is "1" because the test result would not be expected to change during a single day, and thus it is not necessary to perform the test more than once on a single date of service.

5. The nature of a procedure/service may limit UOS and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).
    a. The MUE for many surgical or medical procedures is "1" because the procedure is rarely, if ever, performed more than 1 time per day (e.g., colonoscopy, motion analysis tests).
    b. The MUE value for a procedure is "1" because of the amount of time required to perform the procedure (e.g., overnight sleep study).

6. The nature of equipment may limit UOS and is in general determined by the number of items of equipment that would be used. For example, the MUE value for a wheelchair code is "1" because only 1 wheelchair is used at 1 time and Medicare policy does not cover back-up equipment.

7. Although clinical judgment considerations and determinations based on input from numerous physicians and certified coders are sometimes initially used to establish some MUE values, these values are subsequently validated or changed based on submitted and/or paid claims data.

8. Prescribing information is based on FDA labeling as well as off-label information published in CMS-approved drug compendia. See below for additional information about how prescribing information is used in determining the MUE values.

9. Submitted and paid claims data (100%) from a six-month period is used to ascertain the distribution pattern of UOS typically reported for a given HCPCS/CPT code.

10. Published policies of the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) may limit UOS for some durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). For example:
    a. The MUE values for many ostomy and urological supply codes, nebulizer codes, and CPAP accessory codes are typically based on a three-month supply of items.
    b. The MUE values for surgical dressings, parenteral and enteral nutrition, immunosuppressive drugs, and oral anti-cancer drugs are typically based on a one-month supply.
    c. The MUE values take into account the requirement for reporting certain codes with date spans.
    d. The MUE value of a code may be "0" if the item is noncovered, not medically necessary, or not separately payable.
    e. The MUE value of a code may be "0" if the code is invalid for claim submission to the DME MAC.

UOS denied based on an MUE may be appealed. Because a denial of services due to an MUE is a coding denial, not a medical necessity denial, the presence of an Advanced Beneficiary Notice of Noncoverage (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of "3," contractors will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of "1." CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under Section 1879 of the Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider/supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for UOS denied based on an MUE.

HCPCS J-code and drug related C and Q-code MUEs are based on prescribing information, how product is supplied, and/or 100% claims data for a six-month period of time. Using the prescribing information, the highest total daily dose for each drug was determined. This dose and its corresponding UOS were evaluated against paid and submitted claims data. Some of the guiding principles used in developing these edits are as follows:

(1) If the prescribing information defined a maximum daily dose, this value was used to determine the MUE value. For some drugs there is an absolute maximum daily dose. For others there is a maximum "recommended" or "usual" dose. In the latter 2 cases, the

daily dose calculation was evaluated against claims data.

(2) If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110-150 kg was evaluated against the claims data. If the maximum daily dose calculation is based on ideal body weight, a dose based on a weight range of 90-110 kg was evaluated against claims data. If the maximum daily dose calculation is based on body surface area (BSA), a dose based on a BSA range of 2.4 - 3.0 square meters was evaluated against claims data.

(3) For drugs where the maximum daily dose is based on patient response or need, prescribing information and claims data were used to establish the MUE values.

(4) Published off-label use of a drug was considered for the maximum daily dose calculation.

(5) The MUE values for some drug codes are set to "0." The rationale for such values include but are not limited to: discontinued manufacture of drug, non-FDA-approved compounded drug, practitioner MUE values for oral anti-neoplastic, oral anti-emetic, and oral immune suppressive drugs which should be billed to the DME MACs, outpatient hospital MUE values for inhalation drugs which should be billed to the DME MACs, and Practitioner/ASC MUE values for HCPCS C codes describing medications that would not be related to a procedure performed in an ASC.

Non-drug related HCPCS/CPT codes may be assigned an MUE of "0" for a variety of reasons including, but not limited to, outpatient hospital MUE value for a surgical procedure only performed as an inpatient procedure, noncovered service, bundled service, DME MUE value for implanted devices and items related to implanted devices which should not be billed to the DME MACs, or packaged service.

The MUE files on the CMS NCCI website display an "Edit Rationale" for each HCPCS/CPT code. Although an MUE may be based on several rationales, only one is displayed on the website. One of the listed rationales is "Data." This rationale indicates that 100% claims data from a six-month period of time was the major factor in determining the MUE value. If a physician appeals an MUE denial for a HCPCS/CPT code where the MUE is based on "Data," the reviewer will usually confirm that (1) the correct code is reported; (2) the correct UOS are used; (3) the number of reported UOS were performed; and (4) all UOS were medically reasonable and necessary.

The first MUEs were implemented January 1, 2007. Additional MUEs are added on a quarterly basis on the same schedule as NCCI PTP updates. Prior to implementation proposed MUEs are sent to numerous national healthcare organizations for a 60-day review and comment period.

Many surgical procedures may be performed bilaterally. Instructions in 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

require that bilateral surgical procedures be reported using modifier 50 with one unit of service 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. If a bilateral surgical procedure is performed at different sites bilaterally, one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

Some A/B MACs allow providers/suppliers to report repetitive services performed over a range of dates on a single line of a claim with multiple UOS. If a provider/supplier reports services in this fashion, the provider/supplier should report the "from date" and "to date" on the claim line. Contractors are instructed to divide the UOS reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line.

Providers/Suppliers billing services to the DME MACs typically report some HCPCS codes for supply items for a period exceeding a single day. The DME MACs have billing rules for these codes. For some codes the DME MACs require that the "from date" and "to date" be reported. The MUEs for these codes are based on the maximum number of UOS that may be reported for a single date of service. For other codes the DME MACs permit multiple days' supply items to be reported on a single claim line where the "from date" and "to date" are the same. The DME MACs have rules allowing supply items for a maximum number of days to be reported at one time for each of these types of codes. The MUE values for these codes are based on the maximum number of days that may be reported at one time. As with all MUEs, the MUE value does not represent a utilization guideline. Providers/suppliers shall not assume that they may report UOS up to the MUE value on each date of service. Providers/suppliers may only report supply items that are medically reasonable and necessary.

Most MUE values are set so that a provider or supplier would only very occasionally have a claim line denied. If a provider/supplier encounters a code with frequent denials due to the MUE or frequent use of a CPT modifier to bypass the MUE, the provider or supplier should consider the following: (1) Is the HCPCS/CPT code being used correctly? (2) Is the unit of service being counted correctly? (3) Are all reported services medically reasonable and necessary? and (4) Why does the provider's or supplier's practice differ from national patterns? A provider or supplier may choose to discuss these questions with the local Medicare contractor or a national healthcare organization whose members frequently perform the procedure.

Most MUE values are published on the CMS MUE webpage. However, some MUE values are not published and are confidential. These values shall not be published in oral or written form by any party that acquires one or more of them.

MUEs are not utilization edits. Although the MUE value for some codes may represent the commonly reported UOS (e.g., MUE of "1" for appendectomy), the usual UOS for many HCPCS/CPT codes is less than the MUE value. Claims reporting UOS less than the MUE value may be subject to review by claims processing contractors, Unified Program Integrity Contractor

(UPICS), Recovery Audit Contractors (RACs), and Department of Justice (DOJ).

Since MUEs are coding edits, rather than medical necessity edits, claims processing contractors may have UOS edits that are more restrictive than MUEs. In such cases, the more restrictive claims processing contractor edit would be applied to the claim. Similarly, if the MUE is more restrictive than a claims processing contractor edit, the more restrictive MUE would apply.

W. Add-on Code Edits

Add-on Codes (AOCs) are discussed in Chapter I, Section R (Add-on Codes). CMS publishes a text file of AOCs and their primary codes annually prior to January 1. CMS updates the file quarterly based on the AMA's CPT Errata documents or implementation of new HCPCS/CPT add-on codes. CMS identifies AOCs and their primary codes based on *CPT Professional* instructions, CMS interpretation of HCPCS/CPT codes, and CMS coding instructions.

An AOC is a HCPCS/CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

For Type 1 AOCs edits, the *CPT Professional* or HCPCS files define all acceptable primary codes. MACs should not allow other primary codes with Type 1 AOCs. CPT code 99292 (Critical care, evaluation, and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) is included as a Type 1 AOC since its only primary code is CPT code 99291 (Critical care, evaluation, and management of the critically ill or critically injured patient; first 30-74 minutes). For Medicare purposes, CPT code 99292 may be eligible for payment to a physician without CPT code 99291 if another physician of the same specialty and physician group reports and is paid for CPT code 99291.

For Type 2 AOCs edits, the *CPT Professional* and HCPCS files do not define any primary codes. MACs should develop their own lists of acceptable primary codes.

For Type 3 AOCs edits, the *CPT Professional* or HCPCS files define some, but not all, acceptable primary codes. MACs should allow the listed primary codes for these AOCs but may develop their own lists of additional acceptable primary codes.

Although the AOC and primary code are normally reported for the same date of service, there are unusual circumstances where the 2 services may be reported for different dates of service (e.g., CPT codes 99291 and 99292).

CMS updates the complete file of AOC edits with their primary procedure codes on an annual basis on or by January 1 every year based on changes to the *CPT Professional* or HCPCS Level II Manual. CMS posts quarterly updates as a complete file of AOC edits, if necessary, on April

1, July 1, and October 1 of each year. If no changes occur in the AOC edits, no quarterly update will be posted.