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FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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INTRODUCTION
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
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Introduction

On December 19, 1989, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) was enacted. Section 6102 of P.L. 101-239 amended Title XVIII of the Social Security Act (the Act) by adding a new section 1848, "Payment for Physicians' Services". This section of the Act provided for replacing the previous reasonable charge mechanism of actual, customary, and prevailing charges with a resource-based relative value scale (RBRVS) fee schedule that began in 1992.

With the implementation of the Medicare Physician Fee Schedule, it was important to assure that uniform payment policies and procedures were followed by all carriers so that the same service would be paid similarly in all carrier jurisdictions. Accurate coding and reporting of services by physicians is a critical aspect of assuring proper payment.

Purpose

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

Although the NCCI was initially developed for use by Medicare Carriers to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006, all therapy claims paid by Fiscal Intermediaries were also subject to NCCI edits in the OCE.

On January 1, 2007, CMS incorporated Medically Unlikely Edits (MUEs) into the NCCI program. These edits are applicable to claims submitted to Carriers, A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Fiscal Intermediaries (FIs).

In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary. Furthermore, since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "Notice of Exclusions from Medicare Benefits" (NEMB) form.

Since the NCCI is a CMS program, its policies and edits represent CMS national policy. However, NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

Policy Manual Background

The *National Correct Coding Initiative Policy Manual for Medicare Services* and NCCI edits have been developed for application to Medicare services billed by a single provider for a single patient on the same date of service.

The National Correct Coding Initiative replaced and is more comprehensive than the "rebundling" program instituted by CMS, formerly HCFA, in 1991.

The *National Correct Coding Initiative Policy Manual for Medicare Services* and the edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment. The edits and policies do not include all

possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

The *National Correct Coding Initiative Policy Manual for Medicare Services* and edits were initially based on evaluation of procedures referenced in the 1994 *CPT Manual* and HCPCS Level II codes. An ongoing refinement program has been developed to address annual changes in CPT codes and instructions, either additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes occur based on changes in technology, standard medical practice, and input from the AMA, specialty societies, other national healthcare organizations, Medicare contractor medical directors and staff, providers, consultants, etc.

The *National Correct Coding Initiative Policy Manual for Medicare Services* includes a Table of Contents, an Introduction, and 13 narrative chapters. As shown in the Table of Contents, each chapter corresponds to a separate section of the *CPT Manual* except Chapter I which contains general correct coding policies, Chapter XII which addresses HCPCS Level II codes, and Chapter XIII which addresses Category III CPT codes. Each chapter is subdivided by subject to allow easier access to a particular code or group of codes.

The *National Correct Coding Initiative Policy Manual for Medicare Services* in general utilizes paraphrased descriptions of CPT and HCPCS Level II codes. The user of this manual should refer to the AMA's *Current Procedural Terminology (CPT) Manual* and CMS's HCPCS Level II code descriptors for complete descriptors of the codes.

Edit Development and Review Process

The NCCI undergoes constant refinement publishing four versions annually. Medicare Carriers implement the versions effective January 1, April 1, July 1, and October 1. Medicare Fiscal Intermediaries also implement four annual versions of NCCI in OCE on January 1, April 1, July 1, and October 1. Changes appearing in the NCCI edits for Medicare Carriers appear in OCE one quarter later. Changes in NCCI come from three sources: (1) additions, deletions or modifications to CPT or HCPCS Level II codes or *CPT Manual* instructions; (2) CMS policy initiatives; and (3) comments

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from the AMA, national or local medical/surgical societies, other national healthcare organizations, Medicare contractor medical directors and staff, providers, billing consultants, etc.

CMS notifies the AMA and national medical/surgical societies of the quarterly changes in NCCI. Additionally, CMS seeks comment from national medical/surgical societies and other national healthcare organizations before implementing many types of changes in NCCI. Although national medical/surgical societies and other national healthcare organizations generally agree with changes CMS makes to NCCI, CMS carefully considers those adverse comments received. When CMS decides to proceed with changes in NCCI contrary to the comments of national medical/surgical societies or other national healthcare organizations, it does so after due consideration of those comments and other information available to CMS.

Correct Coding

Physicians 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. Although the emphasis in the manual is correct coding, there are certain types of improper coding that physicians must avoid.

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

- A physician should 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 physician should report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician should 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 should not fragment a procedure into component parts. For example, if a physician performs an upper gastrointestinal endoscopy with biopsy of the stomach, the

physician should report CPT code 43239 (Upper gastrointestinal endoscopy...; with biopsy,...). It is improper to unbundle this procedure and report CPT code 43235 (Upper gastrointestinal endoscopy...; diagnostic,...) plus CPT code 43600 (Biopsy of stomach;...). The latter code is not intended to be utilized with an endoscopic procedure code.

- A physician should not unbundle a bilateral procedure code into two unilateral procedure codes. For example if a physician performs bilateral mammography, the physician should report CPT code 77056 (Mammography; bilateral). The physician should not report CPT code 77055 (Mammography; unilateral) with two units of service or 77055-LT plus 77055-RT.
- A physician should not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician should not report CPT code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician 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 should report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician should not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians 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 physician should not report CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criteria 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 physician should 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.

Sources of Information about NCCI

The CMS website contains:

- 1) a copy of the *National Correct Coding Initiative Policy Manual for Medicare Services*
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>);
- 2) a listing of all NCCI edits utilized by Medicare Carriers
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/>);
- 3) a listing of all NCCI edits utilized by Fiscal Intermediaries in the Outpatient Code Editor (OCE)
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/>);and
- 4) NCCI Frequently Asked Questions (FAQ)
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>).

Correspondence to CMS about NCCI and its Contents

The NCCI is maintained for CMS by Correct Coding Solutions, LLC. If the user of this manual has concerns regarding the content of the edits or this manual, an inquiry may be submitted in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax number: (317) 571-1745

CMS makes all decisions about the contents of NCCI and this manual. Correspondence from Correct Coding Solutions, LLC reflects CMS's policies on coding and NCCI.

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CHAPTER I
GENERAL CORRECT CODING POLICIES
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Chapter I

General Correct Coding Policies

A. Introduction

Healthcare providers utilize HCPCS/CPT codes to report medical services performed on patients to Medicare Carriers and Fiscal Intermediaries (FIs). HCPCS (Healthcare Common Procedure Coding System) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA) *CPT Manual* which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare and 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 three times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific 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 with removal of tube(s) and ovary(s) and repair of enterocele)). Because many procedures can be performed by 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.

The CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together. There are two NCCI edit tables: "Column One/Column Two Correct Coding Edit Table" and "Mutually Exclusive Edit Table". 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 reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically

appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment. (NCCI-associated modifiers and their appropriate use are discussed elsewhere in this chapter.) All edits are included in the "Column One/Column Two Correct Coding Edit Table" except those that are based on the "mutually exclusive" (Chapter I, Section P) and "gender specific" (Chapter I, Section Q) criteria in which case the edits are included in the "Mutually Exclusive Edit Table".

When the NCCI 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 two codes that should not be reported together. For example, a provider should not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

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 utilized 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 into a 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 on the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

Many NCCI edits are based on 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 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
- 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
- Surgical supplies, except for specific situations where CMS policy permits separate payment

Although other chapters in this Manual further address issues related to the standards of medical/surgical practice for the procedures covered by that chapter, it is not possible because of space limitations to discuss all NCCI edits based on the principle of the standards of medical/surgical practice. 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 successfully 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:

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

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

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

Surgical:

1. Since 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 "scout" 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 to indicate a staged procedure. A cursory examination of the upper airway during a bronchoscopy with the bronchoscope should 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. Since 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 should 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) should 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 code 37201 (Transcatheter therapy, infusion for thrombolysis other than coronary) should 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 90760-90775 should not be reported separately. 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 90760-90775).

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 75998 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 76001, 77002) should 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 should not report CPT codes 90760-90775 for the administration of anesthetic agents during the procedure. If it is medically reasonable and necessary that a separate provider (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.

Under OPPS, anesthesia for a surgical procedure is an included service and is not separately reportable. For example, a

provider should not report CPT codes 90760-90775 for anesthesia services.

3. 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, 94770).

4. If the result of a diagnostic biopsy is utilized to determine whether to proceed with another procedure, the diagnostic biopsy is separately reportable. However, if a biopsy is obtained for evaluation after the procedure is completed, the biopsy is not separately reportable with an excision, removal, destruction, fulguration, or other elimination procedure of the biopsied lesion. In this latter situation, the biopsy is part of the elimination of the lesion. If a single lesion is biopsied multiple times, only one biopsy code may be reported with a single unit of service. If multiple lesions are non-endoscopically biopsied, a biopsy code may be reported for each lesion appending a modifier indicating that each biopsy was performed on a separate lesion. For endoscopic biopsies, multiple biopsies of a single or multiple lesions are reported with one unit of service of the biopsy code. If it is medically reasonable and necessary to submit multiple biopsies of the same or different lesions for separate pathologic examination, the medical record must identify the precise location and separate nature of each biopsy.

5. 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.

6. 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. For example, debridement of skin to repair a fracture is not separately reportable.

7. 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.

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

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

10. If a procedure utilizing one approach fails and is converted to a procedure utilizing a different approach, only the successful 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.

11. If a laparoscopic procedure fails and is converted to an open procedure, the physician should 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 should not report the failed laparoscopic cholecystectomy nor a diagnostic laparoscopy.

12. If a diagnostic endoscopy is the basis for and precedes an open procedure, the diagnostic endoscopy is separately reportable with modifier -58. However, the medical record must document the medical reasonableness and necessity for the diagnostic endoscopy. A scout 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 successful surgical procedure may be reported. The endoscopic procedure is not separately reportable with the successful procedure.

13. Treatment of complications of primary surgical procedures are 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 and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M

service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day 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

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

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI 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 edit if the Medicare restrictions are fulfilled.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT,
LC, LD, RC
Global surgery modifiers: -25, -58, -78, -79
Other modifiers: -59, -91

It is very important that NCCI-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 modifier indicators of "1" because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pair edits should not be reported with NCCI-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 edit indicates that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers generally should not be utilized.

The appropriate use of most of these modifiers is straightforward. However, further explanation is provided about modifiers -25, -58, and -59. Although modifier -22 is not a

modifier that bypasses an NCCI edit, its use is occasionally relevant to an NCCI edit and is discussed below.

a) **Modifier -22:** Modifier -22 is defined by the *CPT Manual* as an "unusual procedural service". This modifier should not be reported routinely but only when the service performed is significantly more extensive than that defined by the HCPCS/CPT code reported.

Occasionally a provider may perform two procedures that should not be reported together based on an NCCI edit. If the edit allows use of NCCI-associated modifiers to bypass it and the clinical circumstances justify use of one of these modifiers, both services may be reported with the NCCI-associated modifier. However, if the NCCI edit does not allow use of NCCI-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 edit with modifier -22. The Carrier may then evaluate the unusual procedural service to determine whether additional payment is justified.

b) **Modifier -25:** The *CPT Manual* defines modifier -25 as a "significant, separately identifiable evaluation and management service by the same physician 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 (global period of 000 or 010 days) or procedures not covered by global surgery rules (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 should 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 whether the patient is a new or established patient.

c) **Modifier -58:** Modifier -58 is defined by the *CPT Manual* as a "staged or related procedure or service by the same

physician 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 edits that allow use of NCCI-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 "scout" 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) 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 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 NCCI, the principle stated in this paragraph is applicable regardless of whether the selected code pair combination is included in the NCCI tables. A provider should 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-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. The *CPT Manual* defines modifier -59 as follows:

Modifier -59: Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, 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 physician. 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.

NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at different anatomic sites or different patient encounters. Carrier processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier -59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

Some examples of the appropriate use of modifier -59 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 two codes of a code pair edit consisting of two surgical procedures or two diagnostic procedures usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier -59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites

or at separate patient encounters on the same date of service, modifier -59 may be appended to indicate that they are different procedures/surgeries on that date of service.

An exception to this general principle about misuse of modifier -59 applies to some code pair edits consisting of a surgical procedure and a diagnostic procedure. If the diagnostic procedure precedes the surgical procedure and is the basis on which the decision to perform the surgical procedure is made, the two procedures may be reported with modifier -59 under appropriate circumstances. However, if the diagnostic procedure is an inherent component of the surgical procedure, it cannot be reported separately. If the diagnostic procedure follows the surgical procedure at the same patient encounter, modifier -59 may be utilized if appropriate.

Use of modifier -59 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 modifier -59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

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

Example: The column one/column two code edit with column one CPT code 38221 (bone marrow biopsy) and column two CPT code 38220 (bone marrow, aspiration only) includes two distinct procedures when performed at separate anatomic sites or separate patient encounters. In these circumstances, it would be acceptable to use modifier -59. However, if both 38221 and 38220 are performed through the same skin incision at the same patient encounter which is the usual practice, modifier -59 should 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 through the same skin incision at a single patient encounter, CMS does allow separate payment for HCPCS level II code G0364 (bone marrow aspiration performed with bone marrow

biopsy through same incision on the same date of service) with CPT code 38221 under these circumstances.

2. Each NCCI edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant.

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 of the anesthesia service performs one 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 modifier -59.

G. Anesthesia Service Included in the Surgical Procedure

Under the 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 service. 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. However, Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia should 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 service include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion/injection (CPT codes 90760-90768, 90774-90775). 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.

H. HCPCS/CPT Procedure Code Definition

The HCPCS/CPT code descriptors of two codes are often the basis of an NCCI edit. If two HCPCS/CPT codes describe redundant services, they should 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 three views per side
CPT code 70130	complete, minimum of three 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 two codes is the portion of the descriptors following the semicolon. Often as in this case, two 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 two procedures are performed on contralateral mastoids or at two 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 two 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 Manual and CMS Coding Manual Instructions

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

The *CPT Manual* 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 Manual* 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

edits, CMS occasionally disagrees with the information in this publication. If a physician utilizes information from *CPT Assistant* to report services rendered to Medicare patients, it is possible that Medicare Carriers and Fiscal Intermediaries may utilize 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. Modifier -59 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 Manual* 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 utilize 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 should be reported. A physician should 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) should 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 should 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 Manual* 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 two procedures only differ in that one 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 two procedures are performed at separate patient encounters or at separate anatomic sites.

(2) If two procedures only differ in that one 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 two procedures are performed at separate patient encounters or at separate anatomic sites.

(3) If two procedures only differ in that one 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 two procedures are performed at separate patient encounters or at separate anatomic sites.

(4) If two procedures only differ in that one 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 two procedures are performed at separate patient encounters or at separate anatomic sites.

(5) If two procedures only differ in that one 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 two procedures are performed at separate patient encounters or at separate anatomic sites.

(6) If two procedures only differ in that one 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 two procedures are performed at separate patient encounters or at separate anatomic sites.

(7) If two procedures only differ in that one 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 two 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 utilized 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 two different surgical approaches, the two 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 utilizing 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 Manual* defines organ and disease specific panels of laboratory tests. If a laboratory performs all tests included in one of these panels, the laboratory may report the CPT code for the panel or the CPT codes for the individual tests. If the laboratory repeats one 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.

O. Misuse of Column Two Code with Column One Code

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 column two code with 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 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-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 *Claims Processing Manual* (Chapter 12, Section 20.4.5 (Allowable Adjustments)). The NCCI 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-associated modifiers because the two 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 has an edit with column one CPT code of 80061 (lipid profile) and column two CPT code of 83721 (LDL cholesterol by direct measurement). If the triglyceride level is less than 400 mg/dl, the LDL is a calculated value utilizing the results from the lipid profile for the calculation, and CPT code 83721 is not separately reportable. However, if the triglyceride level is greater than 400 mg/dl, the LDL may be measured directly and may be separately reportable with CPT code 83721 utilizing an NCCI-associated modifier to bypass the edit.

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 two 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. With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same patient encounter.

Pairs of HCPCS/CPT codes that are mutually exclusive of one another based either on the HCPCS/CPT code descriptors or the medical impossibility/improbability that the two procedures could be performed at the same patient encounter are identified as code pair edits in the Mutually Exclusive edit table.

Many edits in the Mutually Exclusive edit table allow the use of NCCI-associated modifiers. For example, the two procedures of a code pair edit may be performed at different anatomic sites (e.g., contralateral eyes) or separate patient encounters on the same date of service.

Q. Gender-Specific Procedures (formerly Designation of Sex)

The descriptor of some HCPCS/CPT codes includes a gender-specific restriction on the use of the code. HCPCS/CPT codes specific for one gender should not be reported with HCPCS/CPT codes for the opposite gender. For example, CPT code 53210 describes a total urethrectomy including cystostomy in a female, and CPT code 53215

describes the same procedure in a male. Since the patient cannot have both the male and female procedures performed, the two CPT codes cannot be reported together. Edits based on this principle are included in the Mutually Exclusive edit table since the two procedures of a code pair edit cannot be performed on the same patient.

R. Add-on Codes

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

Add-on codes 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 add-on code. 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 does not include edits with most add-on codes 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 add-on code will also not be paid.) However, NCCI does include edits for some add-on codes when coding edits related to the primary procedures must be supplemented. Examples include edits with add-on codes 69990 (microsurgical techniques requiring use of operating microscope) and 95920 (intraoperative neurophysiology testing).

HCPCS/CPT codes that are not designated as add-on codes should not be misused as an add-on code 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 should 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 with ejection fraction) with the echocardiography (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 utilized in echocardiography.

S. Excluded Service

The NCCI does not 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 Manual* includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are 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 should be reported utilizing an unlisted procedure code. A physician should 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 generally does not include edits with these codes.

U. Modified, Deleted, and Added Code Pairs/Edits

Correct coding (column one/column two) and mutually exclusive edits are adopted after due consideration of Medicare policies including the principles described in the *National Correct Coding Initiative Policy Manual for Medicare Services*, HCPCS and *CPT Manual* code descriptors, *CPT Manual* coding guidelines, coding guidelines of national societies, standards of medical and surgical practice, current coding practice, and provider billing

patterns. Since the NCCI is developed by CMS for the Medicare program, the most important consideration is CMS policy.

Prior to initial implementation of the NCCI in 1996, the proposed edits were evaluated by Medicare Part B Carrier Medical Directors, representatives of the American Medical Association's CPT Advisory Committee, and representatives of other national medical and surgical societies.

The NCCI undergoes continuous refinement with revised edit tables published quarterly. There is a process to address annual changes (additions, deletions, and modifications) of HCPCS/CPT codes and *CPT Manual* coding guidelines. Other sources of refinement are initiatives by the CMS central office and comments from the CMS regional offices, AMA, national medical, surgical, and other healthcare societies/organizations, Medicare contractor medical directors, providers, consultants, other third party payors, and other interested parties. Prior to implementing new edits, CMS generally provides a review and comment period to representative national organizations that may be impacted by the edits. However, there are situations when CMS thinks that it is prudent to implement edits prior to completion of the review and comment period. CMS Central Office evaluates the input from all sources and decides which edits are modified, deleted, or added each quarter.

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 for a HCPCS/CPT code is the maximum number of units of service (UOS) allowable by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE.

Each line of a claim is adjudicated separately against the MUE value of the HCPCS/CPT code reported on that line. If the unit of service on that line exceeds the MUE value, the entire line is denied at the Carrier or the claim is returned to the provider at the Fiscal Intermediary (FI).

If appropriate use of CPT modifiers (e.g., -59, -76, -77, -91, anatomic) causes the same HCPCS/CPT code to appear on separate lines of a claim, each line is separately adjudicated against the MUE value for that HCPCS/CPT code.

UOS denied based on an MUE may be appealed at the Carrier.

The MUE value for each HCPCS/CPT code is based on one or more of the following criteria:

(1) Anatomic considerations may limit UOS based on anatomic structures. For example, the MUE for cataract surgery would be two since there are only two eyes.

(2) CPT code descriptors/CPT coding instructions in the *CPT Manual* may limit UOS. For example, a procedure described as the "initial 30 minutes" would have an MUE of 1 because of the use of the term "initial".

(3) Edits based on established CMS policies may limit units of service. For example, the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB) may limit reporting of bilateral procedures.

(4) The nature of an analyte may limit UOS and is in general determined by one of three considerations:

a) The nature of the specimen may limit the units of service as for a test requiring a 24 hour urine specimen.

b) The nature of the test may limit the units of service as for a test that requires 24 hours to perform.

c) The physiology, pathophysiology, or clinical application of the analyte is such that a maximum units of service for a single date of service can be determined. For example, the MUE for RBC folic acid level would be one since the test would only be necessary 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).

(6) The nature of equipment may limit UOS and is in general determined by the number of items of equipment that would be utilized (e.g., cochlear implant or wheelchair).

(7) Clinical judgment considerations are based on input from numerous physicians and certified coders.

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

A provider, supplier, healthcare organization, or other interested party may request modification of an MUE value for a HCPCS/CPT code. A written request proposing an alternative MUE with rationale may be sent to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907
Fax: 317-571-1745

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CHAPTER II
ANESTHESIA SERVICES
CPT CODES 00000-09999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter II
Anesthesia Services
CPT Codes 00000 - 09999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 00000-01999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

Anesthesia care is provided by an anesthesia practitioner who may be a physician, a certified registered nurse anesthetist (CRNA) with or without medical direction, or an anesthesia assistant (AA) with medical direction. The anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care.

Preoperative evaluation includes a sufficient history and physical examination so that the risk of adverse reactions can be minimized, alternative approaches to anesthesia planned, and all questions regarding the anesthesia procedure by the patient answered. Types of anesthesia include local, regional, epidural, general, moderate conscious sedation, or monitored anesthesia care (MAC). The anesthesia practitioner assumes responsibility for the post-anesthesia recovery period which includes all care until the patient is released to the surgeon or another physician.

Anesthesiologists may personally perform anesthesia services or may supervise anesthesia services performed by a CRNA or AA. CRNAs may perform anesthesia services independently or under the supervision of an anesthesiologist. An AA always performs anesthesia services under the direction of an anesthesiologist. Anesthesiologists personally performing anesthesia services and non-medically directed CRNAs bill in a standard fashion in accordance with CMS regulations as outlined in the *Internet-Only Manuals(IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Sections 50 and 140. CRNAs and AAs practicing under the medical direction of anesthesiologists follow instructions and regulations regarding this arrangement as outlined in the above sections of the *Medicare Claims Processing Manual*.

B. Standard Anesthesia Coding

The following policies reflect national Medicare correct coding guidelines for anesthesia services.

1. CPT codes 00100-01860 specify "Anesthesia for" followed by a general area of surgical intervention. CPT codes 01916-01933 describe anesthesia for diagnostic or interventional radiology procedures. Several CPT codes 01951-01999 describe anesthesia services for burn excision/debridement, obstetrical, and other procedures. CPT codes 99143-99150 describe moderate conscious sedation services.

Anesthesia services include, but are not limited to, preoperative evaluation of the patient, administration of anesthetic, other medications, blood, and fluids, monitoring of physiological parameters, and other supportive services.

Anesthesia codes describe a general anatomic area or service which usually relates to a number of surgical procedures, often from multiple sections of the *CPT Manual*. For Medicare purposes, only one anesthesia code is reported unless the anesthesia code is an add-on code. In this case, both the code for the primary anesthesia service and the anesthesia add-on code are reported according to *CPT Manual* instructions.

2. A unique characteristic of anesthesia coding is the reporting of time units. Payment for anesthesia services increases with time. In addition to reporting a basic unit value

for an anesthesia service, the anesthesia practitioner reports anesthesia time. Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

Example: A patient who undergoes a cataract extraction may require monitored anesthesia care (see below). This may require administration of a sedative in conjunction with a peri/retrobulbar injection for regional block anesthesia. Subsequently, an interval of 30 minutes or more may transpire during which time the patient does not require monitoring by an anesthesia practitioner. After this period, monitoring will commence again for the cataract extraction and ultimately the patient will be released to the surgeon's care or to recovery. The time that may be reported would include the time for the monitoring during the block and during the procedure. The interval time and the recovery time are not to be included in the anesthesia time calculation. Also, if unusual services not bundled into the anesthesia service are required, the time spent delivering these services before anesthesia time begins or after it ends may not be included as reportable anesthesia time.

However, if it is medically necessary for the anesthesia practitioner to continuously monitor the patient during the interval time and not perform any other service, the interval time may be included in the anesthesia time.

3. It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service and is included in the base unit of the anesthesia code. The evaluation and examination are not reported in the anesthesia time. If surgery is canceled, subsequent to the preoperative evaluation, payment may be allowed to the anesthesiologist for an evaluation and management service and the appropriate E&M code (usually a consultation code) may be reported. (A non-medically

directed CRNA may also report an E&M code under these circumstances if permitted by state law.)

Similarly, routine postoperative evaluation is included in the basic unit for the anesthesia service. If this evaluation occurs after the anesthesia practitioner has safely placed the patient under postoperative care, neither additional anesthesia time units nor evaluation and management codes should be reported for this evaluation. Postoperative evaluation and management services related to the surgery are not separately reportable by the anesthesia practitioner except when an anesthesiologist provides significant, separately identifiable ongoing critical care services.

Anesthesia practitioners other than anesthesiologists cannot report evaluation and management codes except as described above when a surgical case is canceled.

Anesthesia practitioners if permitted by state law may separately report significant, separately identifiable postoperative management services after the anesthesia service time ends. These services include, but are not limited to, postoperative pain management and ventilator management unrelated to the anesthesia procedure.

Management of epidural or subarachnoid drug administration (CPT code 01996) is separately payable on dates of service subsequent to surgery but not on the date of surgery. If the only service provided is management of epidural/subarachnoid drug administration, then an evaluation and management service should not be reported in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or non-medically directed CRNA may be able to report this service, only one payment will be made per day.

Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner.

In certain circumstances critical care services are provided by the anesthesiologist. It is currently national CMS policy that CRNAs cannot be reimbursed for evaluation and management services in the critical care area. In the case of anesthesiologists, the routine immediate postoperative care is not separately reported except as described above. Certain procedural services such as insertion of a Swan-Ganz catheter, insertion of a central venous pressure line, emergency intubation (outside of the operating suite), etc. are separately payable to anesthesiologists as well as non-medically directed CRNAs if these procedures are furnished within the parameters of state licensing laws.

4. Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure such as preparation, monitoring, intra-operative care, and post-operative care until the patient is released by the anesthesiologist to the care of another physician. Examples of integral services include, but are not limited to, the following:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of external devices necessary for cardiac monitoring, oximetry, capnography, temperature, EEG, CNS evoked responses (e.g., BSER), doppler flow.
- Placement of peripheral intravenous lines necessary for fluid and medication administration.
- Placement of airway (endotracheal tube, orotracheal tube, etc.).
- Laryngoscopy (direct or endoscopically) for placement of airway (endotracheal tube, etc.).
- Placement of naso-gastric or oro-gastric tube.
- Intra-operative interpretation of monitored functions (blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (arterial blood gases such as pH, pO₂, pCO₂, bicarbonate,

hematology, blood chemistries, lactate, etc.) by the anesthesiologist/CRNA.

- Nerve stimulation for determination of level of paralysis or localization of nerve(s). (Codes for EMG services are for diagnostic purposes for nerve dysfunction. To report these codes a complete diagnostic report must be present in the medical record.)
- Insertion of urinary bladder catheter.
- Blood sample procurement through existing lines or requiring only venipuncture or arterial puncture.

The NCCI contains many edits bundling standard preparation, monitoring, and procedural services into anesthesia CPT codes. Although some of these services may never be reported on the same date of service as an anesthesia service, many of these services could be provided at a separate patient encounter unrelated to the anesthesia service on the same date of service. Providers may utilize modifier -59 to bypass the edits under these circumstances.

CPT codes describing services that are integral to an anesthesia service include but are not limited to, the following:

- 31505, 31515, 31527 (Laryngoscopy) (Laryngoscopy codes are for diagnostic or surgical services)
- 31622, 31645, 31646 (Bronchoscopy)
- 36000, 36010 - 36015 (Introduction of needle or catheter)
- 36400-36440 (Venipuncture and transfusion)
- Blood sample procurement through existing lines or requiring only venipuncture or arterial puncture.
- 62310-62311, 62318-62319 (Injection of diagnostic or therapeutic substance):
CPT codes 62310-62311 and 62318-62319 may be reported on the date of surgery if performed for postoperative pain relief rather than as the means for providing the regional block for the surgical procedure. If a

narcotic or other analgesic is injected through the same catheter as the anesthetic, CPT codes 62310-62319 should not be billed. Modifier -59 will indicate that the injection was performed for postoperative pain relief but a procedure note should be included in the medical record.

Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesiologist reports CPT code 01382 (Anesthesia for diagnostic arthroscopic procedures of knee joint). The epidural catheter is left in place for postoperative pain management. The anesthesiologist should not also report CPT codes 62311 (injection of diagnostic or therapeutic substance) or 01996 (daily management of epidural) on the date of surgery. CPT code 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. On the other hand, if the anesthesiologist performed general anesthesia reported as CPT code 01382 and reasonably believes that postoperative pain is likely to be sufficient to warrant an epidural catheter, CPT code 62319-59 may be reported indicating that this is a separate service from the anesthesia service. In this instance, the service is separately payable whether the catheter is placed before, during, or after the surgery. If the epidural catheter was placed on a different date than the surgery, modifier -59 would not be necessary. Effective January 1, 2004, daily hospital management of continuous epidural or subarachnoid drug administration performed on the day(s) subsequent to the placement of an epidural or subarachnoid catheter (CPT codes 62318-62319) may be reported as CPT code 01996.

- 64400-64565 (Nerve blocks)
- 67500 (Retrobular injection)
- 81000-81015, 82013, 82205, 82270, 82271 (Performance and interpretation of laboratory tests)
- 90760-90776 (Injections, IV infusions, and drug administration)
- 91000, 91055, 91105 (Esophageal, gastric intubation)

- 92511-92520, 92543 (Special otorhinolaryngologic services)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960 (Cardioversion)
- 93000-93010 (Electrocardiography)
- 93015-93018 (Cardiovascular stress tests)
- 93040-93042 (Electrocardiography)
- 93307-93308 (Transthoracic echocardiography when displayed for monitoring purposes.) However, when performed for diagnostic purposes with documentation of a formal report, this service will be considered a significant, separately identifiable, and separately payable service.
- 93312-93317 (Transesophageal echocardiography) However, when performed for diagnostic purposes with documentation of a formal report, this service will be considered a significant, separately identifiable, and separately payable service.
- 93318 (Transesophageal echocardiography for monitoring purposes)
- 93922-93981 (Extremity arterial venous studies) When performed diagnostically with a formal report, this will be considered a significant, separately identifiable, and if medically necessary, a payable service.
- 94640 (Inhalation/IPPB treatments)
- 94002-94004, 94660-94662 (Ventilation management/CPAP services) If performed as management for maintenance ventilation during a surgical procedure, this is part of the anesthesia service. This is separately payable if performed as an ongoing service after transfer out

of the operating room or post-anesthesia recovery to a hospital unit/ICU. Modifier -59 would be necessary to signify that this was a separate service.

- 94664 (Inhalations)
- 94680-94690 (Expired gas analysis)
- 94760-94770 (Oximetry)
- 99201-99499 (Evaluation and management)

(This is not a comprehensive list of all services included in anesthesia services.)

C. Radiologic Anesthesia Coding

In keeping with standard anesthesia billing guidelines for Medicare, only one anesthesia code may be reported for anesthesia services provided in conjunction with radiological procedures. Radiological Supervision and Interpretation (S&I) codes will usually be applicable to radiological procedures being performed.

The appropriate S&I code may be reported by the appropriate provider (radiologist, cardiologist, neurosurgeon, radiation oncologist, etc.). Accordingly, S&I codes are not included in anesthesia codes referable to these procedures; only the appropriate provider, however, may bill for S&I services.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter) can be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable. If the physician performing the radiologic service places a catheter as part of that service, and, through the same site, a catheter is left and used for monitoring purposes, it is inappropriate for either the anesthesiologist/certified registered nurse anesthetist or the physician performing the radiologic procedure to bill for placement of the monitoring catheter (e.g., CPT codes 36500, 36555-36556, 36568-36569, 36580, 36584, 36597).

D. Monitored Anesthesia Care (MAC)

Monitored Anesthesia Care (MAC) may be performed by an anesthesia practitioner who administers sedatives, analgesics, hypnotics, and other anesthetic agents so that the patient remains responsive and breathes on his own. MAC provides anxiety relief, amnesia, pain relief, and comfort. MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and the recognition and treatment of any adverse changes. CMS recognizes this type of anesthesia service as a payable service if medically reasonable and necessary.

Monitored anesthesia care involves the intraoperative monitoring by a physician or qualified individual under the medical direction of a physician of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a preanesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications and provision of indicated postoperative anesthesia care.

Issues of medical necessity are addressed by National and Local Contractor Medical Review Policy.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. Physicians should not report drug administration CPT codes 90760-90776 for anesthetic agents or other drugs administered between the patient's arrival at the operative center and discharge from the post-anesthesia care unit.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90776) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

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

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Chapter III
Surgery: Integumentary System
CPT Codes 10000 - 19999

A. Introduction

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

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Local anesthesia including local infiltration, regional blocks, mild sedation, and all other anesthesia services except moderate conscious sedation reportable as CPT codes 99143-99145 are not separately reportable by a physician performing a medical or surgical procedure.

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

It is a misuse of therapeutic injection or aspiration CPT codes to report administration of local anesthesia for a procedure. For example, it is a misuse of CPT codes 10160 (puncture aspiration), 20500-20501 (injection of sinus tract), 20526-20553 (injection of carpal tunnel, tendon sheath, ligament, trigger points, etc.), 20600-20610 (arthrocentesis) to report administration of local anesthetic for another procedure.

In the postoperative period, patients treated with epidural or subarachnoid continuous drug administration may require daily hospital adjustment/management of the catheter, dosage, etc. (CPT code 01996). This service may be reported by the anesthesia practitioner. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global

period services associated with the operative procedure. If the only surgery performed is placement of an epidural or subarachnoid catheter for continuous drug administration, CPT code 01996 may be reported on subsequent days by the managing physician.

D. Incision and Drainage

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

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

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

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

HCPCS/CPT codes describing complications of a procedure may or may not be separately reportable at the same patient encounter as the procedure causing the complication. (See Chapter I, Section C.13)

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

E. Lesion Removal

HCPCS/CPT codes define different types of removal codes such as destruction (e.g., laser, freezing), debridement, paring/cutting, shaving, or excision. Only one removal HCPCS/CPT code may be reported for a lesion. If multiple lesions are included in a single removal procedure (e.g., single excision of skin containing three nevi), only one removal HCPCS/CPT code may be reported for the procedure. If a removal procedure is begun by one method but is converted to another method to complete the procedure, only the HCPCS/CPT code describing the successful procedure may be reported. If multiple lesions are removed separately, it may be appropriate depending upon the code descriptors for the procedures to report multiple HCPCS/CPT codes utilizing anatomic modifiers or modifier -59 to indicate different sites or lesions. The medical record must document the appropriateness of reporting multiple HCPCS/CPT codes with these modifiers.

The HCPCS/CPT codes for lesion removal include the procurement of tissue from the same lesion by biopsy at the same patient encounter. CPT codes 11000-11001 (biopsy of skin, subcutaneous tissue and/or mucous membrane) should not be reported separately. CPT codes 11000-11001 may be separately reportable with lesion removal HCPCS/CPT codes if the biopsy is performed on a different lesion than the removal procedure.

Removed tissue is often submitted for surgical pathology evaluation generally reported with CPT codes 88300-88309. If multiple lesions are submitted for pathological examination as a single specimen, only one CPT code may be reported for examination of all the lesions even if each lesion is processed separately. However, if it is medically reasonable and necessary to submit multiple lesions separately identifying the precise location of each lesion, a separate surgical pathology CPT code may be reported for each lesion.

If a physician reviews pathology slides from previously removed lesion(s) in association with an evaluation and management (E&M) service to determine whether additional surgery is required, the review of the pathology slides is included in the E&M service. The physician should not report CPT codes 88321-88325 (surgical pathology consultation) in addition to the E&M code.

Lesion removal may require closure (simple, intermediate, or complex), adjacent tissue transfer, or grafts. If the lesion removal requires dressings, strip closure, or simple closure, these services are not separately reportable. Thus, CPT codes 12001-12021 (simple repairs) are integral to the lesion removal codes. Intermediate or complex repairs, adjacent tissue transfer, and grafts may be separately reportable if medically reasonable and necessary. However, excision of benign lesions with excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440) includes simple, intermediate, or complex repairs which should not be reported separately.

If lesion removal, incision, or repair requires debridement of non-viable tissue surrounding a lesion, incision, or injury in order to complete the procedure, the debridement is not separately reportable.

F. Mohs Micrographic Surgery

Mohs micrographic surgery (CPT codes 17311-17315) is performed to remove complex or ill-defined cutaneous malignancy. A single physician performs both the surgery and pathologic examination of the specimen(s). The Mohs micrographic surgery CPT codes include skin biopsy and excision services (CPT codes 11000-11001, 11600-11646, and 17260-17286) and pathology services (88300-88309, 88329-88332). Reporting these latter codes in addition to the Mohs micrographic surgery CPT codes is inappropriate. However, if a suspected skin cancer is biopsied for pathologic diagnosis prior to proceeding to Mohs micrographic surgery, the biopsy (CPT codes 11000, 11001) and frozen section pathology (CPT code 88331) may be reported separately utilizing modifier -59 or -58 to distinguish the diagnostic biopsy from the definitive Mohs surgery. Although the *CPT Manual* indicates that modifier -59 should be utilized, it is also acceptable to utilize modifier -58 to indicate that the diagnostic skin biopsy and Mohs micrographic surgery were staged or planned procedures. Repairs, grafts, and flaps are separately reportable with the Mohs micrographic surgery CPT codes.

G. Intralesional Injections

CPT codes 11900-11901 describe intralesional injections of non-chemotherapeutic agents. CPT codes 96405-96406 describe intralesional injections of chemotherapeutic agents. Two intralesional injection codes should not be reported together

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

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

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

H. Repair and Tissue Transfer

The *CPT Manual* classifies repairs (closure) (CPT codes 12001-13160) as simple, intermediate, or complex. If closure cannot be completed by one of these procedures, adjacent tissue transfer or rearrangement (CPT codes 14000-14350) may be utilized. Adjacent tissue transfer or rearrangement procedures include excision (CPT codes 11400-11646) and repair (12001-13160). Thus, CPT codes 11400-11646 and 12001-13160 should not be reported separately with CPT codes 14000-14350 for the same lesion or injury. Additionally debridement necessary to perform a tissue transfer procedure is included in the procedure. It is inappropriate to report debridement (CPT codes 11000, 11040-11042) with adjacent tissue transfer (CPT codes 14000-14350) for the same lesion/injury.

Skin grafting in conjunction with a repair or adjacent tissue transfer is separately reportable if the grafting is *not* included in the code descriptor of the adjacent tissue transfer code.

Adjacent tissue transfer codes should not be reported with the closure of a traumatic wound if the laceration is coincidentally approximated using a tissue transfer type closure (e.g., Z-plasty, W-plasty). The closure should be reported with repair codes. However, if the surgeon develops a specific tissue transfer to close a traumatic wound, a tissue transfer code may be reported.

Procurement of cultures or tissue samples during a closure is included in the repair or adjacent tissue transfer codes and are not separately reportable.

I. Grafts and Flaps

CPT codes describing skin grafts and skin substitutes are classified by size, location of recipient area defect, and type of graft or skin substitute. For most combinations of location and type of graft/skin substitute, there are two or three CPT codes including a primary code and one or two add-on codes. The primary code describes one size of graft/skin substitute and should not be reported with more than one unit of service. Larger size grafts or skin substitutes are reported with add-on codes.

The primary graft/skin substitute codes (e.g., 15100, 15120, 15200, 15220) are mutually exclusive since only one type of graft/skin substitute can be utilized at an anatomic site. If multiple sites require different types of grafts/skin substitutes, the different graft/skin substitute CPT codes should be reported with anatomic modifiers or modifier -59 to indicate the different sites.

Simple debridement of a skin wound (CPT codes 11000, 11040-11042) prior to a graft/skin substitute is included in the skin graft/skin substitute procedure (CPT codes 15050-15431) and should not be reported separately. If the recipient site requires excision of open wounds, burn eschar, or scar or incisional release of scar contracture, CPT codes 15002-15005 may be separately reportable for certain types of skin grafts/skin substitutes.

1. A *CPT Manual* instruction following CPT code 67911 (Correction of lid retraction) states that autogenous graft CPT codes (20920, 20922, or 20926) may be reported separately. All other services necessary to complete the procedure are included.

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

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

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

The breast procedure codes include incision and closure. Some codes describe mastectomy procedures with lymphadenectomy and/or removal of muscle tissue. The latter procedures are not separately reportable. Except for sentinel lymph node biopsies, ipsilateral lymph node excisions are not separately reportable. Contralateral lymph node excisions may be separately reportable with appropriate modifiers (i.e., -LT, -RT).

Sentinel lymph node biopsy is separately reportable when performed prior to a localized excision of breast or a mastectomy without lymphadenectomy. However, sentinel lymph node biopsy is not separately reportable with a mastectomy procedure that includes lymphadenectomy in the anatomic area of the sentinel lymph node biopsy. Open biopsy or excision of sentinel lymph node(s) should be reported as follows: axillary (CPT codes 38500 or 38525), deep cervical (CPT code 38510), internal mammary (CPT code 38530). (CPT code 38740(axillary lymphadenectomy; superficial) should not be reported for a sentinel lymph node biopsy. Sentinel lymph node biopsy of superficial axillary lymph node(s) is correctly reported as CPT code 38500 (biopsy or

excision of lymph node(s), superficial) which includes the removal of one or more discretely identified superficial lymph nodes. By contrast a superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue.)

Breast reconstruction codes that include the insertion of a prosthetic implant should not be reported with codes that separately describe the insertion of a breast prosthesis.

CPT codes for breast procedures generally describe unilateral procedures.

K. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

L. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. CPT codes 15851 and 15852 describe suture removal and dressing change respectively under anesthesia other than local anesthesia. These codes should not be reported when a patient requires anesthesia for a related procedure (e.g., return to the operating room for treatment of complications where an incision is reopened necessitating removal of sutures and redressing). Additionally, CPT code 15852 should not be reported with a primary procedure.

4. Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure. (See Section C. Anesthesia)

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure

pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

5. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

6. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

8. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

9. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

10. The NCCI edits with column one CPT codes 11055-11057 (Paring or cutting of benign hyperkeratotic lesions) each with column two CPT codes 11720-11721 (Nail debridement by any method) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 11720 or 11721 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed for lesions anatomically separate from one another or if the two procedures are performed at separate patient encounters. CPT codes 11055-11057 must not be used to report removal of hyperkeratotic skin adjacent to nails requiring debridement.

11. The NCCI edits with column one CPT codes 17000 and 17004 (Destruction of benign or premalignant lesions) each with column two CPT code 11100 (Biopsy of single skin lesion) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 11100 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed on separate lesions or at separate patient encounters. Refer to the *CPT Manual* instructions preceding CPT code 11100 for additional clarification about the CPT codes 11100-11101.

12. The NCCI edit with column one CPT code 11719 ((Trimming of nondystrophic nails) and column two CPT code 11720 (Nail debridement by any method, one to five nails) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 11720 of this NCCI edit is only appropriate if the trimming and the debridement of the nails are performed on

different nails or if the two procedures are performed at separate patient encounters.

13. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

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CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter IV
Surgery: Musculoskeletal System
CPT Codes 20000 - 29999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 20000-29999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The

physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For example, CPT codes 20526-20553 (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) should not be reported for the administration of local anesthesia to perform another procedure. The NCCI contains many edits based on this principle. If a procedure and a separate and distinct injection service unrelated to anesthesia for the former procedure are reported, the injection service may be reported with an NCCI-associated modifier if appropriate.

D. Biopsy

A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

E. Arthroscopic Procedure Converted to Open Procedure

If an arthroscopic procedure fails and is converted to an open procedure, only the open procedure is reportable. Thus, arthroscopic procedures are bundled into open procedures. If an arthroscopic procedure and open procedure are performed on different joints, the two procedures may be separately reportable with anatomic modifiers or modifier -59.

F. Fractures and/or Dislocations

1. The application of external immobilization devices (casts, splints, strapping) at the time of a procedure includes the subsequent removal of the device when performed by the same entity (e.g., physician, practice, group, employees, etc.). Providers should not report removal or repair CPT codes 29700-29750 for those services. These removal or repair CPT codes may only be reported if the initial application of the cast, splint, or strapping was performed by a different entity.

2. Casting/splinting/strapping should not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed. Additionally casting/splinting/strapping CPT codes should not be reported for application of a dressing after a therapeutic procedure. For example, if a provider injects an anesthetic agent into a peripheral nerve or branch (CPT code 64450), the provider should not report CPT codes such as 29515, 29540, 29580, or 29590. Similarly, a provider should not report a casting/splinting/strapping CPT code for the same site as an injection or aspiration (e.g., CPT codes 20526-20615).

3. CPT codes for closed or open treatment of fractures or dislocations include the application of casts, splints, or strapping. CPT codes for casting/splinting/strapping should not be reported separately.

4. If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and also assumes the follow-up care, the physician cannot report the casting/splinting/strapping CPT codes since these services are included in the fracture and/or dislocation CPT codes.

5. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report an evaluation and management (E&M) service, a casting/splinting/strapping CPT code, and a cast/splint/strap supply code (Q4001-Q4051).

For OPSS if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.

6. An evaluation and management (E&M) service may be reported with a casting/splinting/strapping CPT code if the E&M service is significant and separately identifiable.

7. There are CPT codes (20670 and 20680) for removal of internal fixation devices (e.g., pin, rod). These codes are not separately reportable if the removal is performed as a necessary integral component of another procedure. For example, if a revision of an open fracture repair requires removal of a previously inserted pin, CPT code 20670 or 20680 is not separately reportable.

Similarly, if a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure.

8. CPT code 20670 or 20680 (removal of implant) should not be reported for the removal of wire sutures during cardiac reoperation procedures or sternal procedures (e.g., debridement, resection, closure of median sternotomy separation).

9. If a closed reduction procedure fails and is converted to an open reduction procedure at the same patient encounter, only the more extensive open reduction procedure is reportable. Similarly, if a closed fracture treatment procedure fails and is converted to an open fracture treatment procedure at the same patient encounter, only the more extensive open fracture treatment procedure is reportable.

10. If interdental wiring (e.g., CPT code 21497) is necessary for the treatment of a facial or other fracture, arthroplasty, facial reconstructive surgery, or other facial/head procedure, the interdental wiring is not separately reportable. However, if interdental wiring is performed unrelated to another facial/head procedure, the interdental wiring may be separately reportable with modifier -59.

11. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is not separately reportable.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. If a tissue transfer procedure such as a graft (e.g., CPT codes 20900-20926) is included in the code descriptor of a primary procedure, the tissue transfer procedure is not separately reportable.

4. CPT code 20926 describes a graft of "other" tissues such as paratenon, fat, or dermis. Similar to other graft codes, this code may not be reported with another code where the code descriptor includes procurement of the graft. Additionally, CPT code 20926 may be reported only if another graft HCPCS/CPT code does not more precisely describe the nature of the graft.

5. Some procedures routinely utilize monitoring of interstitial fluid pressure during the postoperative period (e.g., distal lower extremity procedures with risk of anterior compartment compression). CPT code 20950 (monitoring of interstitial fluid pressure) should not be reported separately for this monitoring.

6. If electrical stimulation is used to aid bone healing, bone stimulation codes (CPT codes 20974-20975) may be reported. CPT codes 64550-64595 describe procedures for neurostimulators which are utilized to control pain and should not be reported for electrical stimulation to aid bone healing. Similarly the physical medicine electrical stimulation codes (CPT codes 97014 and 97032) should not be reported for electrical stimulation to aid bone healing.

7. Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier -59.

8. Debridement of tissue related to an open repair of a fracture or dislocation may be separately reportable with CPT codes 11010-11012. However, debridement of tissue in the surgical field integral to the successful completion of another musculoskeletal procedure is not separately reportable. For example, debridement of muscle and/or bone (CPT codes 11043-11044) associated with excision of a tumor of bone is not separately reportable. Similarly, debridement of tissue superficial (CPT codes 11040-11042, 11720-11721) to, but in the surgical field, of a musculoskeletal procedure is not separately reportable.

9. CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29866-29889). HCPCS code G0289 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee) may be reported.

10. The NCCI has an edit with column one CPT code of 24305 (tendon lengthening, upper arm and elbow, each tendon) and column two CPT code of 64718 (neuroplasty and/or transposition; ulnar nerve at elbow). When performing the tendon lengthening described by CPT code 24305, a neuroplasty of the ulnar nerve is not separately reportable, but a transposition of the ulnar nerve at the elbow is separately reportable. If a provider performs the tendon lengthening described by CPT code 24305 and performs an ulnar nerve transposition at the elbow, the NCCI edit may be bypassed by reporting CPT code 64718 appending modifier -59.

11. Some procedures (e.g., spine) frequently utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package.

12. Spinal arthrodesis, exploration, and instrumentation procedures (CPT codes 22532-22865) include manipulation of the spine as an integral component of the procedures. CPT code 22505 (manipulation of spine requiring anesthesia, any region) should not be reported separately.

13. Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

14. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

15. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are

separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

17. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

18. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

19. Because many musculoskeletal structures are bilateral (e.g., elbow, wrist), many NCCI edits with HCPCS/CPT codes describing procedures on these structures allow use of NCCI-associated modifiers (i.e., modifier indicator of "1") for situations where the two procedures of a code pair edit are performed on contralateral structures. Physicians should be careful to avoid inappropriate use of NCCI-associated modifiers with these edits if the two procedures of a code pair edit are performed on the ipsilateral structure.

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

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

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 30000-39999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never

report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Respiratory System

1. The nose and mouth have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes that describe the procedure as an integumentary procedure (CPT codes 10000-19999), a nasal procedure (CPT codes 30000-30999), or an oral procedure (CPT codes 40000-40899). If a procedure is performed on a lesion at or near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If the code descriptor of a CPT code from the respiratory system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) should not be reported separately.

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

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

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

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

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

A diagnostic endoscopy is not separately reportable with a surgical endoscopy per *CPT Manual* instructions.

If an endoscopic procedure fails and is converted into an open procedure, the endoscopic procedure is not separately reportable with the open procedure.

Example: A patient presents with aspiration of a foreign body. A bronchoscopy is performed identifying lobar foreign body obstruction, and an attempt is made to remove this obstruction bronchoscopically. It would be inappropriate to report CPT codes 31622 (diagnostic bronchoscopy) and 31635 (surgical bronchoscopy)

with removal of foreign body). Only the "surgical" endoscopy, CPT code 31635, may be reported. In this example, if the endoscopic effort is unsuccessful and a thoracotomy is performed, the diagnostic bronchoscopy may be reported separately in addition to the thoracotomy. Modifier -58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. However, the CPT code for the surgical bronchoscopy to remove the foreign body is not separately reportable because the procedure was converted to an open procedure. If the surgeon decides to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, this confirmatory bronchoscopy is not separately reportable although the initial diagnostic bronchoscopy may still be reportable.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service may be reported. *CPT Manual* instructions indicate that surgical sinus endoscopy includes a sinusotomy (if appropriate) and a diagnostic sinus endoscopy. However, if the medically necessary procedure is a sinusotomy and a sinus endoscopy is performed to evaluate adequacy of the sinusotomy and visualize the sinus cavity for disease, it may be appropriate to report the sinusotomy HCPCS/CPT code rather than the sinus endoscopy HCPCS/CPT code.

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

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

medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

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

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

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

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

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

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

13. Because many respiratory system structures are bilateral (e.g., lung, bronchus), many NCCI edits with HCPCS/CPT codes describing procedures on these structures allow use of NCCI-associated modifiers (i.e., modifier indicator of "1") for situations where the two procedures of a code pair edit are performed on contralateral structures. Physicians should be careful to avoid inappropriate use of NCCI-associated modifiers with these edits if the two procedures of a code pair edit are performed on the ipsilateral structure.

D. Cardiovascular System

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

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

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

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

5. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy, and/or bypass. When a thromboendarterectomy is performed at the site of an aneurysm repair or graft insertion, the thromboendarterectomy is not separately reportable. If a bypass procedure requires an endarterectomy to insert the bypass graft, only the code describing the bypass may be reported. The endarterectomy is not separately reportable. If both an aneurysm repair (e.g., after rupture) and a bypass are performed at separate non-contiguous sites, the aneurysm repair code and the bypass code may be reported with an anatomic modifier or modifier -59. If a thromboendarterectomy is medically necessary due to vascular occlusion in a different vessel, the appropriate code may be reported with an anatomic modifier or modifier -59 indicating that the procedures were performed in non-contiguous vessels.

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

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

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

8. The CPT codes 36000, 36406, 36410, etc. represent very common procedures performed to gain venous access for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy, hydration, transfusion, drug administration, etc. When intravenous access is routinely obtained in the course of performing other medical/diagnostic/surgical procedures or is necessary to accomplish the procedure (e.g., infusion therapy, chemotherapy), it is inappropriate to separately report the venous access services. CPT codes 90760-90761 should not be reported for infusions to maintain patency of a vascular access site.

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

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

11. If a median sternotomy is utilized to perform a cardiothoracic procedure, the repair of the sternotomy is not separately reportable. CPT codes 21820-21825 (treatment of

sternum fracture) should not be reported for repair of the sternotomy.

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

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

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

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

15. Vascular obstruction may be caused by thrombosis, embolism, atherosclerosis or other conditions. Treatment may include thrombectomy, embolectomy and/or endarterectomy. CPT codes describe embolectomy/thrombectomy (e.g., CPT codes 34001-34490), atherectomy (e.g., CPT codes 35480-35495), and

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

16. If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly if an angioplasty fails to adequately improve blood flow and is followed by an atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures.

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

18. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (HCPCS/CPT codes 33202-33249, G0297-G0300) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes are not separately reportable with

the procedures described by HCPCS/CPT codes 33202-33249, G0297-G0300, and 93600-93662. Similarly, ultrasound guidance is not separately reportable with these CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by HCPCS/CPT codes 33200-33249, G0297-G0300, or 93600-93662.

19. CPT code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type...) describes an arterial infusion of a non-chemotherapeutic medication for a purpose other than thrombolysis. This code should not be utilized to report intravenous infusions, arterial push injections (CPT code 90773), or chemotherapy infusions.

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

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

procedure. These same principles would apply to CPT code 37216, but it is currently a noncovered service code on the Medicare Physician Fee Schedule.

22. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

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

E. Hemic and Lymphatic Systems

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

F. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

G. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service.

The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT Codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

4. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

5. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

7. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is

performed, the biopsy is not separately reportable with the more extensive procedure.

8. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

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

10. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

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CHAPTER VI
SURGERY: DIGESTIVE SYSTEM
CPT CODES 40000 - 49999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter VI
Surgery: Digestive System
CPT Codes 40000 - 49999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 40000-49999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Endoscopic Services

Endoscopic services may be performed in many places of service (e.g., office, outpatient, ambulatory surgical centers (ASC)). Services that are an integral component of an endoscopic procedure are not separately reportable. These services include, but are not limited to, venous access (e.g., CPT code 36000), infusion/injection (e.g., CPT codes 90760-90775), non-invasive oximetry (e.g., CPT codes 94760 and 94761), and anesthesia provided by the surgeon.

1. Per *CPT Manual* instructions, surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code should not be reported with a surgical endoscopy code.

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

3. If the same endoscopic procedure (e.g., polypectomy) is performed multiple times at a single patient encounter in the same region as defined by the *CPT Manual* narrative, only one CPT code may be reported with one unit of service.

4. Gastroenterologic tests included in CPT code range 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology when performed are integral components of an upper gastrointestinal endoscopy (CPT code 43235). Therefore, CPT codes 91000 (esophageal intubation and collection of washings for cytology. . .) and 91055 (gastric intubation, washings, and preparing slides for cytology . . .) should not be separately reported when performed as part of an upper gastrointestinal endoscopic procedure. Provocative testing (CPT code 91052) may be expedited during gastrointestinal endoscopy (e.g., procurement of gastric specimens). When performed concurrent with an upper gastrointestinal endoscopy, CPT code 91052 should be coded with modifier -52 indicating a reduced level of service was performed.

5. If an endoscopy or enteroscopy is performed as a common standard of practice when performing another service, the endoscopy or enteroscopy is not separately reportable. For example, if a small intestinal endoscopy or enteroscopy is performed during the creation or revision of an enterostomy, the small intestinal endoscopy or enteroscopy is not separately reportable.

6. A "scout" endoscopy to assess anatomic landmarks or assess extent of disease preceding another surgical procedure at the same patient encounter is not separately reportable. However, an endoscopic procedure for diagnostic purposes to decide whether a more extensive open procedure needs to be performed is separately reportable. In the latter situation, modifier -58 may be utilized to indicate that the diagnostic endoscopy and more extensive open procedure were staged procedures.

7. If esophageal dilation as described by CPT codes 43450-43458 is unsuccessful and followed by an endoscopic esophageal dilation procedure, only the endoscopic esophageal dilation procedure may be reported. The physician should not report the unsuccessful procedure.

8. If it is necessary to perform diagnostic or surgical endoscopy of the hepatic/biliary/pancreatic system utilizing different methodologies (e.g., biliary T-tube endoscopy, ERCP) multiple CPT codes may be reported. Modifier -51 indicating multiple procedures were performed at the same patient encounter should be appended.

9. Intubation of the gastrointestinal tract (e.g., percutaneous placement of G-tube) includes subsequent removal of the tube. CPT codes such as 43247 (upper gastrointestinal endoscopic removal of foreign body) should not be reported for routine removal of previously placed therapeutic devices.

10. Rules for reporting biopsies performed at the same patient encounter as an excision, destruction, or other type of removal are discussed in Section F (General Policy Statements) (#16).

11. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. If it

is necessary to repeat an endoscopy to control bleeding at a separate patient encounter on the same date of service, the HCPCS/CPT code for endoscopy for control of bleeding is separately reportable with modifier -78 indicating that the procedure required return to the operating room (or endoscopy suite) for a related procedure during the postoperative period.

12. Only the more extensive endoscopic procedure may be reported for a patient encounter. For example if a sigmoidoscopy is completed and the physician also performs a colonoscopy during the same patient encounter, only the colonoscopy may be reported.

13. If an endoscopic procedure fails and is converted into an open procedure at the same patient encounter, only the open procedure is reportable.

14. If a transabdominal colonoscopy via colostomy(CPT code 45355) and/or standard sigmoidoscopy or colonoscopy is performed as a necessary part of an open procedure (e.g., colectomy), the endoscopic procedure(s) is (are) not separately reportable. However, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the endoscopic procedure may be reported separately. Modifier -58 may be utilized to indicate that the diagnostic endoscopy and the open procedure were staged or planned services.

15. If the larynx is viewed through an esophagoscope or upper gastrointestinal endoscope during endoscopy, a laryngoscopy CPT code cannot be reported separately. However, if a medically necessary laryngoscopy is performed with a separate laryngoscope, both the laryngoscopy and esophagoscopy (or upper gastrointestinal endoscopy) CPT codes may be reported with NCCI-associated modifiers.

D. Abdominal Procedures

During an open abdominal procedure exploration of the surgical field is routinely performed to identify anatomic structures and disease. An exploratory laparotomy (CPT code 49000) is not separately reportable with an open abdominal procedure.

Hepatectomy procedures (e.g., CPT codes 47120-47130, 47133-47142) include removal of the gallbladder based on anatomic

considerations and standards of practice. A cholecystectomy CPT code is not separately reportable with a hepatectomy CPT code.

A medically necessary appendectomy may be reported separately. However, an incidental appendectomy of a normal appendix during another abdominal procedure is not separately reportable.

If a hernia repair is performed at the site of an incision for an open abdominal procedure, the hernia repair (CPT codes 49560-49566) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and should not be reported separately.

If a recurrent hernia requires repair, a recurrent hernia repair code may be reported. A code for incisional hernia repair should not be reported in addition to the recurrent hernia repair code unless a medically necessary incisional hernia repair is performed at a different site. In the latter case, modifier -59 should be appended to the incisional hernia repair code.

Removal of excessive skin and subcutaneous tissue (panniculectomy) at the site of an abdominal incision for an open procedure including hernia repair is not separately reportable. CPT code 15830 should not be reported for this type of panniculectomy. However, an abdominoplasty which requires significantly more work than a panniculectomy is separately reportable. In order to report an abdominoplasty in 2007, CPT requires the physician to report an infraumbilical abdominal panniculectomy (CPT code 15830 in 2007) plus the add-on CPT code 15847 for the abdominoplasty. Since NCCI bundles CPT code 15830 (in 2007) into abdominal wall hernia repair CPT codes, a provider should report CPT codes 15830 plus 15847 with modifier -59 appended to CPT code 15830 in order to report an abdominoplasty with an abdominal hernia repair CPT code.

CPT code 49568 is an add-on code describing implantation of mesh or other prosthesis for incisional or ventral hernia repair. This code may be reported with incisional or ventral hernia repair CPT codes 49560-49566. Although mesh or other prosthesis may be implanted with other types of hernia repairs, CPT code 49568 should not be reported with these other hernia repair codes. If a provider performs an incisional or ventral hernia

repair with mesh/prosthesis implantation as well as another type of hernia repair at the same patient encounter, CPT code 49568 may be reported with modifier -59 to bypass edits bundling CPT code 49568 into all hernia repair codes other than the incisional or ventral hernia repair codes.

Open enterolysis (CPT code 44005) and laparoscopic enterolysis (CPT code 44200) are defined by the *CPT Manual* as "separate procedures". They are not separately reportable with other intra-abdominal or pelvic procedures. However, if a provider performs an extensive and time-consuming enterolysis in conjunction with another intra-abdominal or pelvic procedure, the provider may append modifier -22 to the CPT code describing the latter procedure. The local carrier will determine whether additional payment is appropriate.

Per *CPT Manual* instructions, a diagnostic laparoscopy (CPT code 49320) is not separately reportable with a surgical laparoscopy.

E. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

F. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers

eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. The vagotomy CPT codes 43635-43641 and 64752-64760 are not separately reportable with esophageal or gastric procedures that include vagotomy as part of the service. For example, the esophagogastrostomy procedure described by CPT code 43320 includes a vagotomy if performed. The vagotomy procedures are mutually exclusive, and only one vagotomy procedure code may be reported at a patient encounter.

4. If closure of an enterostomy or fistula involving the intestine requires resection and anastomosis of a segment of intestine, the resection and anastomosis of the intestine are not separately reportable.

5. If multiple services are utilized to treat hemorrhoids at the same patient encounter, only one HCPCS/CPT code describing the most extensive procedure may be reported. If an abscess is drained during the treatment of hemorrhoids, the incision and drainage is not separately reportable unless the incision and drainage is at a separate site unrelated to the hemorrhoids. In the latter case, the incision and drainage code may be reported appending an anatomic modifier or modifier -59.

6. The *CPT Manual* contains groups of codes describing different approaches or methods to accomplish similar results. These codes are generally mutually exclusive of one another. For example CPT codes 45110-45123 describe different proctectomy procedures and are mutually exclusive of one another. Other examples include groups of codes for colectomies (CPT codes

44140-44160), gastrectomies (CPT codes 43620-43635), and pancreatectomies (CPT codes 48140-48155).

7. An enterostomy closure HCPCS/CPT code should not be reported with a code for creation or revision of a colostomy. Closure of an enterostomy is mutually exclusive with the creation or revision of the colostomy.

8. If an excised section of intestine includes a fistula tract, a fistula closure code should not be reported separately. Closure of the fistula is included in the excision of intestine.

9. The mouth and anus have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes that describe the procedure as an integumentary procedure (CPT codes 10000-19999) or as a digestive system procedure (CPT codes 40000-49999). If a procedure is performed on a lesion at or near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If the code descriptor of a CPT code from the digestive system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) should not be reported separately.

10. Laparoscopic procedures are subject to the standard surgical practice guidelines. A surgical laparoscopy includes a diagnostic laparoscopy (CPT code 49320). If an unsuccessful laparoscopic procedure is converted to an open procedure, only the open procedure may be reported.

11. An open cholecystectomy includes an examination of the abdomen through the abdominal wall incision. If this examination is performed laparoscopically, it is not separately reportable as CPT code 49320 (diagnostic laparoscopy).

12. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration

(CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

13. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

14. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

16. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

17. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For

example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

18. The NCCI edit with column one CPT code 45385 (Flexible colonoscopy with removal of tumor(s), polyp(s), or lesion(s) by snare technique) and column two CPT code 45380 (Flexible colonoscopy with single or multiple biopsies) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 45380 of this NCCI edit is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

19. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

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CHAPTER VII
SURGERY: URINARY, MALE GENITAL,
FEMALE GENITAL, MATERNITY CARE
AND DELIVERY SYSTEMS
CPT CODES 50000 -59999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter VII
Surgery: Urinary, Male Genital,
Female Genital, Maternity Care
and Delivery Systems
CPT Codes 50000 - 59999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 50000-59999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Urinary System

1. Many procedures involving the female and male urinary system include the placement of a urethral catheter for postoperative drainage. Because this is integral to the service and represents the standard of medical practice, placement of a urinary catheter is not separately coded. In addition, catheterizations (e.g., CPT codes 51701, 51702, and 51703) are not separately reported when done at the time of or just prior to a surgical procedure.

2. Cystourethroscopy, with biopsy(s) (CPT code 52204) includes all biopsies during the procedure and should be reported with one unit of service.

3. Many lesions of the genitourinary tract which require biopsy, excision or destruction involve the mucocutaneous border and several CPT codes may generally describe the nature of the biopsy obtained. For a biopsy of a lesion or group of similar lesions, one unit of service for the CPT code that most accurately describes the service rendered is reported. Additionally, separate CPT codes for integumentary and genitourinary procedures are not to be reported unless the biopsy, excision, destruction, etc., service involves completely separate lesions in the genitourinary tract and skin. In these cases, modifier -59 will indicate that separate lesions were removed. The medical record should reflect accurately the precise location of the lesions removed, particularly if it is medically necessary to submit each lesion as a separate specimen for pathological evaluation.

4. Policies regarding injections and infusions (e.g., CPT codes 36000, 36410, 90760-90775) as part of more extensive procedures have previously been defined and apply to the genitourinary family of codes. When irrigation procedures or drainage procedures are necessary and are integral to successfully accomplish a genitourinary (or any other) procedure, only the more extensive service is reported.

5. Unless otherwise defined by *CPT Manual* instructions, the repair and closure of surgical procedures are included in the CPT code for the more extensive procedure and are not to be separately reported. In many genitourinary services, hernia repair is included in the *CPT Manual* descriptor for the service; accordingly, a hernia repair is not separately reported. If the hernia repair performed is at a different site, this can be

separately reported with modifier -59 indicating that this service occurred at a different site (i.e., via a different incision).

6. In general, multiple methods of performing a procedure (e.g., prostatectomy) cannot be performed at the same patient encounter. (See general policy on mutually exclusive services.) Therefore, only one method of accomplishing a given procedure may be reported. If an initial approach is unsuccessful and is followed by an alternative approach, only the successful or last unsuccessful approach may be reported.

7. When an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reported. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be separately reported under the diagnostic or surgical endoscopy codes. When an endoscopic procedure is attempted unsuccessfully and converted to an open procedure, only the open procedure is reported (see general policy on sequential procedures). If the endoscopy is performed for diagnostic purposes and a subsequent therapeutic service can be performed at the same session, the procedure is coded at the highest level of specificity. If the *CPT Manual* narrative includes endoscopy, then the diagnostic endoscopy is not separately coded. If the narrative does not include endoscopy and a separate endoscopy is necessary as a diagnostic procedure, this can be reported separately. Modifier -58 may be used to indicate that the diagnostic endoscopy and the subsequent therapeutic service are staged or planned procedures. The medical record must describe the intent and findings of the diagnostic endoscopy in these cases.

8. When multiple endoscopic procedures are performed at the same session, the more comprehensive code accurately describing the service performed is reported; if several procedures are performed at the same endoscopic session, modifier -51 is attached. (For example, if a renal endoscopy is performed through an established nephrostomy, a biopsy is performed, a lesion is fulgurated and a foreign body (calculus) is removed, the appropriate CPT coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.) This policy applies to endoscopic procedures in general and specifically to endoscopic procedures of the genitourinary system.

9. When bladder irrigation is performed as part of a more comprehensive procedure, or in order to accomplish access or visualization of the urinary system, the bladder irrigation (CPT code 51700) is not to be reported. This code is to be used for irrigation with therapeutic agents or for irrigation as an independent therapeutic service.

10. When electromyography (EMG) is performed as part of a biofeedback session, neither CPT code 51784 nor 51785 is to be reported unless a significant, separately identifiable diagnostic EMG service is provided. If either CPT code 51784 or CPT code 51785 is to be used for a diagnostic electromyogram, a separate report must be available in the medical record to indicate this service was performed for diagnostic purposes.

11. When endoscopic visualization of the urinary system involves several regions (e.g., kidney, renal pelvis, calyx, and ureter), the appropriate CPT code is defined by the approach (e.g., nephrostomy, pyelostomy, ureterostomy, etc.) as indicated in the CPT descriptor. When multiple endoscopic approaches are simultaneously necessary to accomplish a medically necessary service (e.g., renal endoscopy through a nephrostomy and cystourethroscopy performed at the same session), they may be separately coded with the multiple procedure modifier -51 on the less extensive codes. When multiple endoscopic approaches are necessary to accomplish the same procedure, the successful endoscopic approach should be reported.

12. When urethral catheterization or urethral dilation (e.g., CPT codes 51701-51703) is necessary to accomplish a more extensive procedure, the urethral catheterization/dilation is not to be separately reported.

13. Multiple ureteral anastomosis procedures are defined by CPT codes 50740-50810, and 50860. In general, they represent mutually exclusive procedures and are not to be reported together. If one anastomosis is performed on one ureter, and a different anastomosis is performed on a contralateral ureter, the appropriate modifier (e.g., -LT, -RT) is used with the appropriate CPT code to describe the service performed on the respective ureter.

14. CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive of CPT codes 50800-50830 (e.g., ureterostomy, ureterocolon conduit, urinary undiversion) unless

performed at different locations in which case an anatomic modifier should be used.

15. The CPT codes 53502-53515 describe urethral repair codes for urethral wounds or injuries (urethrorrhaphy). When an urethroplasty is performed, codes for urethrorrhaphy should not be reported in addition since "suture to repair wound or injury" is included in the urethroplasty service.

16. CPT code 78730 (Urinary bladder, residual study) is a nuclear medicine procedure requiring use of a radio-pharmaceutical. This CPT code should not be utilized to report measurement of residual urine in the urinary bladder determined by other methods.

17. CPT code 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent) describes insertion of a self-retaining indwelling stent during cystourethroscopy with ureteroscopy and/or pyeloscopy and should not be reported to describe insertion and removal of a temporary ureteral stent during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy (CPT codes 52320-52355). The insertion and removal of a temporary ureteral catheter (stent) during these procedures is not separately reportable and should not be reported with CPT codes 52005 or 52007.

18. Prostatectomy procedures (CPT codes 55801-55845) include cystoplasty or cystourethroplasty as a standard of surgical practice. CPT code 51800 (cystoplasty or cystourethroplasty...) should not be reported separately with prostatectomy procedures.

19. CPT code 50650 (ureterectomy, with bladder cuff (separate procedure)) should not be reported with other procedures on the ipsilateral ureter. Since CPT code 50650 includes the "separate procedure" designation, CMS does not allow additional payment for the procedure when it is performed with other procedures in an anatomically related area.

D. Male Genital System

1. Transurethral drainage of a prostatic abscess (e.g., CPT code 52700) is included in male transurethral prostatic procedures and is not reported separately.

2. The puncture aspiration of a hydrocele (e.g., CPT code 55000) is included in services involving the tunica vaginalis and proximate anatomy (scrotum, vas deferens) and in inguinal hernia repairs.

3. The *CPT Manual* contains many codes (CPT codes 52601-52648, 53850-53853, 55801-55845, 55866) which describe various methods of removing or destroying prostate tissue. These procedures are mutually exclusive, and two codes from these code ranges should not be reported together.

E. Female Genital System

1. When a pelvic examination is performed in conjunction with a gynecologic procedure, either as a necessary part of the procedure or as a confirmatory examination, the pelvic examination is not separately reported. A diagnostic pelvic examination may be performed for the purposes of deciding to perform a procedure; however, this examination is included in the evaluation and management service at the time the decision to perform the procedure is made.

2. All surgical laparoscopic, hysteroscopic or peritoneoscopic procedures include diagnostic procedures. Therefore, CPT code 49320 is included in 38120, 38570-38572, 43280, 43651-43653, 44180-44227, 44970, 47560-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, 60650; and 58555 is included in 58558-58563.

3. Lysis of adhesions (CPT code 58660) is not to be reported separately when done in conjunction with other surgical laparoscopic procedures.

4. Pelvic examination under anesthesia (CPT code 57410) is included in all major and most minor gynecological procedures and is not reported separately. This procedure represents routine evaluation of the surgical field.

5. Dilation of vagina or cervix (CPT codes 57400 or 57800), when done in conjunction with vaginal approach procedures, is not reported separately unless the CPT code descriptor states "without cervical dilation."

6. Administration of anesthesia, when necessary, is included in every surgical procedure code, when performed by the surgeon.

7. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a "scout" procedure to confirm the lesion or to assess the surgical field prior to a surgical procedure. A diagnostic colposcopy resulting in the decision to perform a non-colposcopic procedure may be reported with modifier -58. Diagnostic colposcopies (56820, 57420, 57452) are not separately reported with other colposcopic procedures.

F. Maternity Care and Delivery

The majority of procedures in this section (CPT codes 59000-59899) include only what is described by the code in the CPT definition. Additional procedures performed on the same day would be reported separately. The few exceptions to this rule consist of:

- CPT codes 59050 and 59051 (fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT codes 59400 (routine obstetric care, vaginal delivery), 59409 (vaginal delivery only), 59410 (vaginal delivery and postpartum care), 59510 (routine obstetric care, cesarean delivery), 59514 (cesarean delivery only), 59515 (cesarean delivery and postpartum care), 59610 (routine obstetric care, vaginal delivery, after previous cesarean delivery), 59612 (vaginal delivery only after previous cesarean delivery), 59614 (vaginal delivery and postpartum care after previous cesarean delivery), 59618 (routine obstetric care, cesarean delivery, after previous cesarean delivery), 59620 (cesarean delivery only after previous cesarean delivery), and 59622 (cesarean delivery and postpartum care after previous cesarean delivery). They are not to be separately reported.
- The total obstetrical packages (e.g., CPT codes 59400 and 59510) include antepartum care, the delivery, and postpartum care. They do not include among other services, ultrasound, amniocentesis, special screening tests for genetic conditions, visits for unrelated conditions (incidental to pregnancy) or additional and frequent visits due to high risk conditions.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

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

Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

4. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of

bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

5. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

7. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

8. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

9. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

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CHAPTER VIII
SURGERY: ENDOCRINE, NERVOUS,
EYE AND OCULAR ADNEXA, AND
AUDITORY SYSTEMS
CPT CODES 60000 - 69999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter VIII
Surgery: Endocrine, Nervous,
Eye and Ocular Adnexa, and
Auditory Systems
CPT Codes 60000 - 69999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 60000-69999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules

are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant,

separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Endocrine and Nervous Systems

1. A burr hole is often necessary in anticipation for intracranial surgery (e.g., craniotomy, craniectomy), either to gain access to intracranial contents, to alleviate pressure in anticipation of further surgery or to place an intracranial pressure monitoring device as part of the surgery. As these services are integral to the performance of the subsequent services, codes representing these services are not to be separately reported if performed at the same session; if performed prior to the comprehensive procedure, modifier -58 can be used to indicate that the burr hole and the intracranial surgery are staged or planned services.

In addition, taps, punctures or burr holes accompanied by drainage procedures (e.g., hematoma, abscess, cyst, etc.) followed by other procedures, are not separately reported unless performed as staged procedures. Modifier -58 may be used to indicate staged or planned services. Many intracranial procedures include bone grafts by CPT definition and these grafts should not be reported separately.

2. Biopsies performed in the course of Central Nervous System (CNS) surgery should not be reported as separate procedures.

3. Craniotomies and craniectomies always include a general exploration of the accessible field; accordingly it is not appropriate to code an exploratory surgery (e.g., CPT codes 61304, 61305) when another procedure is performed at the same session.

4. A craniotomy is performed through a skull defect resulting from reflection of a skull flap. Replacing the skull flap during the same procedure is an integral component of a craniotomy procedure and should not be reported separately utilizing the cranioplasty CPT codes 62140 and 62141. A cranioplasty may be separately reportable with a craniotomy procedure if the cranioplasty is performed to replace a skull bone flap removed during a procedure at a prior patient encounter or if the cranioplasty is performed to repair a skull defect larger than that created by the bone flap.

5. When services are performed at the same session, but represent different types of services or are being performed at different sites (see example below), modifier -59 should be added. This modifier indicates that this service was a distinct, separate service and should not be included in the column one code.

Example: A patient with an open head injury and a contralateral subdural hematoma requires a craniectomy for the open head injury and a burr hole drainage on the opposite side for the subdural hematoma. The performance of a burr hole at the time of the craniectomy would be considered part of the craniectomy. However, the contralateral burr hole would be considered a separate service not integral to the craniectomy. To correctly code the burr hole for the contralateral subdural hematoma and the column one coded service (the craniectomy), the burr hole should be coded with the appropriate modifier (-59, -RT, -LT, etc.). In this example the correct coding would be CPT codes 61304 with one unit of service and 61154-59 with one unit of service.

6. The use of general intravascular access devices (e.g., intravenous lines, etc.), cardiac monitoring, oximetry, laboratory sample procurement and other routine monitoring for patient safety has been addressed in the previous policy for general anesthesia or monitored anesthesia care (MAC). These policies also apply for procedures that do not require the presence of an anesthesia practitioner. As an example, if a physician is performing a spinal puncture for intrathecal injection and administers an anxiolytic agent, but the procedure does not require the presence of an anesthesia practitioner, the vascular access and any appropriate monitoring necessary is considered part of the spinal puncture procedure and is not to be reported separately.

7. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure itself. The submission of nerve block or facet block codes for local anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate when there is no independent medical necessity of the administration of local anesthetic except for the lumbar puncture. Separate codes are not to be reported. In comparison, if, in the course of a nerve or other anesthetic block procedure, cerebrospinal fluid is withdrawn, it is inappropriate to bill for a diagnostic lumbar puncture; only

the nerve (or other) block should be reported; the CSF procurement is not for diagnostic purposes.

8. If a dural (cerebrospinal fluid) leak occurs during a spinal procedure, repair of the dural leak is integral to the spinal procedure. CPT code 63707 or 63709 (repair of dural/cerebrospinal fluid leak) should not be reported separately for the repair.

9. CPT code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. If a provider reports CPT code 64721, he cannot additionally report CPT code 29848 for the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported.

10. Nerve repairs by suture or neurorrhaphies (CPT codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury to or anastomosis of nerves which are proximally associated (e.g., facial-spinal, facial-hypoglossal, etc.). When neurorrhaphy is performed in conjunction with a nerve graft (CPT codes 64885-64907), a neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., a separate service is not reported for the primary nerve suture.

11. In the same area of the cortex, neurostimulator electrodes can be implanted in only one fashion; accordingly, the CPT code 61850 (burr hole) is included in the CPT code 61860 (craniectomy). Codes describing craniotomy procedures (e.g., CPT codes 62100-62121) are generally bundled into craniectomy codes (e.g., CPT codes 61860-61875).

12. Because procedures necessary to accomplish a column one procedure are included in the column one procedure, CPT codes such as 62310-62311, 62318-62319 (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive back procedures. Additionally, at the same site, codes describing laminotomy procedures are included in laminectomy codes. CPT codes 22100-22116 (partial excision of vertebral components) represent distinct procedures, and, accordingly, are not reported with laminotomy/laminectomy procedures unless the services are performed as described in the codes.

13. CPT codes describing the performance of a tracheostomy are not to be reported with the CPT code 61576 (transoral approach to skull base including tracheostomy) as this service is included in the descriptor for the code.

14. The *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 20.4.5 limits the reporting of use of an operating microscope (CPT code 69990) to procedures described by CPT codes 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898 and 64905-64907. CPT code 69990 should not be reported with other procedures even if an operating microscope is utilized. CMS guidelines for payment of CPT code 69990 differ from *CPT Manual* instructions following CPT code 69990.

15. CPT code 61623 (endovascular temporary balloon arterial occlusion... concomitant neurological monitoring,...) describes a procedure that includes prolonged neurologic assessment. This code should not be utilized to report the temporary arterial occlusion that is an inherent component of CPT code 61624 (transcatheter permanent occlusion or embolization...; central nervous system (intracranial, spinal cord)).

16. Muscle chemodenervation procedures coded as CPT codes 64612-64614 occasionally require needle electromyographic (EMG) guidance. From January 1, 2005 through December 31, 2005, CMS allowed CPT code 95870 to be reported for such guidance when medically reasonable and necessary. Effective January 1, 2006, needle EMG guidance for muscle chemodenervation procedures coded as CPT codes 64612-64614 may be reported with CPT code 95874.

17. Some procedures (e.g., intracranial, spinal) utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package.

D. Ophthalmology

1. When a subconjunctival injection (e.g., CPT code 68200) with a local anesthetic is performed as part of a more extensive anesthetic procedure (e.g., peribulbar or retrobulbar block), a separate service for this procedure is not to be reported. This is a routine part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy, trabeculectomy, and anterior vitrectomy may be performed in conjunction with cataract removal. When an iridectomy is performed in order to accomplish the cataract extraction, it is an integral part of the procedure; it does not represent a separate service, and is not separately reported. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not to be separately reported unless it is medically necessary for a different diagnosis. While a trabeculectomy is not performed as a part of a cataract extraction, it may be performed to control glaucoma at the same time as a cataract extraction. If the procedure is medically necessary at the same time as a cataract extraction, it can be reported under a different diagnosis (e.g., glaucoma). The codes describing iridectomies, trabeculectomies, and anterior vitrectomies, when performed with a cataract extraction under a separate diagnosis, must be reported with modifier -59. This indicates that the procedure was performed as a different service for a separate situation. The medical record should reflect the medical necessity of the service if separately reported. For example, if a patient presents with a cataract and has evidence of glaucoma, (i.e. elevated intraocular pressure preoperatively) and a trabeculectomy represents the appropriate treatment for the glaucoma, a separate service for the trabeculectomy would be separately reported. Performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not to be separately reported.

3. The various approaches to removing a cataract are mutually exclusive of one another when performed on the same eye.

4. Some retinal detachment repair procedures include some vitreous procedures (e.g., CPT code 67108 includes 67015, 67025, 67028, 67031, 67036, 67039, and 67040). Certain retinal detachment repairs are mutually exclusive to anterior procedures

such as focal endolaser photocoagulation (e.g., CPT codes 67110 and 67112 are mutually exclusive to CPT code 67108).

5. CPT codes 68020-68200 (incision, drainage, excision of the conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362).

6. CPT code 67950 (canthoplasty) is included in repair procedures such as blepharoplasties (CPT codes 67917, 67924, 67961, 67966).

7. Correction of lid retraction (CPT code 67911) includes full thickness graft (e.g., CPT code 15260) as part of the total service performed.

8. In the circumstance that it is medically necessary and reasonable to inject sclerosing agents in the same session as surgery to correct glaucoma, the service is included in the glaucoma surgery. Accordingly, codes such as CPT codes 67500, 67515, and 68200 for injection of sclerosing agents (e.g., 5-FU, HCPCS/CPT code J9190) should not be reported with other pressure-reducing or glaucoma procedures.

E. Auditory System

1. When a mastoidectomy is included in the description of an auditory procedure (e.g., CPT codes 69530, 69802, 69910), separate codes describing mastoidectomy are not reported.

2. Myringotomies (e.g., CPT codes 69420 and 69421) are included in tympanoplasties and tympanostomies.

F. Operating Microscope

CMS allows payment for use of the operating microscope (CPT 69990) with a list of procedures identified in the *Internet-Only Manuals(IOM) Medicare Claims Processing Manual* (Publication 100-04), Chapter 12, Section 20.4.5 (Allowable Adjustments). NCCI bundles CPT code 69990 into all other surgical procedures. Most edits do not allow use of NCCI-associated modifiers.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

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

Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

4. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

5. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

7. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

8. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

9. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

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CHAPTER IX
RADIOLOGY SERVICES
CPT CODES 70000 - 79999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter IX
Radiology Services
CPT Codes 70000 - 79999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 70000-79999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day 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.

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate evaluation and management service is not reported. As a rule, if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate evaluation and management service may be reported. In radiation oncology, evaluation and management CPT codes are not separately reportable except for an initial consultation at which time a decision is made whether to proceed with the treatment. Subsequent evaluation and management services are included in the radiation treatment management CPT codes.

C. Non-interventional Diagnostic Imaging

Non-invasive/interventional diagnostic imaging includes but is not limited to standard radiographs, single or multiple views, contrast studies, computerized tomography and magnetic resonance imaging. The *CPT Manual* allows for various combinations of codes to address the number and type of radiographic views. For a given radiographic series, the procedure code that most accurately describes what was performed should be reported. Because the number of views necessary to obtain medically useful information may vary, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code describing the services performed rather than billing multiple codes to describe the service.

If radiographs have to be repeated in the course of a radiographic encounter due to substandard quality, only one unit of service for the code can be reported. Additionally, if the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare

policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service should be reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptor for many of these services refers to a "minimum" number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service should be billed. On the other hand, if additional films are necessary due to a change in the patient's condition, separate reporting may be appropriate.

CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specifically including the additional views. For example, if three views of the shoulder are obtained, CPT code 73030 (Radiologic examination, shoulder; complete, minimum of two views) with one unit of service should be reported rather than CPT code 73020 (Radiologic examination, shoulder; one view) plus CPT code 73030.

When limited comparative radiographic studies are performed (e.g., post-reduction radiographs, post-intubation, post-catheter placement, etc.), the CPT code for the radiographic series should be reported with modifier -52, indicating that a reduced level of interpretive service was provided. This requirement does not apply to OPSS services reported by hospitals.

Some studies may be performed without contrast, with contrast, or both with and without contrast. There are separate codes to describe all of these combinations of contrast usage. When studies require contrast, the number of radiographs obtained varies between patients. All radiographs necessary to complete a study are included in the CPT code description. Unless specifically noted, fluoroscopy necessary to complete a procedure and obtain the necessary permanent radiographic record is included in the major procedure and should not be reported separately.

Preliminary "scout" radiographs prior to contrast administration or delayed imaging radiographs are often performed. If a separate CPT code describes these radiographs, it may be reported. If there is no separate CPT code describing the additional views, these are included in the basic procedure.

D. Interventional/Invasive Diagnostic Imaging

When contrast can be administered orally (upper GI) or rectally (barium enema), the administration is included as part of the procedure and no administration service is reported. When contrast material is parenterally administered, whether the timing of the injection has to correlate with the procedure or not (e.g., IVP, CT scans, gadolinium), venous access and contrast administration (e.g., CPT codes 36000, 36406, 36410, 90760-90775) are included in the contrast studies.

When a contrast study is performed in which there is direct correlation of the timing of the study to the injection or administration (e.g., angiography), and different providers perform separate parts of the procedure, each provider would bill the service he/she rendered. The procedural aspect of the service is coded from outside the CPT 70000 series and the radiographic supervision and interpretation (S&I) service is coded from the 70000 series of codes.

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

The individual CPT codes in the 70000 section identify which injection or administration code is appropriate for a given procedure. In the absence of a parenthetical CPT note, it is not appropriate to submit an administration component. When an intravenous line is placed (e.g., CPT code 36000) simply for access in the event of a problem with the procedure or for administration of contrast, it is considered part of the

procedure. A separate code (e.g., CPT code 36005), is available for the injection procedure for contrast venography and includes the introduction of a needle or an intracatheter (e.g., CPT code 36000).

In the case of urologic procedures and other surgeries, insertion of a urethral catheter (e.g., CPT code 51701-51702) is part of the procedure and is not to be separately reported.

The CPT codes 90773-90775 describe intra-arterial and intravenous therapeutic or diagnostic injections. Injection of contrast or radiopharmaceutical is an included inherent component of radiological/nuclear medicine procedures. CPT codes 90774-90775 cannot be reported separately with radiographic, CT, MRI, or nuclear imaging codes to describe inherent injection procedures.

E. Nuclear Medicine

The general policies promulgated above apply to nuclear medicine as well as standard diagnostic imaging. Several issues specific to the practice of nuclear medicine require comment.

1. The injection of a radiopharmaceutical is included as an inherent component of the procedure. Separate vascular access and injection codes (e.g., CPT codes 36000, 90760-90775) should not be reported.

2. Single photon emission computed tomography (SPECT) studies represent an enhanced methodology over standard planar nuclear imaging. When a limited anatomic area is studied, there is no additional information procured by obtaining both planar and SPECT studies. While both represent medically acceptable imaging studies, when a SPECT study of a limited area is performed, a planar study is not to be separately reported. When vascular flow studies are obtained using planar technology in addition to SPECT studies, the appropriate CPT code for the vascular flow study should be reported, not the flow, planar and SPECT studies. In cases where planar images must be procured because of the extent of the scanned area (e.g., bone imaging), both planar and SPECT scans may be necessary and reported separately.

3. Myocardial perfusion imaging (CPT codes 78460-78465) is not reportable with cardiac blood pool imaging by gated

equilibrium (CPT codes 78472-78473) because the two types of tests utilize different radiopharmaceuticals.

4. CPT codes 76376 and 76377 (3D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78000-78999). However, CPT code 76376 or 76377 may be separately reported with modifier -59 on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported.

F. Radiation Oncology

1. Continuing medical physics consultation (CPT code 77336) is reported "per week of therapy". It may be reported after every five radiation treatments. (It may also be reported if the total number of radiation treatments in a course of radiation therapy is less than five.) Since radiation planning procedures (CPT codes 77261-77334) are generally performed before radiation treatment commences, the NCCI contains edits preventing payment of CPT code 77336 with CPT codes 77261-77295, 77301-77328, and 77332-77334. Because radiation planning procedures may occasionally be repeated during a course of radiation treatment, the edits allow modifier -59 to be appended to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation occur on the same date of service.

2. The *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 13, Section 70.2 (Services Bundled Into Treatment Management Codes) defines services that may not be reported separately with radiation oncology procedures. Based on these requirements, the NCCI contains edits bundling the following CPT codes into all radiation therapy services:

11920-11921 (Tattooing)
16000-16030 (Treatment of burns)
36000, 36410, 36425 (Venipuncture or Introduction of catheter)
51701-51703 (Urinary bladder catheterization)
90760, 90765 (Intravenous infusion)
90804-90822 (Psychotherapy)
90846 (Psychotherapy)
90847 (Psychotherapy)

90862, M0064 (Pharmacologic management)
97802-97804 (Medical nutrition therapy)
99143-99144 (Anesthesia - Moderate conscious sedation)
99185 (Regional hypothermia)
99201-99215 (Evaluation & Management)
99217-99239 (Evaluation & Management)
99281-99456 (Evaluation & Management)

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.
2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.
2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive

strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. Any abdominal radiology procedure that has a radiological supervision and interpretation code (e.g., CPT code 75625 for abdominal aortogram), would also include abdominal x-rays (e.g., CPT codes 74000-74022) as part of the total service.

4. Xeroradiography (e.g., CPT code 76150) is not to be reported with any mammography studies based on CPT coding instruction.

5. Guidance for placement of radiation fields by computerized tomography or ultrasound (CPT code 77014 or 76950) for the same anatomical area are mutually exclusive of one another.

6. Ultrasound guidance services and diagnostic echography should be reported only when both procedures are performed. Ultrasound guidance services alone do not represent diagnostic echography.

7. CPT code 76970 (ultrasound study, follow-up) cannot be reported with any other echocardiographic or ultrasound guidance procedures because it represents a follow-up procedure on the same day.

8. CPT code 77790 (supervision, handling, loading of radiation source) is not to be reported with any of the remote afterloading brachytherapy codes (e.g., CPT codes 77781-77784) since these procedures inherently include the supervision of the radioelement.

9. Bone studies such as CPT codes 77072-77076 require a series of radiographs; billing separately for bone studies and individual radiographs obtained in the course of the bone study is inappropriate.

10. Radiologic supervision and interpretation codes for specific procedures include all the radiologic services necessary for that procedure. For example, do not additionally report fluoroscopy (e.g., CPT codes 76000, 76001, 77002, 77003) or ultrasound guidance (e.g., CPT codes 76942, 76998).

11. Abdominal ultrasound examinations (CPT codes 76700-76775) and abdominal duplex examinations (CPT codes 93975, 93976) are generally performed for different clinical scenarios although there are some instances where both types of procedures are medically reasonable and necessary. In the latter case, the abdominal ultrasound procedure CPT code should be reported with an NCCI-associated modifier.

12. Tumor imaging by positron emission tomography (PET) may be reported with CPT codes 78811-78816. If a concurrent computed tomography (CT) scan is performed for attenuation correction and anatomical localization, CPT codes 78814-78816 should be reported rather than CPT codes 78811-78813. A CT scan for localization should not be reported separately with CPT codes 78811-78816. However, a medically reasonable and necessary diagnostic CT scan may be separately reported with an NCCI-associated modifier.

13. Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 77079, 77081, 76977, or G0130. Although it may be medically reasonable and necessary to report both axial and peripheral bone density studies on the same date of service, NCCI edits prevent the reporting of multiple CPT codes for the axial bone density study or multiple CPT codes for the peripheral site bone density study on the same date of service.

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

15. Radiologic studies with contrast (e.g., CT, CTA, MRI, MRA, angiography) utilize subtraction techniques as a standard of practice. CPT code 76350 (subtraction in conjunction with

contrast studies) should not be reported with procedures that typically utilize contrast.

16. CPT codes 70540-70543 are utilized to report magnetic resonance imaging of the orbit, face, and/or neck. Only one code may be reported for an imaging session regardless of whether one, two, or three areas are evaluated in the imaging session.

17. An MRI study of the brain (CPT codes 70551-70553) and MRI study of the orbit (CPT codes 70540-70543) are separately reportable only if they are both medically reasonable and necessary and are performed as distinct studies. An MRI of the orbit is not separately reportable with an MRI of the brain if an incidental abnormality of the orbit is identified during an MRI of the brain since only one MRI study is performed.

18. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

19. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

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CHAPTER X
PATHOLOGY / LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter X
Pathology and Laboratory Services
CPT Codes 80000 - 89999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 80000-89999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

Pathology and laboratory CPT coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens, or tissue specimens obtained by invasive/surgical procedures) in order to provide information to the treating physician. This information, coupled with information obtained from history and examination findings and other data, provides the physician with the background upon which medical decision making is established.

Generally, pathology and laboratory specimens are prepared and/or screened by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed personally by the pathologist. CPT coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist. On the occasion that a pathologist provides evaluation and management

services (significant, separately identifiable, patient care services that satisfy the criteria set forth in the E&M guidelines developed by CMS, formerly HCFA, and the AMA), appropriate coding should be rendered from the evaluation and management section of the *CPT Manual*.

If, after a test is ordered and performed, additional related procedures are necessary to provide or verify the result, these would be considered part of the ordered test. For example, if a patient with leukemia has a thrombocytopenia, and a manual platelet count (CPT code 85032) is performed in addition to the performance of an automated hemogram with automated platelet count (CPT code 85027), it would be inappropriate to report CPT codes 85032 and 85027 because the former provides verification for the automated hemogram and platelet count (CPT code 85027). As another example, if a patient has an abnormal test result and repeat performance of the test is done to verify the result, the test is reported as one unit of service rather than two.

If a treating physician orders an automated complete blood count with automated differential WBC count (CPT code 85025) or without automated differential WBC count (CPT code 85027), the laboratory sometimes examines a blood smear in order to complete the ordered test based on laboratory selected criteria flagging the results for additional verification. The laboratory should NOT report CPT code 85007 (microscopic blood smear examination with manual WBC differential count) or CPT code 85008 (microscopic blood smear examination without manual WBC differential count) for the examination of a blood smear to complete the ordered automated hemogram test (CPT codes 85025 or 85027). The same principle applies if the treating physician orders any type of blood count and the laboratory's practice is to perform an automated complete blood count with or without automated differential WBC count.

If a treating physician orders an automated hemogram (CPT code 85027) and a manual differential WBC count (CPT code 85007), both codes may be reported. However, a provider may not report an automated hemogram with automated differential WBC count (CPT code 85025) with a manual differential WBC count (CPT code 85007) because this combination of codes results in duplicate payment for the differential WBC count. CMS does not pay twice for the same laboratory test result even if performed by two different methods unless the two methods are medically reasonable and necessary.

By contrast some laboratory tests if positive require additional separate follow-up testing which is implicit in the physician's order. For example, if an RBC antibody screen (CPT code 86850) is positive, the laboratory routinely proceeds to identify the RBC antibody. The latter testing is separately reportable. Similarly, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable. In these cases, the initial positive results have limited clinical value without the additional testing. The additional testing is separately reportable because it is not performed to complete the ordered test. Furthermore, the ordered test if positive requires the additional testing in order to have clinical value. This type of testing is a category of reflex testing that must be distinguished from other reflex testing performed on a positive test result which may have clinical value without additional testing. An example of a latter type of test is a serum protein electrophoresis with a monoclonal protein band. A laboratory should not routinely perform serum immunofixation or serum immunoelectrophoresis to identify the type of monoclonal protein unless ordered by the treating physician. If the patient has a known monoclonal gammopathy, perhaps identified at another laboratory, the serum immunofixation or immunoelectrophoresis would not be appropriate unless ordered by the treating physician.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable

on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant,

separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Organ or Disease Oriented Panels

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of a group of specified tests. If all tests of a CPT defined panel are performed, the provider may bill the panel code or the individual component test codes. The panel codes may be used when the tests are ordered as that panel or if the individual component tests of a panel are ordered separately. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service could be billed as a lipid panel (CPT code 80061).

NCCI contains edits pairing each panel CPT code (column one code) with each CPT code corresponding to an individual laboratory test that is included in the panel (column two code). These edits allow use of NCCI-associated modifiers to bypass them if one or more of the individual laboratory tests are reported on the same date of service. The repeat testing must be medically reasonable and necessary. Modifier -91 may be utilized to report this repeat testing. Based on the *Internet-Only Manuals(IOM)*, *Medicare Claims Processing Manual*, Publication 100-04, Chapter 16, Section 100.5.1, the repeat testing cannot be performed to "confirm initial results; due to testing problems with specimens and equipment or for any other reason when a normal, one-time, reportable result is all that is required."

D. Evocative/Suppression Testing

Evocative/suppression testing involves administration of agents to determine a patient's response to those agents (CPT codes 80400-80440 are to be used for reporting the laboratory components of the testing). When the test requires physician administration of the evocative/suppression agent as described by CPT codes 90760-90775 (therapeutic/ diagnostic injections/infusions), these codes can be separately reported. However, when physician attendance is not required, and the agent is administered by ancillary personnel, these codes are not to be separately reported. In the inpatient setting, these codes are only reported if the physician performs the service personally. In the office setting, the service can be reported when performed

by office personnel if the physician is directly supervising the service. While supplies necessary to perform the testing are included in the testing, the appropriate HCPCS J codes for the drugs can be separately reported for the diagnostic agents. Separate evaluation and management services are not to be reported, including prolonged services (in the case of prolonged infusions) unless a significant, separately identifiable service is provided and documented.

E. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. CMS payment policy allows only one unit of service for CPT codes 88321, 88323, and 88325 per beneficiary per provider on a single date of service. Providers should not report these codes on separate lines of a claim utilizing CPT modifiers to bypass the MUEs for these codes.

F. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include

some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. Multiple CPT codes are descriptive of services performed for bone and bone marrow evaluation. When a biopsy is performed for evaluation of bone matrix structure, the appropriate code to bill is CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology evaluation.

When a bone marrow aspiration is performed alone, the appropriate coding is CPT code 38220. Appropriate coding for the interpretation is CPT code 85097 when the only service provided is the interpretation of the bone marrow smear. When both are performed by the same provider, both CPT codes may be reported. The pathological interpretations (CPT code 88300-88309) are not reported in addition to CPT code 85097 unless separate specimens are processed.

When it is medically necessary to evaluate both bone structure and bone marrow, and both services can be provided with one biopsy, only one code (CPT code 38221 or CPT code 20220) can be reported. If two separate biopsies are necessary, then both can be reported using modifier -59 on one of the codes. Pathological interpretation codes 88300-88309 may be separately reported for multiple separately submitted specimens. If only one specimen is submitted, only one code can be reported regardless of whether the report includes evaluation of both bone structure and bone marrow morphology or not.

4. The family of CPT codes 87040-87158 refers to microbial culture studies. The type of culture is coded to the highest level of specificity regarding source, type, etc. When a culture is processed by a commercial kit, report the code that describes the test to its highest level of specificity. A screening culture and culture for definitive identification are not performed on

the same day on the same specimen and therefore are not reported together.

5. When cytopathology codes are reported, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a group of related codes describing a group of services that could be performed on a specimen with the same end result (e.g., 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) is to be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier -59 should be used to indicate that different levels of service were provided for different specimens from different anatomic sites. This should be reflected in the cytopathologic reports. A cytopathology preparation from a fluid, washing, or brushing is to be reported using one code from the range of CPT codes 88104-88112. It is inappropriate to additionally use CPT codes 88160-88162 because the smears are included in the codes referable to fluids (or washings or brushings) and 88160-88162 references "any other source" which would exclude fluids, washings, or brushings.

6. The CPT codes 80500 and 80502 are used to indicate that a pathologist has reviewed and interpreted, with a subsequent written report, a clinical pathology test. These codes additionally are not to be used with any other pathology service that includes a physician interpretation (e.g., surgical pathology). If an evaluation and management service (face-to-face contact with the patient) takes place by the pathologist, then the appropriate E&M code is reported, rather than the clinical pathology consultation codes, even if, as part of the evaluation and management service, review of the test result is performed. Reporting of these services (CPT codes 80500 and 80502) requires the written order for consultation by a treating physician.

7. The CPT codes 88321-88325 are to be used to review slides, tissues, or other material obtained and prepared at a different location and referred to a pathologist for a second opinion. (These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or material also examined and reported by another pathologist in the same provider group. Medicare generally does not pay twice for an interpretation of a given technical service (e.g., EKGs,

radiographs, etc.). CPT codes 88321-88325 are reported with one unit of service regardless of the number of specimens, paraffin blocks, stained slides, etc.

When reporting CPT codes 88321-88325, providers should not report other pathology CPT codes such as 88312, 88313, 88342, 88187, 88188, 88189, etc., for interpretation of stains, slides or material previously interpreted by another pathologist. CPT codes 88312, 88313 and 88342 may be reported with CPT code 88323 if provider performs and interprets these stains de novo.

CPT codes 88321-88325 are not to be used for a face-to-face evaluation of a patient. In the event that a physician provides an evaluation and management service to a patient and, in the course of this service, specimens obtained elsewhere are reviewed as well, this is part of the evaluation and management service and is not to be reported separately. Only the evaluation and management service would be reported.

8. Multiple tests to identify the same analyte, marker, or infectious agent should not be reported separately. For example, it would not be appropriate to report both direct probe and amplified probe technique tests for the same infectious agent.

9. Medicare does not pay for duplicate testing. CPT codes 88342 (immunocytochemistry, each antibody) and 88184, 88187, 88188, 88189 (flow cytometry) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The provider may report both CPT codes if both methods are required because the initial method is nondiagnostic or does not explain all the light microscopic findings. The provider can report both methods utilizing modifier -59 and document the need for both methods in the medical record.

If the abnormal cells in two or more specimens are morphologically similar and testing on one specimen by one method (88342 or 88184, 88187, 88188, 88189) establishes the diagnosis, the same or other method should not be reported on the same or similar specimen. Similar specimens would include, but are not limited to:

- (1) blood and bone marrow;
- (2) bone marrow aspiration and bone marrow biopsy;

- (3) two separate lymph nodes; or
- (4) lymph node and other tissue with lymphoid infiltrate.

10. Quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging) should not be reported as CPT code 88342 with CPT code 88358. Prior to January 1, 2004, it should have been reported as CPT code 88342. Beginning January 1, 2004, it should be reported as CPT code 88361. CPT code 88361 should not be used to report any service other than quantitative or semi-quantitative immunohistochemistry using computer-assisted technology (digital cellular imaging). Digital cellular imaging includes computer software analysis of stained microscopic slides. Beginning January 1, 2005, quantitative or semi-quantitative immunohistochemistry performed by manual techniques should be reported as CPT code 88360. Immunohistochemistry reported with qualitative grading such as 1⁺ to 4⁺ should be reported as 88342.

11. DNA ploidy and S-phase analysis of tumor by digital cellular imaging technique should not be reported as CPT code 88313 with CPT code 88358. Prior to January 1, 2004, it should have been reported as CPT code 88313. Beginning January 1, 2004, it should be reported as CPT code 88358. Prior to January 1, 2004, CPT code 88358 should have been utilized to report DNA ploidy and S-phase analysis of tumor by non-digital cellular imaging techniques. CPT code 88358 should not be used to report any service other than DNA ploidy and S-phase analysis. One unit of service for CPT code 88358 includes both DNA ploidy and S-phase analysis.

12. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) is used to report direct measurement of the LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol in addition to total cholesterol (CPT code 82465) or lipid panel (CPT code 80061) may be reasonable and necessary if the triglyceride level is too high (greater than or equal to 400 mg/dl) to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier -59.

13. Prior to January 1, 2005, qualitative, semi-quantitative, and quantitative (tissue) *in situ* hybridization should have been reported as CPT code 88365 when performed by a physician (limited to M.D./D.O.). Beginning January 1, 2005,

quantitative or semi-quantitative *in situ* hybridization (tissue or cellular) performed by computer-assisted technology should be reported as CPT code 88367 when performed by a physician (limited to M.D./D.O.). Beginning January 1, 2005, quantitative or semi-quantitative *in situ* hybridization (tissue or cellular) performed by manual methods should be reported as CPT code 88368 when performed by a physician (limited to M.D./D.O.). Do not report CPT code 88365 with CPT codes 88367 or 88368 for the same probe. Only one unit of service may be reported for CPT code 88365, 88367 or 88368 for each reportable probe. When *in situ* hybridization is performed on tissue or cytology specimens by a non-physician (provider other than M.D./D.O.), it should be reported using appropriate CPT codes in the range 88271-88275. For each reportable probe, a provider should not report CPT codes both from the range 88365-88368 and the range 88271-88275. *In situ* hybridization reported as CPT codes 88365-88368 includes both physician (limited to M.D./D.O.) and non-physician (non-M.D./D.O.) services to obtain a reportable probe result. The physician (limited to M.D./D.O.) work component of 88365-88368 requires that a physician (limited to M.D./D.O.) rather than laboratory scientist or technician read, quantitate (88367,88368), and interpret the tissues/cells stained with the probe(s). If this work is performed by a laboratory scientist or technician, CPT codes 88271-88275 should be reported.

When a physician (limited to M.D./D.O.) reads/quantitates (CPT codes 88367, 88368) and interprets (CPT codes 88365-88368) the tissues/cells stained with the probe(s), the provider may report the global code or professional component (modifier -26) as appropriate. When the professional component of CPT codes 88365-88368 is reported by the physician (limited to M.D./D.O.), the laboratory may report the technical component (modifier -TC), and a hospital reporting an outpatient laboratory test may report the appropriate CPT code. If a non-physician (provider other than M.D./D.O.) reads and quantitates the tissues/cells stained with the probe(s), the laboratory should not report the technical component (-TC) of CPT codes 88367-88368, and a hospital reporting an outpatient laboratory test should not report CPT codes 88367 or 88368. The laboratory or hospital may report these services with CPT codes 88271-88275.

14. Beginning January 1, 2005, flow cytometry interpretation should be reported using CPT codes 88187-88189. Only one code should be reported for all flow cytometry performed

on a specimen. Since Medicare does not pay for duplicate testing, do not report flow cytometry on multiple specimens on the same date of service unless the morphology or other clinical factors suggest differing results on the different specimens. There is no CPT code for interpretation of one marker. The provider should not bill for interpretation of a single marker using another CPT code. Quantitative cell counts performed by flow cytometry (CPT codes 86064, 86359-86361, 86379, and 86587) should not be reported with the flow cytometry interpretation CPT codes 88187-88189 since there is no interpretative service for these quantitative cell counts.

15. Infectious agent molecular diagnostic testing utilizing nucleic acid probes is reported with CPT codes 87470-87801, 87901-87904. These CPT codes include all the molecular diagnostic processes, and CPT codes 83890-83913 should not be additionally reported with these CPT codes. If the provider performs infectious agent molecular diagnostic testing utilizing nucleic acid probes (87470-87801, 87901-87904) on the same date of service as non-infectious agent molecular diagnostic testing or infectious agent molecular diagnostic testing utilizing methodology that does not incorporate nucleic acid probes, the molecular diagnostic testing CPT codes 83890-83913 may be reported separately with an NCCI-associated modifier.

16. CPT code 83912 describes a medically reasonable and necessary "interpretation and report" associated with molecular diagnostic testing described with CPT codes 83890-83906. CPT code 83912 should not be reported as an "interpretation and report" with CPT codes 87470-87801, 87901-87904 or 88271-88275.

17. Free thyroxine (CPT code 84439) is generally considered to be a better measure of the hypothyroid or hyperthyroid state than total thyroxine (CPT code 84436). If free thyroxine is measured, it is not considered appropriate to measure total thyroxine with or without thyroid hormone binding ratio (CPT code 84479). NCCI does not permit payment of CPT codes 84436 or 84479 with CPT code 84439.

18. CPT codes 88384-88386 describe array-based evaluations of multiple molecular probes. Although CPT code 88384 is Carrier priced, CPT codes 88385 and 88386 are payable from the Medicare Physician Fee Schedule and include significant physician work. If array-based evaluation of multiple molecular probes is

performed by a laboratory scientist or technician rather than a physician, it should not be reported with CPT code 88385 or 88386 but with an unlisted procedure code.

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CHAPTER XI
MEDICINE
EVALUATION AND MANAGEMENT SERVICES
CPT CODES 90000 - 99999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter XI
Medicine
Evaluation and Management Services
CPT Codes 90000 - 99999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 90000-99999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

1. The HCPCS/CPT codes 90760-90775 and C8957 describe services involving therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs. The CPT codes 96401-96549 describe administration of chemotherapeutic (primarily antineoplastic) agents. Issues related to chemotherapy administration are discussed in this section as well as Section N.(Chemotherapy Administration).

2. The CPT codes 90760, 90765, 90774, 96409, and 96413 represent "initial" service codes. For a given date of service only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate vascular access sites. To report two different "initial" service codes use NCCI-associated modifiers.

3. Because the placement of peripheral vascular access devices is integral to vascular (intravenous, intra-arterial) infusions and injections, the CPT codes for placement of these devices are not to be separately reported. Accordingly, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 90760-90775, 90774-90775, 96409-96415, and 96417) should not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, these services may be reported separately. Because intra-arterial infusion often involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes may be reported separately.

4. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 90760-90775. If the sole purpose of fluid administration (e.g., saline, D₅W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and should not be reported separately. Similarly, the fluid utilized to administer drug(s)/substance(s) is incidental hydration and should not be reported separately.

Transfusion of blood or blood products includes the insertion of a peripheral intravenous line (e.g., CPT codes 36000, 36410) which is not separately reportable. Administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is incidental hydration and is not separately reportable.

If therapeutic fluid administration is medically necessary (e.g., correction of dehydration, prevention of nephrotoxicity) before or after transfusion or chemotherapy, it may be reported separately.

5. The drug and chemotherapy administration CPT codes 90760-90775 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other office/outpatient

evaluation and management CPT codes (99201-99205, 99212-99215) are separately reportable with modifier -25 if the physician provides a significant and separately identifiable E&M service.

6. CPT codes 90760-90775, 96401-96402, 96409-96417, 96420-96425, 96521-96523, and 96542 are reportable by physicians for services performed in physicians' offices. These drug administration services performed in hospital facilities including emergency departments are not separately reportable by physicians. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may bill separately for drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare carriers for services payable on the "Medicare Physician Fee Schedule".

7. Flushing or irrigation of an implanted vascular access port or device prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Do not report CPT code 96523.

8. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration. These codes should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir) and CPT code 96521 (refilling and maintenance of portable pump) should not be reported with CPT code 96416 (initiation of prolonged intra-venous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the

initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump. Similarly under the OPPS, CPT codes 96521 (refilling and maintenance of portable pump) and 96522 (refilling and maintenance of portable or implantable pump or reservoir) should not be reported with HCPCS/CPT code C8957 (initiation of prolonged intravenous infusion (more than 8 hours)).

9. Medicare Anesthesia Rules prevent separate payment for anesthesia services for a medical or surgical service when provided by the physician performing the service. Drug administration services, CPT codes 90760-90775 should not be reported for anesthesia provided by the physician performing a medical or surgical service.

10. Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

11. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported as HCPCS/CPT codes G0008, G0009, or G0010 respectively. Administration of other immunization(s) not excluded by law is reported with CPT codes 90465-90468 or 90471-90474 depending upon the patient's age and physician counseling of the patient/family. Based on CPT instructions a provider should report administration of all immunizations other than influenza, pneumococcal, or hepatitis B vaccines on a single date of service from either of these two code ranges and may not report a combination of HCPCS/CPT codes from the two code ranges.

12. Similar to drug and chemotherapy administration CPT codes, CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I) is not reportable with vaccine administration HCPCS/CPT codes 90465-90474, G0008-G0010.

C. Psychiatric Services

CPT codes for psychiatric services include general and special diagnostic services as well as a variety of therapeutic services. By *CPT Manual* definition, therapeutic services (e.g., HCPCS/CPT codes 90804-90829) include psychotherapy and continuing medical diagnostic evaluation; therefore, CPT codes 90801 and 90802 are not reported with these services.

Interactive services (diagnostic or therapeutic) are distinct forms of services for patients who have "lost, or have not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment...". Accordingly, non-interactive services would not be possible at the same session as interactive services and are not to be reported together with interactive services.

Drug management is included in some therapeutic services (e.g., HCPCS/CPT codes 90801-90829, 90845, 90847-90853, 90865-90870) and therefore CPT code 90862 (pharmacologic management) is not to be reported with these codes.

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

D. Biofeedback

Biofeedback services involve the use of electromyographic techniques to detect and record muscle activity. The CPT codes 95860-95872 (EMG) should not be reported with biofeedback services based on the use of electromyography during a biofeedback session. If an EMG is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate EMG codes (e.g., CPT codes 95860-95872) may be reported. Modifier -59 should be added to indicate that the service performed was a separately identifiable diagnostic service. Reporting only an objective electromyographic response to biofeedback is not sufficient to bill the codes referable to diagnostic EMG.

E. Dialysis

Renal dialysis procedures coded as CPT codes 90935, 90937, 90945, and 90947 include evaluation and management (E&M) services related to the dialysis procedure. If the physician additionally performs on the same date of service medically reasonable and necessary E&M services that are significant and separately identifiable, these services may be separately reportable. CMS allows physicians to additionally report if appropriate CPT codes 99201-99215, 99221-99223, 99238-99239, 99241-99245, 99251-99255, and 99291-99292. These codes must be reported with modifier -25 if performed on the same date of service as the dialysis procedure.

F. Gastroenterology

Gastroenterological tests included in CPT codes 91000-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology are described as part of upper endoscopy (e.g., CPT code 43235); therefore, CPT codes 91000 (esophageal intubation) and 91055 (gastric intubation) are not separately reported when performed as part of an upper endoscopy. Provocative testing (CPT code 91052) can be expedited during GI endoscopy (procurement of gastric specimens). When performed at the same time as GI endoscopy, CPT code 91052 is reported with modifier -52 indicating that a reduced level of service was performed.

G. Ophthalmology

General ophthalmological services (e.g., CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-92014) are not to be reported; the same services would be represented by both series of codes.

Special ophthalmologic services represent specific services not described as part of a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services.

For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are necessary to accomplish the procedure and are included in the procedure. Accordingly, CPT codes 36000 (introduction of a needle or catheter), 36410 (venipuncture), 90760-90775 (IV infusion), and 90774-90775 (IV injection) as well as selective vascular catheterization codes are not to be separately reported with services requiring intravenous injection (e.g., CPT codes 92230, 92235, 92240, 92287, for angiography and angiography).

Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92135) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier -59 to CPT code 92250.

CPT codes 92230 and 92235 (fluorescein angiography and angiography) include injection procedures for angiography.

H. Otorhinolaryngologic Services

CPT coding for otorhinolaryngologic services includes codes for tests that may be performed qualitatively during physical examination or quantitatively with electrical recording equipment. The procedures described by CPT codes 92552-92557, 92561-92588, and 92597 may be reported only if calibrated electronic equipment is utilized. Qualitative estimation of

these tests by the physician is part of the evaluation and management service.

Speech language pathologists may perform services coded as CPT codes 92507, 92508, or 92526. They do not perform services coded as CPT codes 97110, 97112, 97150, 97530, or 97532 which are generally performed by physical or occupational therapists. Speech language pathologists should not report CPT codes 97110, 97112, 97150, 97530, or 97532 as unbundled services included in the services coded as 92507, 92508, or 92526.

Treatment of swallowing dysfunction and/or oral function for feeding (CPT code 92526) may utilize electrical stimulation. HCPCS code G0283 (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code 92526 for electrical stimulation during the procedure. The NCCI edit (92526/G0283) for Medicare Carriers does not allow use of NCCI-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit in OCE for Fiscal Intermediaries does allow use of NCCI-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different patient encounters on the same date of service.

I. Cardiovascular Services

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

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

2. In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately reported. A number of therapeutic and diagnostic cardiovascular procedures (e.g., CPT codes 92950-92998, 93501-93545, 93600-93624, 93640-93652) routinely utilize intravenous or intra-arterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques; accordingly, separate codes for routine access, monitoring, injection or infusion services are not to be reported. Fluoroscopic guidance procedures are integral to invasive intravascular procedures and are included in those services. In unique circumstances, where these services are performed, not as an integral part of the procedure, the appropriate code can be separately reported with modifier -59. When supervision and interpretation codes are identified in the *CPT Manual* for a given procedure, these can be separately reported.

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

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

5. When a physician who is in attendance for a cardiac stress test obtains a history, and performs a limited examination referable specifically to the cardiac stress test, a separate evaluation and management service is not reported unless a significant, separately identifiable service is performed unrelated to the performance of the cardiac stress test and in accordance with the evaluation and management guidelines. The evaluation and management service would be reported with modifier -25 in this instance.

6. CPT codes 93040-93042 describe diagnostic rhythm EKG testing. They should not be reported for cardiac rhythm monitoring in any site of service.

7. Routine monitoring of EKG rhythm and review of daily hemodynamics including cardiac output are part of critical care evaluation and management services. Separate reporting of EKG rhythm strips and cardiac output measurements (e.g., CPT codes 93040-93042, 93561, 93562) with critical care evaluation and management services is inappropriate. An exception to this may include a sudden change in patient status associated with a change in cardiac rhythm requiring a return to the ICU or telephonic transmission to review a rhythm strip. If reported separately, time included for this service is not included in the critical care time calculated for the critical care service.

8. Percutaneous coronary artery interventions include stent placement, atherectomy, and balloon angioplasty. For reimbursement purposes, Medicare recognizes three coronary arteries: right coronary artery (modifier -RC), left circumflex coronary artery (modifier -LC) and left anterior descending coronary artery (modifier -LD). For a given coronary artery and its branches, the provider should report only one intervention, the most complex, regardless of the number of stent placements, atherectomies, or balloon angioplasties performed in that coronary artery and its branches. From a coding perspective, stent placement is considered more complex than an atherectomy which is considered more complex than a balloon angioplasty. These interventions should be reported with the appropriate modifier (-RC, -LC, -LD) indicating in which coronary artery (including its branches) the procedure(s) was (were) performed. Since Medicare recognizes three coronary arteries (including their branches) for reimbursement purposes, it is possible that a provider will report up to three percutaneous interventions if an intervention is performed in each of the three coronary arteries or their branches. The first reported procedure must utilize a primary code (CPT codes 92980, 92982, 92995) corresponding to the most complex procedure performed. The procedure(s) performed in the other one or two coronary arteries (including their branches) are reported with the CPT add-on codes (CPT codes 92981, 92984, 92996). Modifier -59 should not be utilized to report percutaneous coronary artery stent placement, atherectomy, or balloon angioplasty.

9. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (HCPCS/CPT codes 33202-33249, G0297-G0300) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization

or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes are not separately reportable with the procedures described by HCPCS/CPT codes 33202-33249, G0297-G0300, and 93600-93662. Similarly, ultrasound guidance is not separately reportable with these HCPCS/CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by HCPCS/CPT codes 33202-33249, G0297-G0300, or 93600-93662.

10. While withdrawing the catheter during a cardiac catheterization procedure, providers often inject a small amount of dye to examine the renal arteries and/or iliac arteries. These services when medically reasonable and necessary may be reported with HCPCS codes G0275 or G0278. A provider should not report CPT codes 75722 or 75724 (renal angiography) unless the renal artery(s) is (are) catheterized and a complete renal angiogram including the venous phase is performed and interpreted. A provider should not report CPT codes 75625 (abdominal aortography) or 75630 (abdominal aortography with bilateral iliofemoral lower extremity angiography) unless a complete study including venous phase is performed and interpreted. In order to report angiography CPT codes 75625, 75630, 75722, 75724, or others with a cardiac catheterization procedure, the angiography procedure must be as complete a procedure as it would be without concomitant cardiac catheterization.

11. Occasionally it is medically reasonable and necessary to perform echocardiography (CPT codes 93303-93318) utilizing intravenous push injections of contrast. The injections of the contrast (CPT codes 90765, 90774, 90775) are not separately reportable.

12. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

13. Cardiac catheterization and coronary artery angioplasty, atherectomy, or stenting procedures include

insertion of a needle and/or catheter, infusion, fluoroscopy and EKG strips (e.g., CPT codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 90760-90775, 76000-76001, 93040-93042). All are components of performing a cardiac catheterization or coronary artery angioplasty, atherectomy, or stenting.

14. Cardiac catheterization procedures may require procurement of EKG tracings during the procedure to assess chest pain during catheterization and angioplasty; when performed in this fashion, these EKG tracings are not separately reported. EKGs procured prior to, or after, the procedure may be separately reported with modifier -59.

15. CPT codes 93501, 93505-93545 (cardiac catheterization) include CPT codes 71034, 76000, and 76001 (fluoroscopy).

16. Placement of an occlusive device such as an angio seal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure should be reported as HCPCS code G0269. Providers should not report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

17. Renal artery angiography at the time of cardiac catheterization should be reported as HCPCS code G0275 if selective catheterization of the renal artery is not performed. HCPCS code G0275 should not be reported with CPT code 36245 for selective renal artery catheterization or CPT codes 75722 or 75724 for renal angiography. If it is medically necessary to perform selective renal artery catheterization and renal angiography, HCPCS code G0275 should not be additionally reported.

18. Cardiovascular stress tests include insertion of needle and/or catheter, infusion (pharmacologic stress tests) and EKG strips (e.g., CPT codes 36000, 36410, 90760-90775, 93000-93010, 93040-93042).

J. Pulmonary Services

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

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

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

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

4. Complex pulmonary stress testing (e.g., CPT code 94621) is a comprehensive stress test with a number of component tests separately defined in the *CPT Manual*. It is inappropriate to separately code venous access, EKG monitoring, spirometric parameters performed before, during and after exercise, oximetry, O₂ consumption, CO₂ production, rebreathing cardiac output calculations, etc., when performed as part of a complex pulmonary stress test. It is also inappropriate to bill for a cardiac stress test and the component codes used to perform a simple pulmonary stress test (CPT code 94620), when a complex pulmonary stress test is performed. If using a standard exercise protocol, serial electrocardiograms are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, the professional components for both a cardiac and pulmonary stress test may be reported. Modifier -59 should be reported with the secondary procedure. Both tests must satisfy the requirement for medical necessity. (Since a complex pulmonary stress test includes electrocardiographic recordings, the technical components for both the cardiac stress test and the pulmonary stress test should not be reported separately.)

5. Pursuant to the *Federal Register* (Volume 58, Number 230, 12/2/1993, pages 63640-63641), ventilation management CPT codes (94002-94004 and 94660-94662) are not separately reportable with evaluation and management (E&M) CPT codes. If an E&M code

and a ventilation management code are reported, only the E&M code is payable.

6. The procedure described by CPT code 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour) does not include any physician work RVU's. When performed in a facility, the procedure utilizes facility staff and supplies, and the physician does not have any practice expenses related to the procedure. Thus, a physician should not report this code when the physician orders it in a facility. This code should not be reported with CPT codes 99217-99239, 99251-99255, 99281-99285, 99289-99300, 99304-99318, and 99324-99337 unless the physician supervises the performance of the procedure at a separate patient encounter on the same date of service outside the facility where the physician does have practice expenses related to the procedure.

K. Allergy Testing and Immunotherapy

The *CPT Manual* divides allergy and clinical immunology into testing and immunotherapy. Immunotherapy is divided into codes that include preparation of the antigen when it is administered at the same session and when it is prepared but delivered for immunotherapy by a different physician. Several specific issues are identified regarding allergy testing and immunotherapy.

1. If percutaneous or intracutaneous (intradermal) single test (CPT codes 95004 or 95024) and "sequential and incremental" tests (CPT codes 95010, 95015, or 95027) are performed on the same date of service, both the "sequential and incremental" test and single test codes may be reported if the tests are for different allergens or different dilutions of the same allergen. The unit of service to report is the number of separate tests. Do not report both a single test and a "sequential and incremental" test for the same dilution of an allergen. For example, if the single test for an antigen is positive and the provider proceeds to "sequential and incremental" tests with three additional *different* dilutions of the same antigen, the provider may report one unit of service for the single test code and three units of service for the "sequential and incremental" test code.

2. When photo patch tests (e.g., CPT code 95052) are performed (same antigen/same session) with patch or application tests, only the photo patch testing should be reported. Additionally, if photo testing is performed including application

or patch testing, the code for photo patch testing (CPT code 95052) is to be reported, not CPT code 95044 (patch or application tests) and CPT code 95056 (photo tests).

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

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

L. Neurology and Neuromuscular Procedures

The *CPT Manual* defines codes for neuromuscular diagnostic/therapeutic services not requiring surgical procedures. Sleep testing, nerve and muscle testing and electroencephalographic procedures are included. The *CPT Manual* guidelines regarding sleep testing are very precise and should be reviewed carefully before billing for these services.

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

2. Polysomnography requires at least one central and usually several other EEG electrodes. EEG procurement for polysomnography (sleep staging) differs greatly from that required for diagnostic EEG testing (i.e. speed of paper, number of channels, etc.). Accordingly, EEG testing is not to be reported with polysomnography unless performed separately; the EEG tests, if rendered with a separate report, are to be reported with modifier -59, indicating that this represents a different session from the sleep study.

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) represent different services than those provided during sleep testing; accordingly these codes are only

to be reported when a separately identifiable service is performed and documented. Additionally, billing standard EEG services would only be appropriate if a significant, separately identifiable service is provided. These codes are to be reported with modifier -59 to indicate that a different service is clearly documented.

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

5. Intraoperative neurophysiology testing (CPT code 95920) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package.

6. The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 95900 of this NCCI edit is only appropriate if the two procedures are performed on different nerves or in separate patient encounters.

M. Central Nervous System Assessments/Tests

1. Neurobehavioral status exam (CPT code 96116) should not be reported when a mini-mental status examination is performed. CPT code 96116 may never be reported with psychiatric diagnostic examinations (CPT codes 90801 or 90802). CPT code 96116 may be reported with other psychiatric services or evaluation and management services only if a complete neurobehavioral status

exam is performed. If a mini-mental status examination is performed by a physician, it is included in the evaluation and management service.

2. CPT codes 96101-96103 describe psychological testing differing by method of performance and interpretation. Two or more codes from this code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different psychological tests. Similarly, CPT codes 96118-96120 describe neuropsychological testing differing by method of performance and interpretation. Two or more codes from this latter code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different neuropsychological tests.

N. Chemotherapy Administration

1. The CPT codes 90760, 90765, 90774, 96409, and 96413 represent "initial" service codes. For a given date of service only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate vascular access sites. To report two different "initial" service codes use NCCI-associated modifiers.

2. The drug and chemotherapy administration HCPCS/CPT codes 90760-90775 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other office/outpatient evaluation and management CPT codes (99201-99205, 99212-99215) are separately reportable with modifier -25 if the physician provides a significant and separately identifiable E&M service.

3. CPT codes 90760-90775, 96401-96402, 96409-96417, 96420-96425, 96521-96523, and 96542 are reportable by physicians for services performed in physicians' offices. These drug administration services performed in hospital facilities including emergency departments are not separately reportable by physicians. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may bill separately for drug administration services when appropriate. For purposes

of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare carriers for services payable on the "Medicare Physician Fee Schedule".

4. Flushing or irrigation of an implanted vascular access port or device prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the chemotherapy drug administration service and is not separately reportable. Do not report CPT code 96523.

5. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration. These codes should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir) and CPT code 96521 (refilling and maintenance of portable pump) should not be reported with CPT code 96416 (initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump.

6. A concurrent intravenous infusion of an antiemetic or other non-chemotherapeutic drug with intravenous infusion of chemotherapeutic agents may be reported separately as CPT code 90768 (concurrent intravenous infusion). CPT code 90768 may be reported with a maximum of one unit of service per patient encounter regardless of the number of concurrently infused drugs or the length of time for the concurrent infusion(s).

7. Prior to January 1, 2005, the NCCI edits with column one CPT codes 96408 (Intravenous chemotherapy administration by

push technique) and 96410 (Intravenous chemotherapy administration by infusion technique, up to one hour) each with column two CPT code 90780 (Therapeutic or diagnostic intravenous infusion up to one hour) were often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 90780 of these NCCI edits was only appropriate if the 90780 procedure was for hydration, antiemetic, or other non-chemotherapy drug administered before, after, or at different patient encounters than the chemotherapy. Modifier -59 should not have been used for "keep open" infusion for the chemotherapy.

O. Physical Medicine and Rehabilitation

With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. (The only exception involves a "supervised modality" defined by CPT codes 97010-97028 which may be reported for the same fifteen minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI edits pair a "timed" CPT code with another "timed" CPT code or a non-timed CPT code. These edits may be bypassed with modifier -59 if the two procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter. NCCI does not include all edits pairing two physical medicine and rehabilitation services (excepting "supervised modality" services) even though they should never be reported for the same fifteen minute time period.

NCCI contains edits with column one codes of the physical medicine and rehabilitation therapy services and column two codes of the physical therapy and occupational therapy re-evaluation CPT codes of 97002 and 97004 respectively. The re-evaluation services should not be routinely reported during a planned course of physical or occupational therapy. However, if the patient's status should change and a re-evaluation is warranted, it may be reported with modifier -59 appended to CPT code 97002 or 97004 as appropriate.

The procedure coded as CPT code 97755 (assistive technology assessment...direct one-on-one contact by provider, with written report, each 15 minutes) is intended for use on severely impaired patients requiring adaptive technology. For example, a patient with the use of only one or no limbs might require the use of high level adaptive technology.

The NCCI edit with column one CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column two CPT code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 97530 of this NCCI edit is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.

P. Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is subject to Global Surgery Rules. Per Medicare Anesthesia Rules a provider performing OMT cannot separately report anesthesia services such as nerve blocks or epidural injections for OMT. In addition, per Medicare Global Surgery Rules, postoperative pain management after OMT (e.g., nerve block, epidural injection) is not separately reportable. Epidural or nerve block injections performed on the same date of service as OMT and unrelated to the OMT may be reported with OMT using modifier -59.

Q. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier -59.

R. Miscellaneous Services

1. When CPT code 99175 is reported, observation time provided exclusively to monitor the patient for a response to an emetogenic agent is not to be included in other timed codes (e.g., critical care, office visits, prolonged services, etc.).

2. If hypothermia (e.g., CPT code 99185) is accomplished by regional infusion techniques, separate services for chemotherapy administration should not be reported unless

chemotherapeutic agents are also administered at the same session.

3. Therapeutic phlebotomy services (e.g., CPT code 99195) are not to be reported with transfusion service codes (e.g., CPT codes 86890, 86891), plasmapheresis codes, or exchange transfusion codes. Services necessary to perform the phlebotomy (e.g., CPT codes 36000, 36410, 90760-90775) are included in the procedure.

S. Evaluation and Management (E&M) Services

CPT codes for evaluation and management (E&M) services are principally included in the group of CPT codes, 99201-99499. The codes describe the place of service (e.g., office, hospital, home, nursing facility, emergency department, critical care, etc.), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter, consultation, etc.), and various miscellaneous services (e.g., prolonged physician service, care plan oversight service, etc.). E&M services are further classified by the complexity of the relevant clinical history, physical examination, and medical decision making.

Rules governing the reporting of more than one E&M code for a patient on the same date of service are very complex and are not described herein. However, the NCCI contains numerous edits based on several principles including, but not limited to:

1. A physician may report only one "new patient" code on a single date of service.

2. A physician may report only one code from a range of codes describing an initial E&M service on a single date of service.

3. A physician may report only one "per diem" E&M service from a range of per diem codes on a single date of service.

4. A physician should not report an "initial" per diem E&M service with the same type of "subsequent" per diem service on the same date of service.

5. E&M codes describing observation/inpatient care services with admission and discharge on same date (CPT codes 99234-99236) should not be reported on the same date of service as initial hospital care per diem codes (99221-99223), subsequent hospital

care per diem codes (99231-99233), or hospital discharge day management codes (99238-99239).

The prolonged physician service with direct face-to-face patient contact E&M codes (CPT codes 99354-99357 may be reported in conjunction with other evaluation and management codes. These prolonged service E&M codes are add-on codes that may generally be reported with the E&M codes listed in the CPT instruction following each CPT code in the code range 99354-99357. However, CMS rules do not permit the reporting of CPT codes 99354-99357 with nursing facility E&M codes (99304-99318).

Other E&M services are described by codes based on the duration of the encounter (e.g., critical care services).

Evaluation and management services, in general, are cognitive services and significant procedural services are not included in the evaluation and management services. Certain procedural services that arise directly from the evaluation and management service are included as part of the evaluation and management service. For example, cleansing of traumatic lesions, closure of lacerations with adhesive strips, dressings, counseling and educational services are included in evaluation and management services.

Digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an evaluation and management code. CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

"As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

Because of the intensive nature of caring for critically ill patients, certain services beyond patient history, examination and medical decision making are included in the overall evaluation and management associated with critical care. By CPT definition, services including the interpretation of cardiac

output measurements (CPT codes 93561 and 93562), chest X-rays (CPT codes 71010 and 71020), blood gases, and data stored in computers (EKGs, blood pressures, hematologic data), gastric intubation (CPT code 91105), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94002-94004, 94660, 94662), and vascular access procedures (CPT codes 36000, 36410, 36600) are included in critical care services.

Certain sections of CPT codes have incorporated codes describing specialty-specific services which primarily involve evaluation and management services. When codes for these services are reported, a separate evaluation and management service described by the range of CPT codes 99201-99499 is not to be reported on the same date of service. Examples of these codes include general and special ophthalmologic services and general and special diagnostic and therapeutic psychiatric services.

Procedural services involve some degree of physician involvement or supervision which is integral to the service. Separate evaluation and management services are not reported unless a significant, separately identifiable service is provided. Examples of such procedures include allergy testing and immunotherapy, osteopathic manipulative treatment, physical therapy services, neurologic and vascular testing procedures.

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of

deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day 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.

T. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.
2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to

bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

U. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

4. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

5. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are

separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

7. If the code descriptor of a HCPCS/CPT code includes the phrase, "separate procedure", the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a "separate procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

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

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Chapter XII
Supplemental Services
HCPCS Level II Codes A0000 - V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range A0000-V9999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc. The general correct coding policies described in Chapter I apply to these codes as well as CPT codes. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicare carriers and Fiscal Intermediaries for Part B services.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are

performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.
2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

D. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of

this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. HCPCS code M0064 is not to be reported separately from CPT codes 90801-90857 (psychiatric services). This code describes a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.

4. HCPCS code Q0091, for screening pap smears includes the services necessary to procure and transport the specimen to the laboratory. If an evaluation and management service is performed at the same visit solely for the purpose of performing a screening pap smear, then the evaluation and management service is not reported separately. If a significant, separately identifiable evaluation and management service is performed to evaluate other medical problems, then both the screening pap smear and the evaluation and management service are reported. By appending the modifier -25 to the evaluation and management code, the provider is indicating that a significant, separately identifiable service was rendered.

5. HCPCS code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E&M) services under certain circumstances. If a Medicare covered E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported. However, if the Medicare covered E&M

service and the screening services, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier -25 to the E&M service CPT code. Use of modifier -25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

6. HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an evaluation and management code (CPT codes 99201-99499). CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

"As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

7. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the

physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

8. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

9. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those

surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

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

11. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

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CHAPTER XIII
Category III Codes
CPT Codes 0001T - 0199T
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter XIII
Category III Codes
CPT Codes 0001T - 0199T

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 0001T-0199T. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

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

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

The *CPT Manual* contains Category III codes, XXXXT, that represent emerging technologies, services, and procedures. Each Category III code is referenced in another section of the *CPT Manual* that contains related procedures. The NCCI contains edits for many of these codes. The coding policies used to establish these edits are the same as those used for other procedures in the related section of the *CPT Manual*. For example, if the XXXXT code describes a laboratory procedure, the coding policies that apply are those found in Chapter I (General Correct Coding Policies) and Chapter X (Pathology and Laboratory Services (CPT Codes 80000-89999)) of the "*National Correct Coding Initiative Policy Manual for Medicare Services*".

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with

procedures covered by these rules. This section summarizes some of the rules.

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

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure,

intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier -25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier -25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.
2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

D. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the

policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*.

Under Medicare Global Surgery Rules, drug administration services (90760-90775) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications

such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 90760-90775) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

4. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

5. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

6. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately

reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier -78.

7. A biopsy performed at the time of another more extensive procedure (e.g. excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier -59.

If the biopsy is performed on the same lesion on which the more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination. Modifier -58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.