

***National Correct Coding Initiative  
Policy Manual  
for Medicare Services  
Version 16.3  
Effective Date: October 1, 2010***

**National Correct Coding Initiative  
Correct Coding Solutions, LLC  
Final Due Date: August 31, 2010**

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TABLE OF CONTENTS  
FOR  
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL  
FOR MEDICARE SERVICES

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## TABLE OF CONTENTS

### Introduction

Introduction	viii
Purpose	viii
Policy Manual Background	x
Edit Development and Review Process	xi
Correct Coding	xi
Sources of Information about NCCI and MUE	xiii
Correspondence to CMS about NCCI and its Contents	xiv

### Chapter I - General Correct Coding Policies

A. Introduction	I-1
B. Coding Based on Standards of Medical/Surgical Practice	I-3
C. Medical/Surgical Package	I-5
D. Evaluation and Management (E&M) Services	I-10
E. Modifiers and Modifier Indicators	I-12
F. Standard Preparation/Monitoring Services for Anesthesia	I-18
G. Anesthesia Service Included in the Surgical Procedure	I-18
H. HCPCS/CPT Procedure Code Definition	I-19
I. <i>CPT Manual</i> and CMS Coding Manual Instructions	I-20
J. CPT "Separate Procedure" Definition	I-21
K. Family of Codes	I-21
L. More Extensive Procedure	I-22
M. Sequential Procedure	I-23
N. Laboratory Panel	I-23
O. Misuse of Column Two Code with Column One Code	I-24
P. Mutually Exclusive Procedures	I-25

## TABLE OF CONTENTS (Continued)

Q. Gender-Specific Procedures (formerly Designation of Sex)	I-25
R. Add-on Codes	I-26
S. Excluded Service	I-27
T. Unlisted Procedure Codes	I-27
U. Modified, Deleted, and Added Code Pairs/Edits	I-27
V. Medically Unlikely Edits (MUEs)	I-28
 <b>Chapter II - Anesthesia Services(CPT codes 00000 - 09999)</b>	
A. Introduction	II-1
B. Standard Anesthesia Coding	II-2
C. Radiologic Anesthesia Coding	II-10
D. Monitored Anesthesia Care (MAC)	II-11
E. General Policy Statements	II-11
 <b>Chapter III - Surgery: Integumentary System (CPT Codes 10000 - 19999)</b>	
A. Introduction	III-1
B. Evaluation and Management (E&M) Services	III-1
C. Anesthesia	III-3
D. Incision and Drainage	III-4
E. Lesion Removal	III-5
F. Mohs Micrographic Surgery	III-6
G. Intralesional Injections	III-7
H. Repair and Tissue Transfer	III-7
I. Grafts and Flaps	III-8

**TABLE OF CONTENTS (Continued)**

J. Breast (Incision, Excision, Introduction, Repair and Reconstruction)	III-9
K. Medically Unlikely Edits (MUEs)	III-10
L. General Policy Statements	III-11

**Chapter IV - Surgery: Musculoskeletal System (CPT Codes 20000 - 29999)**

A. Introduction	IV-1
B. Evaluation and Management (E&M) Services	IV-1
C. Anesthesia	IV-3
D. Biopsy	IV-4
E. Arthroscopy	IV-4
F. Fractures and/or Dislocations	IV-5
G. Medically Unlikely Edits (MUEs)	IV-7
H. General Policy Statements	IV-8

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

A. Introduction	V-1
B. Evaluation and Management (E&M) Services	V-2
C. Respiratory System	V-3
D. Cardiovascular System	V-8
E. Hemic and Lymphatic Systems	V-16
F. Mediastinum	V-17
G. Medically Unlikely Edits (MUEs)	V-18
H. General Policy Statements	V-18

**TABLE OF CONTENTS (Continued)**

**Chapter VI - Surgery: Digestive System (CPT Codes 40000 - 49999)**

A. Introduction	VI-1
B. Evaluation and Management (E&M) Services	VI-1
C. Endoscopic Services	VI-3
D. Esophageal Procedures	VI-6
E. Abdominal Procedures	VI-6
F. Laparoscopy	VI-8
G. Medically Unlikely Edits (MUEs)	VI-9
H. General Policy Statements	VI-10

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

A. Introduction	VII-1
B. Evaluation and Management (E&M) Services	VII-1
C. Urinary System	VII-3
D. Male Genital System	VII-8
E. Female Genital System	VII-9
F. Laparoscopy	VII-9
G. Maternity Care and Delivery	VII-10
H. Medically Unlikely Edits (MUEs)	VII-11
I. General Policy Statements	VII-12

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

A. Introduction	VIII-1
B. Evaluation and Management (E&M) Services	VIII-1
C. Nervous System	VIII-3
D. Ophthalmology	VIII-8

## TABLE OF CONTENTS (Continued)

E. Auditory System	VIII-10
F. Operating Microscope	VIII-11
G. Laparoscopy	VIII-12
H. Medically Unlikely Edits (MUEs)	VIII-12
I. General Policy Statements	VIII-13

### Chapter IX - Radiology Services (CPT Codes 70000 - 79999)

A. Introduction	IX-1
B. Evaluation and Management (E&M) Services	IX-1
C. Non-interventional Diagnostic Imaging	IX-4
D. Interventional/Invasive Diagnostic Imaging	IX-6
E. Nuclear Medicine	IX-9
F. Radiation Oncology	IX-10
G. Medically Unlikely Edits (MUEs)	IX-13
H. General Policy Statements	IX-14

### Chapter X - Pathology and Laboratory Services (CPT Codes 80000 - 89999)

A. Introduction	X-1
B. Evaluation and Management (E&M) Services	X-3
C. Organ or Disease Oriented Panels	X-4
D. Evocative/Suppression Testing	X-5
E. Chemistry	X-5
F. Hematology and Coagulation	X-6
G. Microbiology	X-8
H. Anatomic Pathology (Cytopathology and Surgical Pathology)	X-8
I. Medically Unlikely Edits (MUEs)	X-12
J. General Policy Statements	X-15

**TABLE OF CONTENTS (Continued)**

**Chapter XI - Medicine, Evaluation and Management Services (CPT  
Codes 90000 - 99999)**

A. Introduction	XI-1
B. Therapeutic or Diagnostic Infusions/Injections and Immunizations	XI-1
C. Psychiatric Services	XI-6
D. Biofeedback	XI-7
E. Dialysis	XI-7
F. Gastroenterology	XI-8
G. Ophthalmology	XI-8
H. Otorhinolaryngologic Services	XI-9
I. Cardiovascular Services	XI-11
J. Pulmonary Services	XI-17
K. Allergy Testing and Immunotherapy	XI-18
L. Neurology and Neuromuscular Procedures	XI-19
M. Central Nervous System Assessments/Tests	XI-21
N. Chemotherapy Administration	XI-22
O. Special Dermatological Procedures	XI-24
P. Physical Medicine and Rehabilitation	XI-25
Q. Medical Nutrition Therapy	XI-26
R. Osteopathic Manipulative Treatment	XI-26
S. Chiropractic Manipulative Treatment	XI-27
T. Miscellaneous Services	XI-27
U. Evaluation and Management (E&M) Services	XI-27
V. Medically Unlikely Edits (MUEs)	XI-32
W. General Policy Statements	XI-33

**TABLE OF CONTENTS (Continued)**

**Chapter XII - Supplemental Services (HCPCS Level II Codes**

**A0000 - V9999)**

A. Introduction	XII-1
B. Evaluation and Management (E&M) Services	XII-2
C. Medically Unlikely Edits (MUEs)	XII-3
D. General Policy Statements	XII-4
E. Specific Code Issues	XII-7

**Chapter XIII - Category III Codes (CPT Codes 0001T - 0299T)**

A. Introduction	XIII-1
B. Evaluation and Management (E&M) Services	XIII-1
C. Medically Unlikely Edits (MUEs)	XIII-3
D. General Policy Statements	XIII-4
E. Specific Code Issues	XIII-8

INTRO.doc  
Version 16.3

INTRODUCTION  
FOR  
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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 (A/B MACs processing practitioner service claims) so that the same service would be paid similarly in all carrier (A/B MAC processing practitioner service claims) 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.

NCCI edits are utilized by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) 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 (A/B MACs processing outpatient hospital service claims) 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 (A/B MACs processing outpatient hospital service claims) were also subject to NCCI edits in the OCE.

NCCI edits incorporated into OCE appear in OCE one calendar quarter after they appear in NCCI. Hospitals like physicians and other providers must code correctly even in the absence of NCCI or OCE edits. For example, new category I CPT codes are generally effective on January 1 each year, and many new edits for these codes appear in NCCI on January 1. However, the new edits for these codes do not appear in OCE until the following April 1. Hospitals must code correctly during the three month delay.

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 MACs processing practitioner service claims), A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Fiscal Intermediaries (FIs) A/B MACs processing outpatient hospital service claims).

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. If a provider determines that he/she has been coding incorrectly, the provider should contact his/her Carrier, Fiscal Intermediary, or MAC about potential payment adjustments.

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, 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' 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 (A/B MACs processing practitioner service claims) implement the versions effective January 1, April 1, July 1, and October 1. Medicare Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims) 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 (A/B MACs processing practitioner service claims) 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 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 77055LT plus 77055RT.
- 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 and MUE**

The CMS website contains:

- 1) *National Correct Coding Initiative Policy Manual for Medicare Services*  
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>);
- 2) NCCI edits utilized for practitioner claims  
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/>);
- 3) NCCI edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE)  
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/>);
- 4) NCCI Frequently Asked Questions (FAQ)  
(<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>);
- 5) MUE Overview  
([http://www.cms.hhs.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage));

- 6) MUE Frequently Asked Questions (FAQ)  
([http://www.cms.hhs.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage));
- 7) HCPCS/CPT codes with published MUE values in the Practitioner/DME Supplier MUE table  
([http://www.cms.hhs.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage));
- 8) HCPCS/CPT codes with published MUE values in the Hospital Outpatient Services MUE table  
([http://www.cms.hhs.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage));
- 9) Medicare Learning Network Publication: "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC"  
([http://www.cms.gov/MLNProducts/downloads/MCRP\\_Booklet.pdf](http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf)); and
- 10) Medicare Learning Network Publication: "How to Use the National Correct Coding Initiative (NCCI) Tools"  
(<http://www.cms.gov/MLNProducts/downloads/How-to-Use-NCCI-Tools.pdf>)

Sources of information about NCCI published by entities other than CMS or its NCCI contractor should not be relied upon for guidance about the NCCI or MUE in legal matters regarding the Medicare program.

### **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' policies on coding and NCCI.

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

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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 (A/B MACs processing practitioner service claims) 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.

In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

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 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 96360-96376

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 96360-96376).

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

Insertion of a central venous access device (e.g., central venous catheter, pulmonary artery catheter) requires passage of a catheter through central venous vessels and, in the case of a pulmonary artery catheter, through the right atrium and ventricle. These services often require the use of fluoroscopic guidance. Separate reporting of CPT codes for right heart catheterization, selective venous catheterization, or pulmonary artery catheterization is not appropriate when reporting a CPT code for insertion of a central venous access device. Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 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 96360-96376 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 96360-96376 for anesthesia services.

When anesthesia services are not separately reportable, physicians and facilities should not unbundle components of anesthesia and report them in lieu of an anesthesia code.

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. 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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.

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 completed procedure may be reported. For example, if a laparoscopic hysterectomy is converted to an open hysterectomy, only the open hysterectomy procedure code may be reported.

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 completed surgical procedure may be reported. The endoscopic procedure is not separately reportable with the completed surgical procedure.

13. Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operating room during the procedure or (2) if it occurs postoperatively and does not require return to the operating room. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.

#### **D. Evaluation 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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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.

#### **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: 27, 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 pairs 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 "Increased Procedural Services". This modifier should not be reported routinely but only when the service(s) performed is(are) substantially more extensive than the usual service(s) included in the procedure described by the HCPCS/CPT code reported.

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 (A/B MAC processing practitioner service claims) may then evaluate the unusual procedural service to determine whether additional payment is justified.

For example, CMS limits payment for CPT code 69990 (microsurgical techniques, requiring use of operating microscope...) to procedures listed in the Internet-Only Manual (IOM) (*Claims Processing Manual*, Pub. 100-4, 12-§20.4.5). If a physician reports CPT code 69990 with two other CPT codes and one of the codes is not on this list, an NCCI edit with the code not on the list will prevent payment for CPT code 69990. Claims processing systems do not determine which procedure is linked with CPT code 69990. In situations such as this, the physician may submit his claim to the local carrier (A/B MAC processing practitioner service claims) for readjudication appending modifier 22 to the CPT code. Although the carrier (A/B MAC processing practitioner service claims) cannot override an NCCI edit that does not allow use of NCCI-associated modifiers, the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

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 (A/B MAC processing practitioner service claims) 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 are 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 appended to the column two HCPCS/CPT code 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 treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of 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.

3. Modifiers 76 ("repeat procedure or service by same physician") and 77 ("repeat procedure by another physician") are not NCCI-associated modifiers. Use of either of these modifiers does not bypass an NCCI edit.

#### **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 procedure. For example, separate payment is not allowed for the physician's performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. However, Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by same physician performing a 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 procedure include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), intravenous infusion/injection

(CPT codes 96360-96368, 96374-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042). However, if these services are not related to the delivery of an anesthetic agent, or are not an inherent component of the procedure or global service, they may be reported separately.

#### **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 (A/B MACs processing practitioner service claims) 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 or a more specific modifier (e.g., anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service.

## **K. Family of Codes**

The *CPT 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 should 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) under most circumstances 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.

All practitioner claims submitted to Carriers (A/B MACs processing practitioner service claims), outpatient facility services claims (Type of Bill 13X, 14X, 85X) submitted to Fiscal Intermediaries (A/B MACs processing facility claims), and supplier claims submitted to Durable Medical Equipment (DME) MACs are tested against MUEs. Each line of a claim is adjudicated separately against the MUE value for 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.

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. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.

UOS denied based on an MUE may be appealed.

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

(1) Anatomic considerations may limit units of service based on anatomic structures. For example, the MUE value for an appendectomy is one since there is only one appendix.

(2) CPT code descriptors/CPT coding instructions in the *CPT Manual* may limit units of service. For example, a procedure described as the "initial 30 minutes" would have an MUE value 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 units of service 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 unit of service for a single date of service can be determined. For example, the MUE for RBC folic acid level is one since the test would only be necessary once on a single date of service.

(5) The nature of a procedure/service may limit units of service 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 units of service 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.

(8) Submitted claims data (100%) from a six month period is utilized.

HCPCS J code and drug related C and Q code MUEs are based on prescribing information and 100% claims data for a six month period of time. Utilizing the prescribing information the highest total daily dose for each drug was determined. This dose and its corresponding units of service were evaluated against paid and submitted claims data. Some of the guiding principles utilized in developing these edits are as follows:

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

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

(3) For "as needed" (PRN) drugs and drugs where maximum daily dose is based on patient response, prescribing information and claims data were utilized to establish MUE values.

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

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.

Some A/B MACs allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the "from date" and "to date" on the claim line. Contractors are instructed to divide

the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line.

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

A denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier may not issue an Advanced Beneficiary Notice of Noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

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

Most MUE values are published on the CMS MUE webpage ([http://www.cms.hhs.gov/NationalCorrectCodInitEd/08\\_MUE.asp#TopOfPage](http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage)). However, some MUE values are not published and are confidential. These values should not be published in oral or

written form by any party that acquires one or more of them.

MUEs are not utilization edits. Although the MUE value for some codes may represent the commonly reported units of service (e.g., MUE of "1" for appendectomy), the usual units of service for many HCPCS/CPT codes is less than the MUE value. Claims reporting units of service less than the MUE value may be subject to review by claims processing contractors, Program Safeguard Contractors (PSCs), Zoned Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs), and Department of Justice (DOJ).

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

A provider, supplier, healthcare organization, or other interested party may request reconsideration 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

CHAP 2.doc  
Version 16.3

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 description of a surgical intervention. CPT codes 01916-01933 describe anesthesia for diagnostic or interventional radiology procedures. Several CPT codes (01951-01999, excluding 01996) 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 base 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 (i.e., when the patient may be placed safely under postoperative care). 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

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 anesthesia practitioner 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 including, but not limited to, those for cardiac monitoring, oximetry, capnography, temperature monitoring, EEG, CNS evoked responses (e.g., BSER), doppler flow.
- Placement of peripheral intravenous lines for fluid and medication administration.
- Placement of airway (e.g., endotracheal tube, orotracheal tube).
- Laryngoscopy (direct or endoscopic) for placement of airway (e.g., endotracheal tube).
- Placement of naso-gastric or oro-gastric tube.
- Intra-operative interpretation of monitored functions (e.g., blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (e.g., arterial blood gases such as pH, pO<sub>2</sub>, pCO<sub>2</sub>, bicarbonate, CBC, blood chemistries, lactate) 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 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 describe diagnostic or surgical services.)
- 31622, 31645, 31646 (Bronchoscopy)
- 36000, 36010-36015 (Introduction of needle or catheter)
- 36400-36440 (Venipuncture and transfusion)
- 62310-62311, 62318-62319 (Epidural or subarachnoid injections of diagnostic or therapeutic substance)

CPT codes 62310-62311 and 62318-62319 (Epidural or subarachnoid injections of diagnostic or therapeutic substance) may be reported on the date of surgery if performed for postoperative pain management 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 agent, CPT codes 62310-62319 should not be reported. Modifier 59 may be reported to indicate that the injection was performed for postoperative pain management, and a procedure note should be included in the medical record.

Pain management performed by an anesthesia practitioner after the postoperative anesthesia care period terminates may be separately reportable. However, postoperative pain management by the physician performing a surgical procedure is not separately reportable by that physician. Postoperative pain management is included in the global surgical package.

Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesia practitioner reports CPT code 01382 (Anesthesia for diagnostic arthroscopic procedures of knee joint). The epidural catheter is left in place for postoperative pain management. The anesthesia practitioner should not also report CPT codes 62311 or 62319 (epidural/subarachnoid 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 anesthesia practitioner performed general anesthesia reported as CPT code 01382 and at the request of the operating physician inserted an epidural catheter for treatment of anticipated postoperative pain, the anesthesia practitioner may report CPT code 62319-59 indicating that this is a separate service from the anesthesia service. In this instance, the service is separately reportable whether the catheter is placed before, during, or after the surgery. Since treatment of postoperative pain is included in the global surgical package, the operating physician may request the assistance of the anesthesia practitioner if the degree of postoperative pain is expected to exceed the skills and experience of the operating physician to manage it. 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.

- 64400-64530 (Nerve blocks)

CPT codes 64400-64530 (Nerve blocks) may be reported on the date of surgery if performed for postoperative pain management 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 agent, CPT codes 62310-62319 should not be reported. Modifier 59 may be reported to indicate that the injection was performed for postoperative

pain management, and a procedure note should be included in the medical record.

- 67500 (Retrobular injection)
- 81000-81015, 82013, 82205, 82270, 82271(Performance and interpretation of laboratory tests)
- 91000, 91055, 91105 (Esophageal, gastric intubation)
- 92511-92520, 92543 (Special otorhinolaryngologic services)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960, 92961 (Cardioversion)
- 93000-93010 (Electrocardiography)
- 93040-93042 (Electrocardiography)
- 93303-93308 (Transthoracic echocardiography when utilized for monitoring purposes) However, when performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service.
- 93312-93317 (Transesophageal echocardiography when utilized for monitoring purposes) However, when performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service.
- 93318 (Transesophageal echocardiography for monitoring purposes)
- 93561-93562 (Indicator dilution studies)
- 93701 (Thoracic electrical bioimpedance)
- 93922-93981 (Extremity or visceral arterial or venous vascular studies) When performed diagnostically with a formal report, this service may be considered a significant, separately identifiable, and if medically necessary, a separately reportable service.
- 94640(Inhalation/IPPB treatments)

- 94002-94004, 94660-94662 (Ventilation management/CPAP services) If these services are performed during a surgical procedure, they are included in the anesthesia service. These services may be separately reportable if performed by the anesthesia practitioner after post-operative care has been transferred to another physician by the anesthesia practitioner. Modifier 59 may be reported to indicate that these services are separately reportable. For example, if an anesthesia practitioner who provided anesthesia for a procedure initiates ventilation management in a post-operative recovery area prior to transfer of care to another physician, CPT codes 94002-94003 should not be reported for this service since it is included in the anesthesia procedure package. However, if the anesthesia practitioner transfers care to another physician and is called back to initiate ventilation because of a change in the patient's status, the initiation of ventilation may be separately reportable.
- 94664 (Inhalations)
- 94680-94690, 94770 (Expired gas analysis)
- 94760-94762 (Oximetry)
- 96360-96376 (Drug administration)
- 99201-99499 (Evaluation and management)

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

5. Several nerve block CPT codes (e.g., 62318-62319 (epidural or subarachnoid), 64416 (brachial plexus), 64446 (sciatic nerve), 64448 (femoral nerve), 64449 (lumbar plexus)) describe "continuous infusion by catheter (including catheter placement)". Two epidural/subarachnoid injection CPT codes 62318-61319 describe continuous infusion or intermittent bolus injection including placement of catheter. If an anesthesia practitioner places a catheter for continuous infusion epidural/subarachnoid or nerve block for intraoperative pain management, the service is included in the 0XXXX anesthesia procedure and is not separately reportable on the same date of service as the anesthesia 0XXXX code even if it is also utilized for postoperative pain management.

Per CMS Global Surgery rules postoperative pain management is a component of the global surgical package and is the responsibility of the physician performing the global surgical procedure. If the physician performing the global surgical procedure does not have the skills and experience to manage the postoperative pain and requests that an anesthesia practitioner assume the postoperative pain management, the anesthesia practitioner may report the additional services performed once this responsibility is transferred to the anesthesia practitioner. Pain management services subsequent to the date of insertion of the catheter for continuous infusion may be reported with CPT code 01996 for epidural/subarachnoid infusions and with evaluation and management codes for nerve block continuous infusions.

### **C. Radiologic Anesthesia Coding**

Medicare's anesthesia billing guidelines allow only one anesthesia code to be reported for anesthesia services provided in conjunction with radiological procedures. Radiological Supervision and Interpretation (RS&I) codes may be applicable to radiological procedures being performed.

The appropriate RS&I code may be reported by the appropriate provider (e.g., radiologist, cardiologist, neurosurgeon, radiation oncologist). The RS&I codes are not included in anesthesia codes for these procedures.

Since Medicare anesthesia rules, with one exception, do not permit the physician performing a surgical or diagnostic procedure to separately report anesthesia for the procedure, the RS&I code(s) should not be reported by the same physician reporting the anesthesia service. Medicare rules allow physicians performing a surgical or diagnostic procedure to separately report medically reasonable and necessary moderate conscious sedation with a procedure unless the procedure is listed in Appendix G of the *CPT Manual*.

If a physician performing a radiologic procedure inserts a catheter as part of that procedure, and through the same site a catheter is utilized for monitoring purposes, it is inappropriate for either the anesthesia practitioner or the physician performing the radiologic procedure to separately report 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, or 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 includes the intraoperative monitoring by an anesthesia practitioner of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse reaction to the surgical procedure. It also includes the performance of a pre-anesthesia evaluation and examination, prescription of the anesthesia care, administration of necessary oral or parenteral medications, and provision of indicated postoperative anesthesia care.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)) may be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable.

Issues of medical necessity are addressed by national CMS policy and local contractor coverage policies.

#### **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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. Physicians should not report drug administration CPT codes 96360-96376 for anesthetic agents or other drugs administered between the patient's arrival at the operative center and discharge from the post-anesthesia care unit.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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 (A/B MAC processing practitioner service claims). 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. 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.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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 procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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.

CPT codes 64450 (injection, anesthetic agent; other peripheral nerve or branch) and 64455 (injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)) should not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately.

In the postoperative period, patients treated with epidural or subarachnoid continuous drug administration may require daily hospital adjustment/management of the catheter, dosage, etc., (CPT code 01996). This service may be reported by the anesthesia practitioner. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global period services associated with the operative procedure. If the only surgery performed is placement of an epidural or subarachnoid catheter for continuous drug administration, CPT code 01996 may be reported on subsequent days by the managing physician.

#### **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 completed 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.
3. The unit of service for fine needle aspiration (CPT codes 10021 and 10022) is the separately identifiable lesion. If a physician performs multiple "passes" into the same lesion to obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for separate aspiration(s) of a distinct separately identifiable lesion.

## **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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. 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.

5. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

6. 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.

7. 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.

8. 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.

9. 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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.

10. 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 (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

11. 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.

12. 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.

13. 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.

14. 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.

15. Most NCCI edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to

bypass the edit. The existence of the NCCI edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

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

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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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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 procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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.

CPT codes 64450 (injection, anesthetic agent; other peripheral nerve or branch) and 64455 (injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)) should not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately.

#### **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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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. Arthroscopy**

1. Surgical arthroscopy includes diagnostic arthroscopy which is not separately reportable. If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient encounter, only the surgical arthroscopy may be reported.

2. If an arthroscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not

separately reportable. If the findings of a diagnostic arthroscopy leads to the decision to perform an open procedure, the diagnostic arthroscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic arthroscopy and non-arthroscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic arthroscopy.

3. If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code should be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.

#### **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. If an ankle fracture or dislocation repair is stabilized with a strapping, the ankle fracture or dislocation repair CPT code should not be reported with a strapping code such as CPT code 29581 (application of multi-layer venous wound compression system, below knee) even if the strapping simultaneously treats another problem such as edema or a venous stasis ulcer. Fracture and dislocation CPT codes include the initial casting, strapping, or splinting.

4. CPT codes for closed, percutaneous, 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.

5. 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.

6. 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.

7. 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.

8. 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 revision of an open fracture repair for nonunion or malunion of bone 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.

9. 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).

10. 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.

11. 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.

12. 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.

13. When a fracture or dislocation is repaired, only one fracture/dislocation repair code may be reported. Closed repair codes, percutaneous repair codes, and open repair codes for the same anatomic site are mutually exclusive of one another, and only one of these codes may be reported for the repair of a fracture or dislocation at an anatomic site.

#### **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.

3. The code descriptors for CPT codes 20670 (removal of implant; superficial...) and 20680 (removal of implant; deep...) do not define the unit of service. CMS allows one unit of service for all implants removed from an anatomic site. This single unit of service includes the removal of all screws, rods, plates, wires, etc. from an anatomic site whether through one or more surgical incisions. An additional unit of service may be reported only if implant(s) are removed from a distinct and separate anatomic site.

4. The MUE values for CPT codes 20931 (allograft for spine surgery only . . .), 20937 (autograft for spine surgery only . . .; morselized . . .), and 20938 (autograft for spine surgery only . . .: structural . . .) are one (1). Each of these codes may be reported with only one unit of service per operative procedure regardless of the number of vertebral levels fused.

## **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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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 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.

10. 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.

11. 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.

12. 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.

13. Spinal arthrodesis, exploration, and instrumentation procedures (CPT codes 22532-22865) and other spinal procedures 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.

14. Many spinal procedures are grouped into a family of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within the same family of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. For these types of spinal procedures, a provider should report only one primary code within the family of codes for one level and should report additional levels utilizing the add-on code(s) in the family of codes.

15. Fluoroscopy reported as CPT codes 76000 or 76001 should not be reported with spinal procedures unless there is a specific *CPT Manual* instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure.

16. CPT codes 28288, 28306, 28307, 28310, and 28315 should not be reported with bunionectomy CPT codes 28290-28299 for procedures performed on the ipsilateral first toe or metatarsal. CPT codes 28306, 28307, and 28310 (osteotomy procedures) should not be reported with a bunionectomy code because there are bunionectomy codes that include osteotomy of the first metatarsal

or proximal phalanx of the first toe. CPT code 28288 (ostectomy ...) should not be reported with a bunionectomy code because it is a misuse of this code to report ostectomy of the median eminence of the metatarsal bone which is integral to the bunionectomy procedure. Additionally, some bunionectomy procedures include excision of the head of the first metatarsal. CPT code 28315 (sesamoidectomy, first toe (separate procedure)) includes the "separate procedure" designation in its code descriptor. CMS payment policy does not allow separate payment for a procedure designated as a "separate procedure" when performed along with another procedure in the same anatomic area.

17. CPT codes 28008, 28060, 28062, 28250 and 29893 describe procedures that may be performed on plantar fascia. No two codes from this group should be reported for treatment of plantar fascia of the ipsilateral foot at the same patient encounter.

18. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of arthroscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an arthroscopic procedure.

19. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose

unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

20. 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.

21. 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.

22. 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.

23. 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 (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

24. 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.

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

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

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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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same

date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. 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 an 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 whether it is limited ("cursory") or complete.

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 decision to perform 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, assess extent of disease, 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. Neither the surgical endoscopy nor diagnostic endoscopy code should be reported with the open procedure code when a surgical endoscopy is converted to an 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 fails 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 diagnostic thoracoscopy (CPT codes 32601, 32602, 32605, 32606) is not separately reportable with a surgical thoracoscopy on the ipsilateral side of the thorax.

A diagnostic thoracoscopy to assess the surgical field or extent of disease prior to an open thoracotomy, thoracostomy, or mediastinal procedure is not separately reportable. However, a diagnostic thoracoscopy is separately reportable with an open thoracotomy, thoracostomy, or mediastinal procedure if the findings of the diagnostic thoracoscopy lead to the decision to perform an open thoracotomy, thoracostomy, or mediastinal procedure. Modifier 58 may be reported to indicate that the diagnostic thoracoscopy and open procedure were staged or planned.

If a surgical thoracoscopy is converted to an open thoracotomy, thoracostomy, or mediastinal procedure, the surgical thoracoscopy is not separately reportable. Additionally a diagnostic thoracoscopy should not be reported in lieu of the surgical thoracoscopy with the open thoracotomy, thoracostomy, or mediastinal procedure. Neither a surgical thoracoscopy nor diagnostic thoracoscopy code should be reported with the open thoracotomy, thoracostomy, or mediastinal procedure code when a surgical thoracoscopy is converted to an open procedure.

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. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

14. The procedures described by CPT codes 30801 and 30802 (cautery and/or ablation of mucosa of inferior turbinates) are performed to reduce the size of the inferior turbinates of the nose. These two codes should not be reported for access to the nose or sinuses or for control of intraoperative bleeding with other codes describing nasal or sinus endoscopy or other nasal procedures. Since the procedure described by CPT code 30802 (intramural, unilateral or bilateral) is more extensive than the procedure described by CPT code 30801 (superficial, unilateral or bilateral), both codes should not be reported for the same patient encounter.

#### **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, intervacular 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 a failed 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 completed 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 96360-96361 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. If a physician attempts a graft with one material but completes the graft with another material, only the one code describing the completed procedure should be reported.

15. Bypass grafts (CPT codes 35500-35683) include blood vessel repair. CPT codes 35201-35286 (direct repair, repair with vein graft, and repair with graft other than vein) should not be reported with a bypass graft code for the same anatomic site.

16. 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 completed procedure, generally the more extensive open procedure, may be reported.

17. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the more comprehensive atherectomy that was performed (generally the open procedure) should be reported (see sequential procedure policy, Chapter I, Section M). Effective January 1, 2011 there are new lower extremity endovascular revascularization procedure CPT codes which include in single codes various combinations of angioplasty, atherectomy, and/or placement of stent(s). In addition effective January 1, 2011, Category I CPT codes for atherectomy of vessels in other anatomic sites are deleted and replaced by Category III CPT codes.

18. 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.

19. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (CPT codes 33202-33249) 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 (e.g., CPT codes 76000, 76001) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures (e.g., CPT code 71090 for fluoroscopy during insertion of a pacemaker) may be reported separately. Additionally, 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 CPT codes 33200-33249 or 93600-93662.

20. Electronic analysis (i.e., interrogation and programming) is integral to the insertion or replacement of a pacemaker or cardioverter-defibrillator pulse generator. The interrogation and programming codes should not be reported separately.

21. CPT code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type...) describes an arterial infusion directly into an artery of a non-chemotherapeutic medication to treat the artery for disease (e.g., vasospasm) other than thrombolysis. This code should not be utilized to report intravenous infusions, arterial push injections (CPT code 96373), or chemotherapy infusions. It should not be reported for infusion for systemic therapy. This code should not be reported for infusion into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is

already in the blood vessel. This code may be reported separately when a catheter is inserted into a blood vessel for the purpose of the transcatheter therapy of the blood vessel. CPT code 75896 (Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation) may be reported for the radiological supervision and interpretation associated with the transcatheter therapy described by CPT code 37202.

Similarly CPT code 37201 (Transcatheter therapy, infusion for thrombolysis other than coronary) may be reported when a blood vessel is catheterized for the purpose of transcatheter infusion for thrombolysis of a non-coronary vessel. It should not be reported for infusion of a thrombolytic agent into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. CPT code 75896 may be reported for the radiological supervision and interpretation associated with the transcatheter therapy described by CPT code 37201.

22. 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.

23. 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.

24. 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.

25. 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...).

26. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan Ganz)) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569 (insertion of peripherally inserted central venous catheter) for the insertion of a single catheter. If a physician does not complete the insertion of one type of catheter and subsequently inserts another at the same patient encounter, only the completed procedure may be reported.

27. CPT codes 33203, 33265, and 33266 describe surgical endoscopic procedures (CPT code 33203 - insertion of epicardial electrodes; CPT codes 33265, 33266 - operative tissue ablation). CPT codes 32603 and 32604 describe diagnostic thoracoscopy of the pericardial sac. Since surgical endoscopy includes diagnostic

endoscopy, CPT codes 32603/32604 should not be reported separately with CPT codes 33203/33265/33266 for the same patient encounter.

28. If an ascending aorta graft procedure (CPT codes 33860-33864) extends anatomically into the transverse aortic arch proximal to the origin of the brachiocephalic artery, CPT code 33870 (transverse arch graft . . .) should not be reported separately.

29. Effective January 1, 2010 CMS discontinued use of HCPCS codes G0392 and G0393 to report percutaneous transluminal balloon angioplasty for maintenance of a hemodialysis access. CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) may be reported with one unit of service for percutaneous transluminal balloon angioplasty of all lesions in the venous outflow vessel of a hemodialysis access defined as the "vessel" originating at the arterial anastomosis through the venous outflow tract to the subclavian vein. CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) may be reported with one unit of service for percutaneous transluminal balloon angioplasty of all lesions in the arterial inflow tract.

30. Replacement of a ventricular assist device (VAD) includes removal of the old pump, insertion of a new pump, and initiation of the new pump. CPT codes describing implantation (insertion) or removal of a VAD should not be reported separately with a CPT code describing replacement of a VAD.

31. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. The chest radiologic examination is integral to the procedure, and a chest radiologic examination (e.g., CPT codes 71010, 71020) should not be reported separately.

#### **E. Hemic and Lymphatic Systems**

1. 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.

2. CPT code 38747 (abdominal lymphadenectomy, regional, including celiac, gastric, portal, peripancreatic, with or without para-aortic and venal caval nodes . . .) should not be reported for the excision of lymph nodes that are in the operative field of another surgical procedure. For example CPT code 38747 should not be reported for the excision of lymph nodes in the operative field of a gastrectomy, pancreatectomy, hepatectomy, colectomy, enterectomy, or nephrectomy.

3. If an iatrogenic laceration of the spleen occurs during the course of another procedure, repair of the laceration with or without splenectomy is not separately reportable. Treatment of an iatrogenic complication of surgery such as a splenic laceration is not a separately reportable service. For example if an iatrogenic laceration of the spleen occurs during an enterectomy, colectomy, gastrectomy, pancreatectomy, or nephrectomy procedure, the physician should not separately report a splenectomy CPT code (e.g., 38100, 38101, 38120).

## **F. Mediastinum**

1. CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with "exploration, drainage, removal of foreign body, or biopsy". Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 should not be reported separately for exploration of the mediastinum when performed with procedures on mediastinal structures (e.g., esophagus, bronchi, aorta, heart) or structures accessed through the mediastinum (e.g., lungs, vertebrae). These codes may be reported separately if mediastinal drainage, removal of foreign body, or biopsy is performed.

## **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.

3. If CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) is reported for percutaneous transluminal balloon angioplasty of one or more lesions in the venous outflow vessel of a hemodialysis access defined as the "vessel" originating at the arterial anastomosis through the venous outflow tract to the subclavian vein, it should be reported with only one (1) unit of service.

If CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) is reported for percutaneous transluminal balloon angioplasty of one or more lesions in the arterial inflow tract of a hemodialysis access, it should be reported with only one (1) unit of service.

## **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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

5. 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.

6. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical

procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

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

8. 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.

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

10. 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable

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.

11. 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 (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

12. 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.

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

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

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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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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.

The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. 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 96360-96376), 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 fails and is followed by an endoscopic esophageal dilation procedure, only the endoscopic esophageal dilation procedure may be reported. The physician should not report the failed 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 H (General Policy Statements) (#19).

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. Neither a surgical endoscopy nor diagnostic endoscopy procedure code should be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

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.

16. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

#### **D. Esophageal Procedures**

1. CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with "exploration, drainage, removal of foreign body, or biopsy". Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 should not be reported separately for exploration of the mediastinum when performed with an esophageal procedure. These codes may be reported separately if mediastinal drainage, removal of foreign body, or biopsy is performed. However, these codes should not be reported separately for removal of foreign body with CPT code 43020 (esophagotomy, cervical approach, with removal of foreign body) or CPT code 43045 (esophagotomy, thoracic approach, with removal of foreign body).

#### **E. Abdominal Procedures**

1. 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.

2. 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.

3. A medically necessary appendectomy may be reported separately. However, an incidental appendectomy of a normal

appendix during another abdominal procedure is not separately reportable.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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 (A/B MAC processing practitioner service claims) will determine whether additional payment is appropriate.

9. If an iatrogenic laceration/perforation of the small or large intestine occurs during the course of another procedure, repair of the laceration/perforation is not separately reportable. Treatment of an iatrogenic complication of surgery such as an intestinal laceration/perforation is not a separately reportable service. For example CPT codes describing suture of the small intestine (CPT codes 44602, 44603) or suture of large intestine (CPT codes 44604, 44605) should not be reported for repair of an intestinal laceration/perforation during an enterectomy, colectomy, gastrectomy, pancreatectomy, hysterectomy, or oophorectomy procedure.

10. A Whipple type pancreatectomy procedure (CPT codes 48150-48154) includes removal of the gallbladder. A cholecystectomy (e.g., CPT codes 47562-47564, 47600-47620) should not be reported separately.

11. If closure of a fistula requires excision of a portion of an organ into which the fistula passes, excision of that tissue should not be reported separately. For example, if closure of an enterocolic fistula requires removal of a portion of adjacent small intestinal tissue and a portion of adjacent colonic tissue, closure of the enterocolic fistula (CPT code 44650) includes the removal of the small and large intestinal tissue. The excision of the small intestinal or colonic tissue should not be reported separately.

#### **F. Laparoscopy**

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

4. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

5. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

6. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all laparoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with a laparoscopic procedure.

#### **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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with

the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. 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.

5. 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.

6. 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.

7. 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).

8. 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.

9. 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.

10. 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.

11. If a physician must drain an abscess in order to complete a sialolithotomy procedure, the drainage of the abscess is not separately reportable. If a definitive surgical procedure requires access through diseased tissue, treatment of the diseased tissue for this access is not separately reportable.

12. 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).

13. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

14. CPT codes 43770-43774 describe laparoscopic gastric restrictive procedures. Only one of these procedure codes may be reported for a single patient encounter. If a patient develops a complication during the postoperative period of the initial procedure requiring return to the operating room for a different laparoscopic gastric restrictive procedure to treat the complication, the second procedure should be reported with modifier 78.

15. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

16. 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.

17. 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.

18. 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.

19. 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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.

20. 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 (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

21. 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.

22. 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.

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

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

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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.

The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. 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.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. Urinary System**

1. Insertion of a urinary bladder catheter is a component of the global surgical package. Urinary bladder catheterization (CPT codes 51701, 51702, and 51703) is not separately reportable with a surgical procedure when performed at the time of or just prior to the procedure.

Additionally, many procedures involving the urinary tract include the placement of a urethral/bladder catheter for postoperative drainage. Because this is integral to the procedure, placement of a urinary catheter is not separately reportable.

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

3. Some lesions of the genitourinary tract occur at mucocutaneous borders. The *CPT Manual* contains integumentary system (CPT codes 10000-19999) and genitourinary system (CPT codes 50000-59899) codes to describe various procedures such as biopsy, excision, or destruction. A single code from one of these two sections of the *CPT Manual* that best describes the biopsy, excision, destruction, or other procedure performed on

one or multiple similar lesions at a mucocutaneous border should be reported. Separate codes from the integumentary system and genitourinary system sections of the *CPT Manual* may only be reported if separate procedures are performed on completely separate lesions on the skin and genitourinary tract. Modifier 59 should be utilized to indicate that the procedures are on separate lesions. The medical record should accurately describe the precise locations of the lesions.

4. If an irrigation or drainage procedure is necessary and integral to complete a genitourinary or other procedure, only the more extensive procedure should be reported. The irrigation or drainage procedure is not separately reportable.

5. The CPT code descriptor for some genitourinary procedures includes a hernia repair. A HCPCS/CPT code for a hernia repair is not separately reportable unless the hernia repair is performed at a different site through a separate incision. In the latter case, the hernia repair may be reported with modifier 59.

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 fails and is followed by an alternative approach, only the completed or last uncompleted approach may be reported.

7. If a diagnostic endoscopy leads to the performance of a laparoscopic or open procedure, the diagnostic endoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic endoscopy and non-endoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic endoscopy. However, if an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reportable. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a separate diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be reported separately with a diagnostic or surgical endoscopy code.

8. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical endoscopy nor a diagnostic endoscopy code should be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

9. Surgical endoscopy includes diagnostic endoscopy which is not separately reportable. If a diagnostic endoscopy leads to a surgical endoscopy at the same patient encounter, only the surgical endoscopy may be reported.

10. When multiple endoscopic procedures are performed at the same patient encounter, the most comprehensive code accurately describing the service(s) performed should be reported. If several procedures not included in a more comprehensive code are performed at the same endoscopic session, multiple HCPCS/CPT codes may be reported with modifier 51. (For example, if renal endoscopy is performed through an established nephrostomy with biopsy, fulguration of a lesion, and foreign body (calculus) removal, the appropriate CPT coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.) This policy applies to all endoscopic procedures, not only those of the genitourinary system.

11. CPT code 51700 (bladder irrigation, simple, lavage and/or instillation) is used to report irrigation with therapeutic agents or as an independent therapeutic procedure. It is not separately reportable if bladder irrigation is part of a more comprehensive service such as to gain access to or visualize the urinary system. Irrigation of a urinary catheter is included in the global surgical package. CPT code 51700 should not be misused to report irrigation of a urinary catheter.

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

13. 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 at the same patient encounter are medically reasonable and necessary (e.g., renal endoscopy through a nephrostomy and cystourethroscopy) to perform different procedures, they may be separately reported appending modifier 51 to the less extensive procedure codes. However, when multiple endoscopic approaches are utilized to attempt the same procedure, only the completed approach should be reported.

14. Endoscopic procedures include all minor related functions performed at the same encounter. Although CPT codes may exist to describe these functions, they should not be reported separately. For example, transurethral resection of the prostate includes meatotomy, urethral calibration and/or dilation, urethroscopy, and cystoscopy. Codes for the included procedures should not be reported separately.

15. When urethral catheterization or urethral dilation (e.g., CPT codes 51701-51703) is necessary to complete a more extensive procedure, the urethral catheterization/dilation is not separately reportable.

16. Ureteral anastomosis procedures are described by CPT codes 50740-50825, and 50860. In general, they represent mutually exclusive procedures that are not reported together. If one type of anastomosis is performed on one ureter, and a different type of anastomosis is performed on the contralateral ureter, the appropriate modifier (e.g., LT, RT) should be reported with the CPT code to describe the service performed on each ureter. For example, the procedure described by CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive with the procedures described by CPT codes 50800-50830 (e.g., ureteroenterostomy, ureterocolon conduit, urinary undiversion) unless performed on contralateral ureters in which case anatomic modifiers should be reported.

17. 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.

18. 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.

19. 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 52320-52330, 52334-52355). 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.

20. 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.

21. 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.

22. The code descriptors for CPT codes 52310 and 52315 (cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure)...) include the "separate procedure" designation. Per CMS payment policy for procedures with the "separate procedure" designation, these codes should not be reported with other cystourethroscopy CPT codes for the same patient encounter.

23. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

24. Cystourethroscopy and transurethral procedures include fluoroscopy when performed. CPT codes describing fluoroscopy or fluoroscopic guidance (e.g. 76000, 76001, 77002) should not be reported separately with a cystourethroscopy or transurethral procedure CPT code.

25. A ureteral stent is commonly inserted at the site of an anastomosis of a ureter and another structure in order to maintain patency of the ureter. A ureteral stent is also often inserted into a ureter if the ureter is incised during a procedure (e.g., nephrectomy, cystectomy, ureteral anastomosis). With these procedures, insertion of the ureteral stent is integral to the procedure and is not separately reportable. For example, CPT code 50605 (Ureterotomy for insertion of indwelling stent, all types) should not be reported with CPT codes describing cystectomy, urinary diversion, or ureteral anastomosis for insertion of a ureteral stent to maintain patency at the site of a ureteral anastomosis.

#### **D. Male Genital System**

1. Transurethral drainage of a prostatic abscess (e.g., CPT code 52700) is included in male transurethral prostatic procedures and should not be 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 (e.g., scrotum, vas deferens) and in inguinal hernia repairs and should not be reported separately.

3. The *CPT Manual* contains many codes (CPT codes 52601-52649, 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.

4. Scrotal exploration (CPT code 55110) is not separately reportable with procedures of the scrotum, scrotal sac, or its contents including the testes and epididymes. Exploration of the surgical field is not separately reportable.

## **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 reportable. A diagnostic pelvic examination may be performed for the purpose of deciding to perform a procedure. 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 CPT codes 38120, 38570-38572, 43280, 43651-43653, 44180-44227, 44970, 47560-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, and 60650. CPT code 58555 is included in CPT codes 58558-58565.

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

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

5. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a "scout" procedure to confirm a 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 separately with modifier 58. Diagnostic colposcopies (CPT codes 56820, 57420, 57452) are not separately reportable with other colposcopic procedures.

## **F. Laparoscopy**

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

4. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

5. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

6. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all laparoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with a laparoscopic procedure.

## **G. Maternity Care and Delivery**

1. The total obstetrical packages (e.g., CPT codes 59400 and 59510) include antepartum care, the delivery, and postpartum care. They do not include other services such as ultrasound, amniocentesis, special screening tests for genetic disorders, visits for unrelated conditions (incidental to pregnancy), or additional frequent visits due to high risk conditions.

2. 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 separately reportable.

3. Antepartum care includes urinalysis which is not separately reportable.

#### **H. 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.

## I. 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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure

pain management, the drug administration service (CPT codes 96360-96375) 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the

time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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 (e.g., 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. 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.

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

encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

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

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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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. Nervous System**

1. A burr hole is often necessary for intracranial surgery (e.g., craniotomy, craniectomy) to access intracranial contents, to alleviate pressure, or to place an intracranial pressure monitoring device. When this service is integral to the performance of other services, CPT codes describing this services are not separately reportable if performed at the same patient encounter. A burr hole is separately reportable with another cranial procedure only if performed at a separate site unrelated to the other cranial procedure or at a separate patient encounter on the same date of service.

In addition, taps, punctures, or burr holes accompanied by drainage procedures (e.g., hematoma, abscess, cyst, etc.) followed by other procedures are not separately reportable unless performed as staged procedures. Modifier 58 may be reported 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. An exploratory craniectomy or craniotomy (CPT code 61304 or 61305) should not be reported separately with another craniectomy/craniotomy procedure performed at the same anatomic site and same patient encounter.

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. If two procedures are performed at the same anatomic site and same patient encounter, one procedure may be bundled into the other. (e.g., one procedure may be integral to the other.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters, they may be separately reportable. Modifier 59 may be reported to indicate that the two procedures are distinct and separately reportable services under these circumstances.

Example: A patient with an open head injury and a contre-coup subdural hematoma requires an exploratory craniectomy for the open head injury and a burr hole drainage on the contralateral side for a subdural hematoma. The creation of a burr hole at the site of the exploratory craniectomy would be considered integral to the craniectomy. However, the contralateral burr hole drainage is a separate service not integral to the exploratory craniectomy. To correctly report the burr hole drainage for the contralateral subdural hematoma and the exploratory craniectomy, the burr hole should be reported with the appropriate modifier (e.g., 59, RT, LT). In this example the correct coding would be CPT codes 61304 (exploratory craniectomy) with one unit of service and 61154-59 (burr hole with drainage of subdural hematoma) with one unit of service.

6. The use of general intravascular access devices (e.g., intravenous lines), cardiac monitoring, oximetry, laboratory sample procurement, and other routine monitoring for patient safety during general anesthesia, monitored anesthesia care (MAC), or other anesthesia are included in the anesthesia service and are not separately reportable. For example, if a physician performing a spinal puncture for intrathecal injection administers an anxiolytic agent, the vascular access and any appropriate monitoring is considered part of the spinal puncture procedure and is not separately reportable.

7. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure. The reporting of nerve block or facet block CPT codes for anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate.

8. If cerebrospinal fluid is withdrawn during a nerve block procedure, the withdrawal is not separately reportable (e.g., diagnostic lumbar puncture). It is integral to the nerve block procedure.

9. 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.

10. 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. The procedure coded as CPT code 64721 includes the procedure coded as CPT code 29848 when performed on 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.

11. Nerve repairs by suture (neurorrhaphies) (CPT codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury or anastomosis of nerves which are proximally associated (e.g., facial-spinal accessory, facial-hypoglossal, etc.). When neurorrhaphy is performed with a nerve graft (CPT codes 64885-64911), neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., the neurorrhaphy is integral to the procedure and is not separately reportable.

12. Implantation of neurostimulator electrodes in an area of the cerebral cortex may not be reported with two codes describing different approaches. CPT code 61860 describes implantation by craniectomy or craniotomy. CPT code 61850 describes implantation by twist drill or burr hole(s).

13. CPT codes 61885, 61886, and 63685 describe "insertion or replacement" of cranial or spinal neurostimulator pulse generators or receivers. CPT codes 61888 and 63688 describe "revision or removal" of cranial or spinal neurostimulator pulse generators or receivers. If the same pulse generator is removed

and replaced into the same or another skin pocket, the "removal" CPT code is not separately reportable with the "replacement" CPT code. However, if one pulse generator is removed and replaced with a different pulse generator into the same or another skin pocket, the "removal" CPT code may be separately reportable with the "replacement" CPT code.

14. Because procedures necessary to perform a column one coded procedure are included in the column one coded procedure, column two CPT codes such as 62310-62311, 62318-62319 (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive spinal/back procedures.

15. A laminectomy includes excision of all the posterior vertebral components, and a laminotomy includes partial excision of posterior vertebral components. Since a laminectomy is a more extensive procedure than a laminotomy, a laminotomy code should not be reported with a laminectomy code for the same vertebra. CPT codes 22100-22103 (partial excision of posterior vertebral component (e.g., spinous process, lamina, or facet) for intrinsic bony lesion) are not separately reportable with laminectomy or laminotomy procedures for the same vertebra.

16. Some spinal procedures may require manipulation of the spine which is integral to the procedure. CPT code 22505 (Manipulation of the spine requiring anesthesia, any region) should not be reported separately with a spinal procedure.

17. Fluoroscopy reported as CPT codes 76000 or 76001 should not be reported with spinal procedures unless there is a specific *CPT Manual* instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure.

18. Since the code descriptor for CPT code 61576 (transoral approach to skull base... (including tracheostomy)) includes a tracheostomy in the code descriptor, a CPT code describing a tracheostomy should not be reported separately.

19. For reporting CPT code 69990 (operating microscope), the reader is referred to Chapter VIII, Section F (Operating Microscope).

20. 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)).

21. Muscle chemodenervation procedures coded as CPT codes 64612-64614 occasionally require needle electromyographic (EMG) guidance. From January 1 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.

22. 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. The physician performing an operative procedure should not report 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. However, when performed by a different physician during the procedure, intraoperative neurophysiology testing is separately reportable by the second physician.

23. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all endoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an endoscopic procedure.

24. Access to the brachial plexus for a neuroplasty or suture procedure often requires division of a scalene muscle. Since access to the surgical field to perform a surgical procedure is integral to the procedure, division of a scalene muscle is not separately reportable with a brachial plexus procedure.

25. If the injection procedure for discography (CPT codes 62290, 62291) is followed by postoperative pain, treatment of this pain is not separately reportable (e.g., CPT codes 62310, 62311). The injection procedure codes have a global surgical indicator of 000 days. Medicare Global Surgery Rules include treatment of postoperative pain in the global surgical package.

## **D. Ophthalmology**

1. When a subconjunctival injection (e.g., CPT code 68200) with local anesthetic is performed as part of a more extensive anesthetic procedure (e.g., peribulbar or retrobulbar block), the subconjunctival injection is not separately reportable. It is part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy and/or anterior vitrectomy may be performed in conjunction with cataract extraction. If an iridectomy is performed in order to complete a cataract extraction, it is an integral part of the procedure and is not separately reportable. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable. If an iridectomy or vitrectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitrectomy may be reported separately with an NCCI-associated modifier. The medical record must document the distinct medical necessity for each procedure.

A trabeculectomy is separately reportable with a cataract extraction if performed for a purpose unrelated to the cataract extraction. For example, if a patient with glaucoma requires a cataract extraction and a trabeculectomy is the appropriate treatment for the glaucoma, the trabeculectomy may be separately reportable. However, performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not separately reportable.

3. CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye.

4. There are numerous CPT codes describing repair of retinal detachment (e.g., 67101-67113). These procedures are mutually exclusive and should not be reported separately for the ipsilateral eye on the same date of service. Some retinal detachment repair procedures include some vitreous procedures which are not separately reportable. For example, the procedure described by CPT code 67108 includes the procedures described by CPT codes 67015, 67025, 67028, 67031, 67036, 67039, and 67040.

5. The procedures described by CPT codes 68020-68200 (incision, drainage, biopsy, excision, or destruction of the conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362). CPT codes 68020-68200 should not be reported separately with CPT codes 68320-68362 for the ipsilateral eye.

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

7. Correction of lid retraction (CPT code 67911) includes a full thickness graft (e.g., CPT code 15260) as part of the procedure. A full thickness graft code such as CPT code 15260 should not be reported separately with CPT code 67911 for the ipsilateral eye.

8. If it is medically reasonable and necessary to inject anti-sclerosing agents at the same patient encounter as surgery to correct glaucoma, the injection is included in the glaucoma procedure. CPT codes such as 67500, 67515, and 68200 for injection of anti-sclerosing agents (e.g., 5-FU, HCPCS code J9190) should not be reported separately with other pressure-reducing or glaucoma procedures.

9. Since visual field examination (CPT codes 92081-92083) would be performed prior to scheduling a patient for a blepharoplasty (CPT codes 15820-15823) or blepharoptosis (CPT codes 67901-67908) procedure, the visual field examination CPT codes should not be reported separately with the blepharoplasty or blepharoptosis procedure codes for the same date of service.

10. The CPT code descriptors for CPT code 67108 (repair of retinal detachment...) and 67113 (repair of complex retinal detachment...) include removal of lens if performed. CPT codes for removal of lens or cataract extraction (e.g., 66830-66984) should not be reported separately.

11. Medicare Anesthesia Rules prohibit the physician performing an operative procedure from separately reporting anesthesia for that procedure except for moderate conscious sedation for some procedures. CPT codes describing ophthalmic injections (e.g., CPT codes 67500, 67515, 68200) should not be reported separately with other ophthalmic procedure codes when the injected substance is an anesthetic agent. Since Medicare Global Surgery Rules prohibit the separate reporting of postoperative pain management by the physician performing the procedure, the same CPT codes should not be reported separately

by the physician performing the procedure for postoperative pain management.

12. CMS payment policy does not allow separate payment for a blepharoptosis procedure (CPT code 67901-67908) and blepharoplasty procedure (CPT codes 15822, 15823) on the ipsilateral upper eyelid.

13. CPT codes 65420 and 65426 describe excision of pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT codes 65780-65782 should not be reported separately with either of these codes for the ipsilateral eye.

14. CPT codes 92018 and 92019 (ophthalmological examination and evaluation, under general anesthesia . . .) are generally not separately reportable with ophthalmological surgical procedures. The examination and evaluation of an eye while a patient is under general anesthesia for another ophthalmological procedure is integral to the procedure. However, there are unusual circumstances when an adequate ophthalmological examination cannot be completed without anesthesia (e.g., uncooperative pediatric patient, severe eye trauma). In such situations CPT codes 92018 or 92019 may be separately reportable with appropriate documentation.

15. Repair of a surgical skin or mucous membrane incision (CPT codes 12001-13153) is generally included in the global surgical package. For procedures of the eye requiring a skin or mucous membrane incision (e.g., eyelid, orbitotomy, lacrimal system), simple, intermediate, and complex repair codes should not be reported separately.

16. Repair of an incision to perform an ophthalmic procedure is integral to completion of the procedure. It is a misuse of the repair of laceration codes (CPT codes 65270-65286) to separately report closure of a surgical incision of the conjunctiva, cornea, or sclera.

#### **E. Auditory System**

1. If the code descriptor for a procedure of the auditory system includes a mastoidectomy (e.g., CPT codes 69530, 69802, 69910), an additional code describing a mastoidectomy (e.g., 69502-69511) is not separately reportable for the ipsilateral mastoid.

2. A myringotomy (e.g., CPT codes 69420, 69421) is included in a tympanoplasty or tympanostomy procedure and is not separately reportable.

3. If an otologic procedure requires a transcanal or endaural approach with incision of the tympanic membrane and access through the middle ear, exploration of the middle ear (CPT code 69440) and tympanic membrane procedures (e.g., CPT codes 69420, 69421, 69424, 69433, 69436, 69610, 69620) should not be reported separately.

#### **F. Operating Microscope**

1. The *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 20.4.5 (Allowable Adjustments) 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, 64885-64891 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. The NCCI bundles CPT code 69990 into all surgical procedures other than those listed in the *Medicare Claims Processing Manual*. Most edits do not allow use of NCCI-associated modifiers.

2. If a physician performs two procedures utilizing the operating microscope but only one of the procedures is on the CMS list of procedures for which CPT code 69990 is separately payable, payment for CPT code 69990 may be denied because of an edit bundling CPT code 69990 into the other procedure not on the CMS list. (Claims processing systems do not identify which procedure is linked to CPT code 69990.) In these cases, physicians may submit the claim to the local carrier (A/B MAC processing practitioner service claims) appending modifier 22 to the CPT code for the procedure on which the operating microscope was used and a letter of explanation. Although the carrier (A/B MAC processing practitioner service claims) cannot override an NCCI edit that does not allow use of NCCI-associated modifiers, the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

## **G. Laparoscopy**

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

4. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

5. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

6. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of all laparoscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with a laparoscopic procedure.

## **H. 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. The MUE values for CPT code 63661 (removal of spinal neurostimulator electrode percutaneous array(s) . . .) and CPT code 63662 (removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy . . .) are one (1). Each code descriptor includes the removal of some or all electrode percutaneous arrays and some or all electrode plates/paddles for a neurostimulator pulse generator. If a patient has two separate neurostimulator pulse generators and some or all electrodes are removed for each neurostimulator pulse generator separately, the removal of the percutaneous array(s) or plate(s)/paddle(s) for the second neurostimulator pulse generator may be reported with modifier 59.

4. The MUE value for CPT code 64612 (chemodenervation of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm) is two (2). The unit of service for this code is all injections for chemodenervation into any and all muscles innervated by a facial nerve. A provider may separately report a unit of service for chemodenervation of any and all muscles innervated by the left facial nerve and a unit of service for chemodenervation of any and all muscles innervated by the right facial nerve. However, a provider should never report more than one unit of service for chemodenervation of one or more muscles innervated by a single facial nerve.

## **I. 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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPSS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the

same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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 (e.g., 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. 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.

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

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

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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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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.

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 visit 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.

1. 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. 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 descriptors for many of these services refer 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 reported. However, if additional films are necessary due to a change in the patient's condition, separate reporting may be appropriate.

2. 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.

3. When limited comparative radiographic studies are performed (e.g., post-reduction, 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 OPPS services reported by hospitals.

4. 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.

5. Fluoroscopy is inherent in many radiological supervision and interpretation procedures. Unless specifically noted, fluoroscopy necessary to complete a radiologic procedure and obtain the necessary permanent radiographic record is included in the radiologic procedure and should not be reported separately.

6. Preliminary "scout" radiographs prior to contrast administration or delayed imaging radiographs are not separately reportable.

7. *CPT Manual* instructions state that in the presence of a clinical history suggesting urinary tract pathology complete ultrasound evaluation of the kidneys and urinary bladder constitutes a complete retroperitoneal ultrasound study (CPT code 76770). A limited retroperitoneal ultrasound (CPT code 76775) plus limited pelvic ultrasound (CPT code 76857) should not be reported in lieu of the complete retroperitoneal ultrasound (CPT code 76770).

8. CPT code 76380 (computer tomography, limited or localized follow-up study) should not be reported with other computed tomography (CT), computed tomography angiography (CTA), or computed tomography guidance codes for the same patient encounter.

9. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. The chest radiologic examination is integral to the procedure, and a chest radiologic examination (e.g., CPT codes 71010, 71020) should not be reported separately.

10. CPT code 77075 (Radiologic examination, osseous survey; complete (axial and appendicular skeleton)) includes radiologic examination of all bones. CPT codes for radiologic examination of other bones should not be reported in addition to CPT code 77075. However, if a separate and distinct radiologic examination with additional films of a specific area of the skeleton is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.

11. CPT code 77073 (bone length studies . . .) includes radiologic examination of the lower extremities. CPT codes for radiologic examination of lower extremity structures should not be reported in addition to CPT code 77073 for examination of the radiologic films for the bone length studies. However, if a separate and distinct radiologic examination with additional films of a specific area of a lower extremity is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.

#### **D. Interventional/Invasive Diagnostic Imaging**

1. If a radiologic procedure requires that contrast be administered orally (e.g., upper GI series) or rectally (e.g., barium enema), the administration is integral to the radiologic procedure, and the administration service is not separately reportable. If a radiologic procedure requires that contrast material be administered parenterally (e.g., IVP, CT, MRI), the vascular access (e.g., CPT codes 36000, 36406, 36410) and contrast administration (e.g., CPT codes 96360-96376) are integral to the procedure and are not separately reportable.

2. Many services utilizing contrast are composed of a procedural component (CPT codes outside the 70000 section) and a radiologic supervision and interpretation component (CPT code in the 70000 section). If a single physician performs both components of the service, the physician may report both codes. However, if different physicians perform the different components, each physician reports the CPT code corresponding to that component.

3. Many interventional procedures require contrast injections for localization and/or guidance. Unless there are

CPT instructions directing the physician to report specific CPT codes for the localization or guidance, the localization or guidance is integral to the interventional procedure and is not separately reportable.

4. 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.

5. The individual CPT codes in the 70000 section identify which injection or administration code, if any, is appropriate for a given procedure. In the absence of a parenthetical CPT note, the injection or administration service is integral to the procedure and is not separately reportable. If an intravenous line is inserted (e.g., CPT code 36000) for access in the event of a problem with the procedure or for administration of contrast, it is integral to the procedure and is not separately reportable. CPT code 36005 describes the injection procedure for contrast venography of an extremity and includes the introduction of a needle or an intracatheter (e.g., CPT code 36000). CPT code 36005 should not be reported for injections for arteriography or venography of sites other than an extremity.

6. For lymphangiography procedures, injection of dye into subcutaneous tissue is integral to the procedure. CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection . . . ; subcutaneous or intramuscular) should not be reported separately for this injection of dye.

7. When urologic radiologic procedures require insertion of a urethral catheter (e.g., CPT code 51701-51703), this

insertion is integral to the procedure and is not separately reportable.

8. Fluoroscopy reported as CPT codes 76000 or 76001 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and should not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately.

9. Computed tomography (CT) and computed tomographic angiography (CTA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate CT and CTA reports, only one procedure, either the CT or CTA, for the anatomic region may be reported. Both a CT and CTA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the CT and one for the CTA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

Similarly magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA, for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the MRI and one for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

10. Computed tomography of the heart (CPT codes 75571-75573) and computed tomographic angiography of the heart (CPT code 75574) include electrocardiographic monitoring if performed. CPT codes 93000-93010 (electrocardiogram . . .) and 93040-93042 (rhythm ECG . . .) should not be reported separately with CPT codes 75571-75574 for the ECG monitoring integral to these procedures.

## **E. Nuclear Medicine**

The general policies described above apply to nuclear medicine as well as standard diagnostic imaging.

1. The injection of a radiopharmaceutical is an integral component of a nuclear medicine procedure. CPT codes for vascular access (e.g., CPT code 36000) and injection of the radiopharmaceutical (e.g., CPT codes 96360-96376) are not separately reportable.

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, a SPECT study of a limited area is not separately reportable with a planar study of the same area. 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 size 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.

5. CPT codes 78451-78452 (myocardial perfusion imaging; . . . additional quantification. . .) include calculation of the heart-lung ratio if obtained. CPT code 78580 (pulmonary perfusion imaging, particulate) should not be reported for

calculation of the heart-lung ratio during the processing of a SPECT myocardial perfusion procedure.

6. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82 . . .) and A9526 (Nitrogen N-13 Ammonia . . .) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG, . . .) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

7. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic . . .) describes a radiopharmaceutical utilized for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

## **F. Radiation Oncology**

1. Except for an initial visit evaluation and management (E&M) service at which the decision to perform radiation therapy is made, E&M services are not separately reportable with radiation oncology services with one exception as noted below. Effective January 1, 2010, CMS eliminated payment for consultation E&M CPT codes 99241-99255. The initial visit E&M for radiation oncology services may be reported with office/outpatient E&M CPT codes 99201-99215, initial hospital care E&M CPT codes 99221-99223, subsequent hospital care E&M CPT codes 99231-99233, or observation/inpatient hospital care with same day admission and discharge E&M CPT codes 99234-99236.

The only radiation oncology services that may be reported with E&M services in addition to an initial visit E&M service are CPT codes 77785-77787 (remote afterloading high dose rate

radionuclide brachytherapy . . .). E&M services reported with these brachytherapy codes must be significant, separate and distinct from radiation treatment management services.

2. 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 are reported on the same date of service.

3. 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)  
96360-96368 (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)  
99281-99480 (Evaluation & Management)

4. Brachytherapy (CPT codes 77750-77790) includes radiation treatment management (CPT codes 77427 and 77431) and continuing medical physics consultation (CPT code 77336). CPT codes 77427, 77431, and 77336 should not in general be reported separately with brachytherapy services. However, if a patient receives external beam radiation treatment and brachytherapy treatment during the same time period, radiation treatment management and continuing medical physics consultation may be reported for the external beam radiation treatments. Additionally, if a patient has multi-step brachytherapy, it may be appropriate to separately report continuing medical physics consultation with the brachytherapy.

5. The procedures described by CPT codes 77776-77778 (interstitial radiation source application . . .) require that a radiation source be applied interstitially. Reporting a CPT code requires that all essential components of the procedure are performed. These codes should not be reported by a radiation oncologist for intraoperative work with another physician who surgically places catheters interstitially unless the radiation oncologist also applies the radiation source at the same patient encounter. The intraoperative work of the radiation oncologist may be reportable with a non-brachytherapy code. If the radiation source application occurs postoperatively in a different room, the radiation oncologist may report CPT codes 77785-77787 (remote afterloading high dose rate radionuclide brachytherapy . . .) for the radiation source application.

6. Stereotactic radiosurgery (SRS) treatment delivery (CPT codes 77371-77373) includes stereotactic guidance for placement of the radiation therapy fields for treatment delivery. CPT codes 77014 (computed tomography guidance for placement of radiation therapy fields) and 76950 (ultrasonic guidance for placement of radiation therapy fields) should not be reported additionally for guidance for placement of the radiation therapy field for SRS treatment delivery.

7. Since CPT code 0197T (intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy . . .) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields), 77014 (computed tomography guidance for placement of radiation therapy fields), or 77421 (stereoscopic X-ray guidance for

localization of target volume for the delivery of radiation therapy).

8. Partial breast high dose rate brachytherapy may be performed two times a day. The first therapeutic radiology simulation for the course of therapy may be complex and reported as CPT code 77290. However, subsequent simulations during the course of therapy should be reported as CPT code 77280.

#### **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.

3. CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

4. The MUE values for J0152 (injection, adenosine for diagnostic use, 30 mg . . .) and J1245 (injection, dipyridamole, per 10 mg) were set for single pharmacologic stress tests. For the unusual patient who requires two different types of pharmacologic stress tests (e.g., myocardial perfusion and echocardiography) on the same date of service, the amount of drug utilized for each stress test should be reported on separate

lines of a claim with modifier 59 appended to the code on one of the claim lines.

## **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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

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

5. Based on CPT coding instructions xeroradiography (e.g., CPT code 76150) is not separately reportable with mammography studies.

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

7. Ultrasound guidance and diagnostic ultrasound (echography) procedures may be reported separately only if each service is distinct and separate. If a diagnostic ultrasound study identifies a previously unknown abnormality that requires a therapeutic procedure with ultrasound guidance at the same patient encounter, both the diagnostic ultrasound and ultrasound guidance procedure codes may be reported separately. However, a previously unknown abnormality identified during ultrasound guidance for a procedure should not be reported separately as a diagnostic ultrasound procedure.

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

9. CPT code 77790 (supervision, handling, loading of radiation source) is not separately reportable with any of the remote afterloading brachytherapy codes (e.g., CPT codes 77785-77787) since these procedures include the supervision, handling, and loading of the radioelement.

10. Bone studies such as CPT codes 77072-77076 require a series of radiographs. Separate reporting of a bone study and individual radiographs obtained in the course of the bone study is inappropriate.

11. Radiological supervision and interpretation codes include all radiological services necessary to complete the service. CPT codes for fluoroscopy/fluoroscopic guidance (e.g., 76000, 76001, 77002, 77003) or ultrasound/ultrasound guidance (e.g., 76942, 76998) should not be reported separately.

Radiological guidance procedures include all radiological services necessary to complete the procedure. CPT codes for fluoroscopy (e.g., 76000, 76001) should not be reported separately with a fluoroscopic guidance procedure. CPT codes for ultrasound (e.g., 76998) should not be reported separately with an ultrasound guidance procedure. A limited or localized follow-up computed tomography study (CPT code 76380) should not be reported separately with a computed tomography guidance procedure.

12. 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.

13. 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 reportable with an NCCI-associated modifier.

14. 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.

15. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples,

reporting 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.

16. 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.

17. 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.

18. 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.

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.

20. 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.

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

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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 codes describe services to evaluate specimens (e.g., blood, body fluid, tissue) obtained from patients in order to provide information to the treating physician.

Generally, pathology and laboratory specimens are prepared, screened, and/or tested 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 or interpreted 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. If a pathologist provides significant, separately identifiable face-to-face patient care services that satisfy the criteria set forth in the E&M guidelines developed by CMS and the AMA, a pathologist may report

the appropriate code 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.

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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same

date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. Organ or Disease Oriented Panels**

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of groups 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 may be reported as a lipid panel (CPT code 80061).

NCCI contains edits pairing each panel CPT code (column one code) with each CPT code corresponding to the individual laboratory tests that are 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 repeated 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 requires the administration of pharmaceutical agents to determine a patient's response to those agents. CPT codes 80400-80440 describe the laboratory components of the testing. Administration of the pharmaceutical agent may be reported with CPT codes 96365-96376. In the facility setting, these codes may be reported by the facility, but not the physician. In the non-facility setting, these codes may be reported by the physician. While supplies necessary to perform the testing are included in the testing CPT codes, the appropriate HCPCS level II J code for the pharmacologic agent may be reported separately. Separate evaluation and management services including prolonged services (e.g., prolonged infusion) should not be reported separately unless a significant, separately identifiable service medically reasonable and necessary E&M is provided and documented.

#### **E. Chemistry**

1. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) describes direct measurement of 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.

2. CPT code 83912 describes a medically reasonable and necessary "interpretation and report" associated with molecular diagnostic testing described with CPT codes 83890-83909. CPT code 83912 should not be reported as an "interpretation and report" with CPT codes 87470-87801, 87901-87904 or 88271-88275.

3. 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.

#### **F. Hematology and Coagulation**

1. 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.

2. 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.

3. Multiple CPT codes describe bone and bone marrow biopsy and/or aspiration and interpretation of the specimens. If a bone biopsy is performed for evaluation of bone matrix structure, the appropriate CPT codes to report are CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology interpretation.

If a bone marrow aspiration is performed without biopsy, the procedure may be reported as CPT code 38220. Interpretation of the aspirate smear may be reported as CPT code 85097. Both codes may be reported by the same physician if both the procedure and interpretation are performed by that physician. If a cell block is prepared from the bone marrow aspirate, interpretation of the cell block should be reported as CPT code 88305.

Bone marrow biopsy may be reported with CPT code 38221. If bone marrow aspiration is also performed through the same skin incision, it should be reported with HCPCS code G0364. However, it should not be reported with CPT code 38220. Interpretation of the bone marrow biopsy may be reported with CPT code 88305.

The bone marrow aspiration procedure (CPT code 38220) should not be reported separately with the bone marrow biopsy procedure (CPT code 38221) unless the two procedures are performed through medically reasonable and necessary separate skin incisions or at separate patient encounters on the same date of service.

When it is medically necessary to evaluate both bone structure and bone marrow and both can be evaluated from a single biopsy, only one code (CPT code 38221 or 20220) should be reported for the surgical procedure. If two separate biopsies are medically necessary, both may be reported appending modifier 59 to one of the codes. If only one specimen is submitted for surgical pathology, only one surgical pathology code (CPT codes 88305 or 88307 as appropriate) may be reported even if the report includes evaluation of both bone structure and bone marrow morphology.

## **G. Microbiology**

1. CPT codes 87040-87158 describe microbiological 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.

2. 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.

## **H. Anatomic Pathology (Cytopathology and Surgical Pathology)**

1. Cytopathology codes describe varying methods of preparation and examination of different types of specimens. For a single specimen, only one code from a group of related codes describing a group of services that could be performed on the specimen with the same end result (e.g., 88104-88112, 88142-88143, 88150-88154, 88164-88167, etc.) should be reported. If multiple services (i.e., separate specimens from different anatomic sites) are reported, modifier 59 should be utilized to indicate that different levels of service were provided for different specimens from different anatomic sites. This information should be documented in the cytopathology reports. A cytopathology preparation from a fluid, washing, or brushing should be reported using one code from the CPT code range 88104-88112. It is inappropriate to additionally report CPT codes 88160-88162 because the smears are included in the codes referable to fluids (or washings or brushings) and CPT codes

88160-88162 reference "any other source" which would exclude fluids, washings, or brushings.

2. CPT codes 88321-88325 describe surgical pathology consultation services to review slides, tissues, or other material obtained, prepared, and interpreted at a different location by a different pathologist and referred to another pathologist for a second opinion. These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or other 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., ECGs, 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, physicians should not report other pathology CPT codes such as 88312, 88313, 88342, 88187, 88188, 88189, etc., for interpretation of stains, slides or other material previously interpreted by another pathologist. CPT codes 88312, 88313 and 88342 may be reported with CPT code 88323 if the physician performs and interprets these stains *de novo*.

CPT codes 88321-88325 should not be reported with a face-to-face evaluation of a patient. If a physician provides an evaluation and management (E&M) service to a patient, and, in the course of the E&M service, specimens obtained elsewhere are reviewed as well, this review is part of the E&M service and is not reported separately. Only the E&M service should be reported.

3. 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 physician may report both CPT codes if both methods are required because the initial method does not explain all the light microscopic findings. The physician may 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.

4. 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<sup>+</sup> to 4<sup>+</sup> should be reported as CPT code 88342.

5. 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.

6. 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. *In situ* hybridization reported with qualitative grading such as 1<sup>+</sup> to 4<sup>+</sup> should be reported as CPT code 88365. 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.

7. 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 (e.g., 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.

8. CPT codes 88384-88386 describe array-based evaluations of multiple molecular probes. Although CPT code 88384 is Carrier (A/B MAC processing practitioner service claims) 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 global CPT code 88385 or 88386 since these codes include physician work. Rather, it should be reported as 88385-TC or 88386-TC which includes the non-physician work including interpretation.

9. Gross examination of a specimen is an integral component of pathology consultation during surgery (CPT codes 88329-88334) and surgical pathology gross and microscopic examination (CPT codes 88302-88309). CPT code 88300 (level I - surgical pathology, gross examination only) should not be reported with any of the previously listed CPT codes for examination of the same specimen.

#### **I. 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.

4. The code descriptors for CPT codes 83912 (molecular diagnostics; interpretation and report) and 88291 (cytogenetics and molecular cytogenetics, interpretation and report) do not define the units of service for these codes. The MUE value for each of these codes is "1". CMS interprets these codes to include the synthesis with interpretation and report of all molecular diagnostic testing or cytogenetic/molecular cytogenetic testing respectively performed on a single date of service. These codes should not be reported with separate units of service based on the number of specimens or tests on a single date of service.

5. The MUE values for CPT codes 86021 (antibody identification; leukocyte antibodies) and 86022 (antibody identification; platelet antibodies) are "1". The code descriptors are plural, and CMS priced each of these codes to include all antibodies to leukocytes and platelets respectively in a single unit of service.

6. The unit of service for CPT code 88172 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)) is the separately identifiable lesion (tumor). Per the code descriptor all specimens from a single lesion are included in a single unit of service. If a physician performs multiple "passes" into the same lesion to obtain multiple specimens for immediate cytohistologic study, all specimens from the lesion are included in the single unit of service. If a physician evaluates fine needle aspirate specimens from more than one distinct, separate lesion, a separate unit of service may be reported for each lesion. The

same concept applies to the unit of service for CPT code 88173 (cytopathology, evaluation of fine needle aspirate; interpretation and report). A separate unit of service may be reported for each distinct, separate lesion, but only one unit of service may be reported for all specimens from a single lesion.

7. The unit of service for gross and microscopic surgical pathology (CPT codes 88300-88309), pathology consultation during surgery (CPT codes 88329, 88331, 88333), electron microscopy (CPT codes 88348, 88349) and morphometric analysis (CPT codes 88355-88358) is the specimen. A specimen is defined as tissue(s) that are submitted for individual and separate attention, examination, and diagnosis. Separate specimens are usually submitted in separate containers. It must be medically reasonable and necessary to submit the specimens for individual attention, examination, and diagnosis. For example, if colonoscopy identifies two separate polyps at 15 cm and 25 cm, it may be medically reasonable and necessary to submit them as separate specimens. If one of the polyps is malignant, it may be important to know for future therapy which one was malignant. Multiple biopsies of the same polyp are usually submitted as a single specimen.

8. The unit of service for special stains (CPT codes 88312-88313) and immunohistochemistry (CPT codes 88342, 88360, 88361) is each stain. If it is medically reasonable and necessary to perform the same stain on more than one specimen or more than one block of tissue from the same specimen, additional units of service may be reported for the additional specimen(s) or block(s). Physicians should not report more than one unit of service for a stain performed on a single tissue block. For example it is common practice to cut multiple levels from a tissue block and stain each level with the same stain. The multiple levels from the same block of tissue stained with the same stain should not be reported as additional units of service. Only one unit of service should be reported for the stain on multiple levels from the single tissue block. Additionally, controls performed with special stains should not be reported as separate units of service for the stain.

For cytology specimens from a single anatomic site only one unit of service may be reported for each special stain regardless of the number of slides from that site stained with the special stain.

For hematology smears only one unit of service may be reported for each special stain regardless of the number of smears from an anatomic site stained with the special stain. For example if multiple smears of peripheral blood are stained with an iron stain, only one unit of service may be reported. Similarly, if three smears from a bone marrow aspirate are stained with an acid fast stain, only one unit of service may be reported. Smears from peripheral blood, one iliac crest, and contralateral iliac crest are from three separate anatomic sites.

9. The MUE value for CPT code 86807 (Serum screening for cytotoxic percent reactive antibody (PRA); standard method) is two (2). One unit of service may be reported for a PRA test result for class I HLA antigens, and one unit of service may be reported for a PRA test result for class II HLA antigens. Payment for this procedure is based on the test result, not the methodologic steps utilized to obtain the test result. If multiple steps each utilizing cytotoxic antibody testing of a panel of lymphocytes are performed to obtain the final PRA test result for the class I HLA antigens, only one unit of service for 86807 may be reported. The same principle applies to the final PRA test result for class II HLA antigens.

## **J. 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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. CPT codes 80500 and 80502 describe clinical pathology consultation services. CMS has specific rules for reporting these services. There must be a written order for the clinical pathology consultation from the treating physician. The consultation must be related to an abnormal test result that requires medical judgment by a physician (M.D. or D.O.). Since the clinical pathology consultation requires that medical judgment be exercised, the nature of the consultation must include information that could not be provided by a laboratory scientist, technologist, or technician. A written report documenting the consultation must appear in the medical record. A clinical pathology consultation does not require face-to-face patient contact. If face-to-face contact is medically reasonable and necessary, an evaluation and management (E&M) CPT code may be reported in lieu of a clinical pathology consultation code. Since E&M services include interpretation of laboratory test results, a clinical pathology consultation code should never be reported with an E&M code on the same date of service. CPT codes 80500 and 80502 should never be reported for consultation related to a pathology or laboratory service that includes a physician interpretation.

5. Medicare does not pay for duplicate testing. 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.

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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. CPT codes 96360-96379 and C8957 describe hydration and therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs. CPT codes 96401-96549 describe administration of chemotherapy or other highly complex drug or biologic agents. Issues related to chemotherapy administration are discussed in this section as well as Section N. (Chemotherapy Administration).

2. CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous 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 intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 96360-96368, 96374-96379, 96409-96417) should not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, this service may be reported separately. Since 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 96360-96379. If the sole purpose of fluid administration (e.g., saline, D<sub>5</sub>W, 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. Hydration concurrent with other drug administration services is not separately reportable.

6. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services should not be

reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. 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 separately report 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 claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

7. The drug and chemotherapy administration CPT codes 96360-96375 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 non-facility based evaluation and management CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians should not report drug administration services in a facility setting, a facility based evaluation and management CPT code (e.g., 99281-99285) should not be reported by a physician with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the evaluation and management code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

Under OPPS, hospitals may report drug administration services (CPT codes 96360-96376) and chemotherapy administration services (CPT codes 96401-96425) with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

8. Flushing or irrigation of an implanted vascular access port or device of a drug delivery system 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.

9. 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.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir for systemic drug delivery) 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. Similarly under the OPPS, CPT codes 96521 (refilling and maintenance of portable pump) and 96522 (refilling and maintenance of implantable pump or reservoir for systemic drug delivery (e.g., intravenous, intra-arterial)) should not be reported with HCPCS/CPT code C8957 (initiation of prolonged intravenous infusion (more than 8 hours)).

CPT codes 96521 and 96522 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.

10. 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 96360-96376 should not be reported for anesthesia provided by the physician performing a medical or surgical service.

11. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

12. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported with HCPCS 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 physician 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 should not report a combination of CPT codes from the two code ranges.

13. 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 separately reportable with vaccine administration HCPCS/CPT codes 90465-90474, G0008-G0010.

14. CPT codes 96361 and 96366 are utilized to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes

may be reported only if the infusion is medically reasonable and necessary for the patient's treatment or diagnosis. They should not be reported for "keep open" infusions as often occur in the emergency department or observation unit.

### **C. Psychiatric Services**

CPT codes for psychiatric services include diagnostic (CPT codes 90801, 90802) and therapeutic (individual, group, other) procedures. Since psychotherapy includes continuing psychiatric evaluation, CPT codes 90801 and 90802 are not separately reportable with individual psychotherapy codes. CPT code 90801 or 90802 is separately reportable with a group psychotherapy code if the diagnostic interview and group psychotherapy service occur during separate time intervals on the same date of service. Diagnostic services performed during the group therapy session are not separately reportable.

Interactive services (diagnostic or therapeutic) are distinct 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...". Non-interactive services are not performed at the same patient encounter as interactive services and are not separately reportable with interactive services.

Drug management is included in diagnostic and therapeutic psychiatric services (e.g., CPT codes 90801-90829, 90845, 90847-90853, 90865-90880). CPT code 90862 and HCPCS code M0064 (pharmacologic management) are not separately reportable with these codes. Both CPT code 90862 and HCPCS code M0064 require face-to-face patient contact by the practitioner licensed to perform the service. Facilities may report CPT code 90862 or HCPCS code M0064 (pharmacologic management services) with a psychotherapy code if the two services are performed at separate patient encounters on the same date of service.

Based on CMS payment policy for practitioner services evaluation and management (E&M) codes are not separately reportable with psychiatric diagnostic evaluation codes (CPT codes 90801 or 90802). Facilities may separately report E&M codes and psychiatric diagnostic evaluation codes if the services are performed at separate patient encounters on the same date of service.

Individual psychotherapy codes (CPT code 90804-90829) include separate codes for psychotherapy with medical evaluation and management (E&M) services as well as codes for psychotherapy without E&M services. For practitioner services other E&M codes (e.g., 99201-99215) are not separately reportable with individual psychotherapy codes on the same date of service. Facilities may separately report E&M codes and individual psychotherapy codes if the services are performed at separate patient encounters on the same date of service.

For practitioner services E&M codes are not separately reportable on the same date of service as psychoanalysis (CPT code 90845), narcosynthesis (CPT code 90865), or hypnotherapy (CPT code 90880). These psychiatric services include E& M services provided on the same date of service. Facilities may separately report E&M codes and psychoanalysis, narcosynthesis, or hypnotherapy if the services are performed at separate patient encounters on the same date of service.

#### **D. Biofeedback**

Biofeedback services utilize electromyographic techniques to detect and record muscle activity. CPT codes 95860-95872 (EMG) should not be reported separately 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 code(s) (e.g., CPT codes 95860-95872) may be reported separately. Modifier 59 should be appended to the EMG code to indicate that the service was a separately identifiable diagnostic service. Recording an objective electromyographic response to biofeedback is not sufficient to separately report a diagnostic EMG CPT code.

#### **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 and the renal failure. If the physician additionally performs on the same date of service medically reasonable and necessary E&M services unrelated to the dialysis procedure or renal failure 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, and

99291-99292. These codes must be reported with modifier 25 if performed on the same date of service as the dialysis procedure.

Per CMS payment policy any E&M service related to the renal failure (e.g., hypertension, fluid overload, uremia, electrolyte imbalance) or dialysis procedure performed on the same date of service as the dialysis procedure should not be reported separately even if performed at a separate patient encounter. E&M services for conditions unrelated to the dialysis procedure or renal failure even if performed at the same patient encounter as the dialysis procedure may be reported separately with modifier 25.

## **F. Gastroenterology**

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

2. The gastroesophageal reflux test described by CPT code 91035 requires attachment of a telemetry pH electrode to the esophageal mucosa. If a physician uses endoscopic guidance to attach the electrode, the physician should not report CPT codes 43234 (upper gastrointestinal endoscopy, simple primary examination...) or 43235 (upper gastrointestinal endoscopy...; diagnostic...) for the guidance procedure. The guidance is not separately reportable. Additionally it would be a misuse of CPT codes 43234 or 43235 since these codes do not describe guidance, but a more extensive diagnostic endoscopy.

## **G. Ophthalmology**

1. General ophthalmological services (CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management (E&M) codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-

92014) should not be reported separately. The E&M service includes the general ophthalmological services.

2. Special ophthalmologic services represent specific services not included in a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services and may be reported separately.

3. For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are integral to the procedure and are not separately reportable. Therefore, CPT codes 36000 (introduction of a needle or catheter), 36410 (venipuncture), 96360-96368 (IV infusion), 96374-96376 (IV push injection), and selective vascular catheterization codes are not separately reportable with services requiring intravenous injection (e.g., CPT codes 92230, 92235, 92240, 92287).

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

5. 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.

## **H. Otorhinolaryngologic Services**

1. CPT coding for otorhinolaryngologic services includes codes for diagnostic 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 assessment of these tests by the physician is included in the evaluation and management service.

2. 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, or 97530, 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.

3. A single practitioner should not report CPT codes 92507 (treatment of speech, language, voice . . .; individual) and/or 92508 (treatment of speech, language, voice . . .; group) on the same date of service as CPT codes 97532 (development of cognitive skills to improve . . .) or 97533 (sensory integrative techniques to enhance . . .). However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes 92507 and/or 92508 on the same date of service that an occupational therapist performs the procedures described by CPT codes 97532 and/or 97533, a provider entity that employs both types of practitioners may report both services utilizing an NCCI-associated modifier.

4. 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 (A/B MACs processing practitioner service claims) 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.

5. CPT code 92502 (otolaryngologic examination under general anesthesia) is not separately reportable with any other otolaryngologic procedure performed under general anesthesia.

6. Removal of cerumen by an audiologist prior to audiologic function testing is not separately reportable. If the cerumen is impacted, cannot be removed by the audiologist, and requires removal by a physician, the physician may report HCPCS code G0268 (Removal of impacted cerumen (one or both ears) by

physician on same date of service as audiologic function testing). The physician should not report CPT code 69210 (removal of impacted cerumen (separate procedure)) for this 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).

1. If cardiopulmonary resuscitation (CPR) is performed without other evaluation and management (E&M) services, only CPT code 92950 (Cardiopulmonary resuscitation (e.g., in cardiac arrest)) should be reported. For example, if a physician directs cardiopulmonary resuscitation and the patient's attending physician resumes the care of the patient after the patient has been revived, the first physician may report CPT code 92950 but not an E&M code.

2. Critical care E&M services (CPT codes 99291 and 99292) and prolonged physician E&M services (CPT codes 99354-99357) are reported based on time. Providers should not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged physician E&M service time. For example, the time devoted to performing cardiopulmonary resuscitation (CPT code 92950) should not be included in critical care E&M service time.

3. A number of diagnostic and therapeutic 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. Since these services are integral components of the more comprehensive procedures, codes for routine vascular access, ECG monitoring, and injection/infusion services are not separately reportable. Fluoroscopic guidance is integral to diagnostic and therapeutic intravascular procedures and is not separately reportable. HCPCS/CPT codes describing radiologic supervision and interpretation for specific interventional vascular procedures may be separately reportable.

4. Cardiac output measurements (CPT codes 93561-93562) are routinely performed during cardiac catheterization procedures. Per CPT instruction, CPT codes 93561-93562 should not be reported separately with cardiac catheterization codes.

5. CPT codes 93797 and 93798 describe comprehensive services provided by a physician for cardiac rehabilitation. Since these codes include all services necessary for cardiac rehabilitation, evaluation and management (E&M) codes should not be reported separately unless a significant, separately identifiable E&M service is performed and documented in the medical record. The physician should report the E&M service with modifier 25 to indicate that it was significant and separately identifiable.

6. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) should not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately.

7. If a physician in attendance for a cardiac stress test obtains a history and performs a limited physical examination related to the cardiac stress test, a separate evaluation and management (E&M) code should not be reported separately unless a significant, separately identifiable E&M service is performed unrelated to the performance of the cardiac stress test. The E&M code should be reported with modifier 25 to indicate that it is a significant, separately identifiable E&M service.

8. Cardiovascular stress tests include insertion of needle and/or catheter, infusion/injection (pharmacologic stress tests) and ECG strips (e.g., CPT codes 36000, 36410, 96360-96376, 93000-93010, 93040-93042). These services should not be reported separately.

9. Microvolt T-wave alternans (MTWA) (CPT code 93025) testing requires a submaximal stress test that differs from the traditional exercise stress test (CPT codes 93015-93018) which utilizes a standard exercise protocol. CPT codes 93015-93018 should not be reported separately for the submaximal stress test integral to MTWA testing. If a physician performs an MTWA with submaximal stress test followed by a period of rest and then a

traditional stress test on the same date of service, both the MTWA and traditional stress test may be reported separately.

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

11. Routine monitoring of ECG rhythm and review of daily hemodynamics including cardiac output are part of critical care evaluation and management (E&M) services. Separate reporting of ECG rhythm strips and cardiac output measurements (CPT codes 93040-93042, 93561, 93562) with critical care E&M services is inappropriate. An exception to this principle may include a sudden change in patient status associated with a change in cardiac rhythm requiring a diagnostic ECG rhythm strip and return to the critical care unit. If reported separately, the time for this service is not included in the critical care time calculated for reporting the critical care E&M service.

12. 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 physician 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 physician may 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.

13. Cardiac catheterization and percutaneous coronary artery interventional procedures such as angioplasty, atherectomy, or stenting include insertion of a needle and/or catheter, infusion, fluoroscopy and ECG rhythm strips (e.g., CPT codes 36000, 36120, 36140, 36160, 36200-36248, 36410, 96360-96376, 71034, 76000-76001, 93040-93042). All these services are components of a cardiac catheterization or percutaneous coronary artery interventional procedure and are not separately reportable.

14. A cardiac catheterization procedure or a percutaneous coronary artery interventional procedure may require ECG tracings to assess chest pain during the procedure. These ECG tracings are not separately reportable. Diagnostic ECGs performed prior to or after the procedure may be separately reportable with modifier 59.

15. Percutaneous coronary artery interventions (e.g., stent, atherectomy, angioplasty) include coronary artery catheterization, radiopaque dye injections, and fluoroscopic guidance. CPT codes for these procedures (e.g., 93508, 93539, 93540, 93545, 76000) should not be reported separately. If medically reasonable and necessary diagnostic coronary angiography precedes the percutaneous coronary artery intervention, a coronary artery or cardiac catheterization and associated radiopaque dye injections may be reported separately. However, fluoroscopy is not separately reportable with diagnostic coronary angiography or cardiac catheterization.

16. While withdrawing the catheter during a cardiac catheterization procedure, physicians 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 physician 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 physician 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.

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. 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 with HCPCS code G0269. A physician should not separately report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

19. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (CPT codes 33202-33249) 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 (e.g., CPT codes 76000, 76001) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures (e.g., CPT code 71090 for fluoroscopy during insertion of a pacemaker) may be reported separately. Additionally, 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 CPT codes 33202-33249 or 93600-93662.

20. Occasionally it is medically reasonable and necessary to perform echocardiography (CPT codes 93303-93318) utilizing intravenous push injections of contrast. The injection of contrast (e.g., CPT codes 96365, 96374, 96375, 96376) is not separately reportable.

HCPCS codes C8921-C8930 describe echocardiography procedures with contrast and include echocardiography without contrast if performed at the same patient encounter. Under OPPS, facilities should report the appropriate code from the HCPCS code range C8921-C8930 when echocardiography is performed with contrast rather than the corresponding CPT code in the code range 93303-93350. Since the HCPCS codes C8921-C8930 include echocardiography without contrast if performed at the same patient encounter as echocardiography with contrast, a code from the HCPCS code range C8921-C8930 and the corresponding code from the CPT code range 93303-93352 should not be reported separately for the same patient encounter for echocardiography.

CPT code 93352 is an add-on code that describes use of echocardiographic contrast during stress echocardiography. It may be reported by physicians with CPT codes 93350 or 93351 in the appropriate site of service. CPT code 93352 is not separately payable under OPPS.

21. 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.

22. CPT code 93503 (insertion and placement of flow directed catheter (e.g., Swan Ganz)) should not be reported with CPT codes 36555-36556 (insertion of non-tunneled centrally inserted central venous catheter) or CPT codes 36568-36569 (insertion of peripherally inserted central venous catheter) for the insertion of a single catheter. If a physician does not complete the insertion of one type of catheter and subsequently inserts another at the same patient encounter, only the completed procedure may be reported.

23. Since cardioversion includes interrogation and programming of a cardioverter-defibrillator if performed, interrogation and programming of a cardioverter-defibrillator system (e.g., CPT codes 93282-93284, 93289, 93292, and 93295) should not be reported separately with a cardioversion procedure (e.g., CPT codes 92960, 92961).

24. Since electronic analysis of an antitachycardia pacemaker system includes interrogation and programming of the pacemaker system, interrogation and programming of a pacemaker

system (e.g., CPT codes 93279-93281, 93286, and 93288) should not be reported separately with electronic analysis of an antitachycardia pacemaker system (CPT code 93724).

## **J. Pulmonary Services**

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories.

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

2. If a physician in attendance for a pulmonary function study obtains a limited history and performs a limited physical examination related to the pulmonary function testing, separate reporting of an evaluation and management (E&M) service is not appropriate. If a significant, separately identifiable E&M service is performed unrelated to the performance of the pulmonary function test, an E&M service may be reported with modifier 25.

3. If multiple spirometric determinations are necessary to complete the service described by a CPT code, only one unit of service should be reported. For example, CPT code 94070 describes bronchospasm provocation with an administered agent and utilizes multiple spirometric determinations as in CPT code 94010. A single unit of service includes all the necessary spirometric determinations.

4. Complex pulmonary stress testing (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, ECG monitoring, spirometric parameters performed before, during and after exercise, oximetry, O<sub>2</sub> consumption, CO<sub>2</sub> production, rebreathing cardiac output calculations, etc., when performed as part of a complex pulmonary stress test. It is also inappropriate to report 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 RVUs. 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, 99281-99285, 99466-99467, 99291-99292, 99468-99469, 99471-99472, 99478-99480, 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.

7. CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) should not be reported for the same patient encounter. If performed at separate patient encounters on the same date of service, the two services may be reported separately.

#### **K. Allergy Testing and Immunotherapy**

The *CPT Manual* divides allergy and clinical immunology into testing and immunotherapy. Immunotherapy includes codes for the preparation of antigen (allergen) and separate codes for allergen administration.

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. A single test and a "sequential and incremental" test for the same dilution of an allergen should not be reported separately on the same date of service. For example, if the single test for an antigen is positive and the physician proceeds to "sequential and incremental" tests with three additional *different* dilutions of the same antigen, the physician may report one unit of service for the single test code and three units of service for the "sequential and incremental" test code.

2. Photo patch tests (CPT code 95052) consist of applying a patch(s) containing allergenic substance(s) to the skin and exposing the skin to light. Physicians should not unbundle this service by reporting both CPT code 95044 (patch or application tests) plus CPT code 95056 (photo tests) rather than CPT code 95052.

3. Evaluation and management (E&M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. Obtaining informed consent is included in the immunotherapy service and should not be reported with an E&M code. If E&M services are reported, modifier 25 should be utilized.

4. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. These codes should not be reported together for the same date of service. Additionally, testing is an integral component of rapid desensitization kits (CPT code 95180) and is not separately reportable.

#### **L. Neurology and Neuromuscular Procedures**

The *CPT Manual* defines codes for neuromuscular diagnostic and therapeutic services. Sleep testing, nerve and muscle testing, and electroencephalographic procedures are included. The *CPT Manual* guidelines for sleep testing are very precise and should be followed carefully when reporting these services.

1. Sleep testing differs from polysomnography in that the latter requires sleep staging. Sleep staging includes a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. A "sleep study" and "polysomnography" should not be reported separately for the same patient encounter.

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 (e.g., speed of paper, number of channels). EEG testing should not be reported separately with polysomnography unless a complete diagnostic EEG is performed separately in the usual manner at a separate patient encounter on the same date of service. If a complete diagnostic EEG is performed at a separate patient encounter on the same date of service as a polysomnography, modifier 59 should be appended to the EEG code.

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) describe different services than those provided during sleep testing or polysomnography. These procedures may be reported separately with sleep testing only if they are performed as significant, separately identifiable services distinct from EEG testing included in sleep testing or polysomnography. In the latter situation, the EEG codes must be reported with modifier 59 to indicate that a different service was performed.

4. If nerve testing (e.g., EMG, nerve conduction velocity) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the range of CPT codes 95851-95937 are not separately reportable. These codes describe significant, separately identifiable diagnostic services requiring a formal report in the medical record. Electrical stimulation used to identify or locate nerves during a procedure involving treatment of a cranial or peripheral nerve (e.g., nerve block, nerve destruction, neuroplasty, transection, excision, repair) is integral to the procedure and is not separately reportable.

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 report 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 appropriate only if the two procedures are performed on different nerves or at 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 should 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.

3. The psychiatric diagnostic interview examination (CPT codes 90801, 90802) and psychological/neuropsychological testing (CPT codes 96101, 96118) must be distinct services. *CPT Manual* instructions permit physicians "to integrate other sources of clinical data" into the report that is generated for CPT codes 96101 or 96118. Since the procedures described by CPT codes 96101 and 96118 are timed procedures, physicians should be careful to avoid reporting time for duplicating information

included in the psychiatric diagnostic interview examination and report.

4. A physician may report CPT codes 96101 (psychological testing...) or 96118 (neuropsychological testing...) only if the physician personally administers at least one test to the patient.

5. Central nervous system (CNS) assessment/test CPT codes (e.g., 96101-96105, 96118-96125) should not be reported for tests that are reportable as part of an evaluation and management service when performed. In order to report a CNS assessment/test CPT code the test cannot be self administered. It must be administered by a physician, psychologist, technician, or computer as required by the code descriptor of the reported CPT code. The test must assess CNS function (e.g., psychological health, aphasia, neuropsychological health) per requirements of the CNS assessment/test CPT code descriptors. The assessment must utilize tests described by the code descriptor or other tests not available in the public domain.

#### **N. Chemotherapy Administration**

1. The CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report two different "initial" service codes use NCCI-associated modifiers.

2. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services should not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. 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 separately report 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 claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

3. 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 non-facility based evaluation and management CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians should not report drug administration services in a facility setting, a facility based evaluation and management CPT code (e.g., 99281-99285) should not be reported with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the evaluation and management code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

Under OPPS, hospitals may report drug administration services and facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code.

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 drug administration service and is not separately reportable. Under these circumstances, 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.

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.

CPT codes 96521 and 96522 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.

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 96368 (concurrent intravenous infusion). CPT code 96368 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). Hydration concurrent with chemotherapy is not separately reportable.

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. Special Dermatological Procedures**

Medicare does not allow separate payment of E&M CPT code 99211 with photochemotherapy procedures (CPT codes 96910-96913) for services performed by a nurse or technician such as examining a patient prior to a subsequent procedure for burns or reactions to the prior treatment. If a physician performs a significant separately identifiable medically reasonable and necessary E&M

service on the same date of service, it may be reported with modifier 25.

#### **P. Physical Medicine and Rehabilitation**

1. 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.

2. 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 medically reasonable and necessary, it may be reported with modifier 59 appended to CPT code 97002 or 97004 as appropriate.

3. 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.

4. 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 appropriate only 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.

5. Based on *CPT Manual* instructions selective debridement (CPT codes 97597, 97598) should not be reported in conjunction with surgical debridement (CPT codes 11040-11044). Physicians cannot report these codes separately on the same date of service. However, under OPPS a facility may report these codes separately if the selective debridement and surgical debridement are performed on two separate and distinct wounds. The two procedures may be performed by the same practitioner or two separate practitioners and may be performed at the same or separate patient encounters on the same date of service. The same principle applies to CPT code 97602 which is payable under OPPS.

#### **Q. Medical Nutrition Therapy**

1. CPT codes 97802-97804 (medical nutrition therapy; . . .) are utilized to report Medicare covered medical nutrition therapy services after an initial referral each year. If during the same year there is a change in the patient's diagnosis, medical condition, or treatment regimen, the treating physician may make a second referral for medical nutrition therapy. These services should be reported with HCPCS codes G0270-G0271 (medical nutrition therapy . . . following second referral in same year for change in diagnosis, medical condition or treatment regimen . . .) rather than CPT codes 97802-97804.

#### **R. 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.

## **S. 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.

## **T. Miscellaneous Services**

1. When CPT code 99175 (Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison) is reported, observation time provided predominantly to monitor the patient for a response to an emetogenic agent should not be included in other timed codes (e.g., critical care, prolonged services).

2. If hypothermia is accomplished by regional infusion techniques, chemotherapy administration CPT codes should not be reported unless chemotherapeutic agents are also administered at the same patient encounter.

3. Therapeutic phlebotomy (CPT code 99195) is not separately reportable with autologous blood collection (CPT codes 86890, 86891), plasmapheresis, or exchange transfusion. Services integral to performing the phlebotomy (e.g., CPT codes 36000, 36410, 96360-96376) are not separately reportable.

## **U. Evaluation and Management (E&M) Services**

CPT codes for evaluation and management (E&M) services are principally included in the CPT code range 99201-99499. The codes describe the site of service (e.g., office, hospital, home, nursing facility, emergency department, critical care), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter), and various miscellaneous services (e.g., prolonged physician service, care plan oversight service). E&M services are further classified by the complexity of the relevant clinical history, physical examination, and medical decision

making. Some E&M codes are based on the duration of the encounter (e.g., critical care services).

Effective January 1, 2010 Medicare does not recognize consultation E&M CPT codes 99241 - 99255 for billing and payment purposes. If a physician performs a consultation E&M, the physician may report the appropriate level of E&M service for the site of service where the consultation E&M occurs.

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.

Since critical care (CPT codes 99291-99292) and prolonged physician E&M services (CPT codes 99354-99357) are reported based on time, providers should not include the time devoted to

performing separately reportable services when determining the amount of critical care or prolonged physician E&M service time.

Evaluation and management services, in general, are cognitive services, and significant procedural services are not included in 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, application of 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 in addition to patient history, examination, and medical decision making are included in the overall evaluation and management associated with critical and intensive care. Per CPT instructions, services including, but not limited to, 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 (ECGs, 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 and intensive care services and should not be reported separately. Under the OPSS the same services are not separately reportable with critical care CPT

code 99291. The hospital resources necessary to generate the information for interpretation by a physician are included in CPT code 99291.

Per Medicare rules critical and intensive care CPT codes include thoracic electrical bioimpedance (CPT code 93701) which should not be reported separately.

Certain sections of CPT codes include 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 from the range of CPT codes 99201-99499 should not 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.

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 (A/B MACs processing practitioner service claims.) 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 and A/B MACs processing practitioner service claims have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits. The NCCI, Carriers, and A/B MACs processing practitioner service claims do not have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. Examples of XXX procedures include allergy testing and immunotherapy, physical therapy services, and neurologic and vascular diagnostic testing procedures.

Pediatric and neonatal critical and intensive care CPT codes (99468-99480) are per diem codes that can be reported by one physician on each day of service. These codes are reported by the physician directing the inpatient critical or intensive care of the patient. These codes should not be reported by other physicians performing critical care services on the same date of service. Critical care services provided by a second physician of a different specialty may be reported with CPT codes 99291 and 99292.

#### **V. 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. For purposes of reporting units of service (UOS) for antigen preparation (i.e., CPT codes 95145-95170), the physician reports "number of doses". Medicare defines a dose for reporting purposes as 1 milliliter (ml). Thus, if a physician prepares a 10 ml vial of antigen, the physician may only report a maximum of 10 UOS for that vial even if the number of actual administered doses is greater than 10. Medicare payment amounts for these codes were determined by dividing the practice expenses for a 10 ml vial into ten doses. (See *Internet Only Claims Processing Manual*, Publication 100-04, Chapter 12, Section 200 (B)(7)).

4. CPT code 94681 (oxygen uptake, expired gas analysis; including CO<sub>2</sub> output, percentage oxygen extracted) may be reported one time per day. It includes rest and exercise determinations.

5. The unit of service for CPT code 90853 (Group psychotherapy (other than of a multiple family group)) is the patient encounter with completed therapy session even if it lasts longer than one hour. A practitioner may report only one unit of service on a single date of service. An outpatient facility may report one unit of service for each separate and distinct group therapy session provided by a different practitioner. Effective January 1, 2009, group therapy services provided in a PHP (partial hospitalization program) should be reported with HCPCS codes G0410 or G0411 which are timed codes. Prior to January 1, 2009, CMS permitted PHPs to report group therapy services utilizing CPT code 90853 with a unit of service corresponding to forty five to sixty minutes of therapy.

6. The MUE values for CPT codes 93797 and 93798 (physician services for outpatient cardiac rehabilitation . . . (per session)) are two (2). Medicare allows a maximum of 2 1-hour sessions per day.

7. The MUE value for CPT code 92546 (sinusoidal vertical axis rotational testing) is one (1). Since there is only one vertical axis and the word "testing" references all testing, not individual tests, only one unit of service may be reported for a patient encounter. Because it is highly unlikely that a provider would perform this testing at two separate patient encounters on the same date of service, correct reporting of this code on more than one line of a claim should be very uncommon.

## **W. 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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the

same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96375 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) 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. 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.

9. 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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.

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

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

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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 correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicare carriers, Fiscal Intermediaries, and A/B MACs 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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain

some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all (A/B MACs processing practitioner service claims) possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. 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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPSS

HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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. Most NCCI edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

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

#### **E. Specific Code Issues**

1. HCPCS code M0064 describes a brief face-to-face office visit with a practitioner licensed to perform the service for the sole purpose of monitoring or changing drug prescriptions used in the treatment of psychiatric disorders. HCPCS code M0064 is not separately reportable with CPT codes 90801-90857 (psychiatric services).

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

3. 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 reasonable and medically necessary E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported. However, if the Medicare covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

4. 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."

5. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82 . . .) and A9526 (Nitrogen N-13 Ammonia . . .) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG, . . .) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

6. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic . . .) describes a radiopharmaceutical utilized for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

7. HCPCS code A4220 describes a refill kit for an implantable pump. It should not be reported separately with CPT codes 95990 (refilling and maintenance of implantable pump . . . spinal . . . or brain . . .) or 95991 (refilling and maintenance of implantable pump . . . spinal . . . or brain . . .; administered by physician) since Medicare payment for these two CPT codes includes the refill kit.

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

9. HCPCS codes G0422 and G0423 (intensive cardiac rehabilitation; . . . per session) include the same services as the cardiac rehabilitation CPT codes 93797 and 93798 but at a greater frequency. Intensive cardiac rehabilitation may be reported with as many as six hourly sessions on a single date of service. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors.

Medical nutrition therapy (CPT codes 97802-97804) should not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately.

10. Pulmonary rehabilitation (HCPCS code G0424) includes therapeutic services and all related monitoring services to improve respiratory function. It requires measurement of patient outcome which includes, but is not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)). Pulmonary rehabilitation should not be reported with HCPCS codes G0237 (therapeutic procedures to increase strength or endurance of respiratory muscles . . . (includes monitoring)), G0238 (therapeutic procedures to improve respiratory function . . . (includes monitoring)), or G0239 (therapeutic procedures to improve respiratory function or increase strength . . . (includes monitoring)). The services are mutually exclusive. The procedures described by HCPCS codes G0237-G0239 include therapeutic procedures as well as all related monitoring services, the latter including, but not limited to, pulmonary function testing (e.g., pulmonary stress testing (CPT codes 94620 and 94621)).

11. HCPCS codes G0406-G0408 and G0425-G0427 describe inpatient telehealth consultation services. These codes should not be reported on the same date of service that a face-to-face evaluation and management code is reported.

12. HCPCS codes J1460-J1560 describe a series of codes for intramuscular gamma globulin injection. The codes differ in the unit of service ranging from "1 cc" for HCPCS code J1460 to "over 10 cc" for HCPCS code J1560. The MUE value for each code is one (1). For any volume of gamma globulin administered by intramuscular injection, there is only one code that describes that volume, and it may be reported with only one unit of service. Only one code from this series of codes may be reported on a single date of service.

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CHAPTER XIII  
Category III Codes  
CPT Codes 0001T - 0299T  
FOR  
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL  
FOR MEDICARE SERVICES

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**Chapter XIII**  
**Category III Codes**  
**CPT Codes 0001T - 0299T**

**A. Introduction**

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 0001T-0299T. 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 sections 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 (A/B MAC processing practitioner service claims). 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 (A/B MACs processing practitioner service claims) 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. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on

these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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. 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. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual*.

3. 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 or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code

G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Manual*.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999 or 64400-64530 for anesthesia for a procedure. 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), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a 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 96360-96376) 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 96360-96376 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, 62310-62319, 64400-64484, and 96360-

96376 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 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) 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 a 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 diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable 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. Most NCCI edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

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

endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

#### **E. Specific Code Issues**

1. CPT Code 0183T (low frequency, non-contact, non-thermal ultrasound...) is not separately reportable for treatment of the same wound with other active wound care management CPT codes (97597-97606) or wound debridement CPT codes (e.g., 11040-11044).

2. Since CPT code 0197T (intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy . . .) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields), 77014 (computed tomography guidance for placement of radiation therapy fields), or 77421 (stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy).