

CHAPTER XIII

Category III Codes CPT Codes 0001T - 0199T

NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICAID SERVICES

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Chapter XIII
Category III Codes
CPT Codes 0001T - 0199T

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 0001T-0199T. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

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

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

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

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 Medicaid Services".

The presence of a HCPCS/CPT code in an NCCI PTP edit or of an MUE value for a HCPCS/CPT code does not necessarily indicate that the code is covered by any or all state Medicaid programs.

B. Evaluation and Management (E&M) Services

Physician services can be categorized as either major surgical procedures, minor surgical procedures, non-surgical procedures, or evaluation and management (E&M) services. This section summarizes some of the rules for reporting E&M services in relation to major surgical, minor surgical and non-surgical procedures. Even in the absence of NCCI PTP edits, providers shall bill for their services following these rules.

The Medicaid NCCI program uses the same definition of major and minor surgery procedures as the Medicare program.

- Major surgery - those codes with 090 Global Days in the "Medicare Physician Fee Schedule Database / Relative Value File"
- Minor surgery - those codes with 000 or 010 Global Days

The Medicare designation of global days can be found on the Medicare/ National Physician Fee Schedule/ PFS Relative Value Files page of the CMS Medicare website at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html>

Select the calendar year and the file name with highest alphabetical suffix - e.g., RVUxxD - for the most recent version of the fee schedule. In the zip file, select document PPRRVU....xlsx" and refer to "Column O, Global Days".

An E&M service is separately reportable on the same date of service as a major or minor surgical procedure under limited circumstances.

If an E&M service 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 preoperative E&M services on the same date of service as a major surgical procedure are included in the global package for the procedure and are not separately reportable. There are currently no NCCI PTP edits based on this rule.

In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and *shall* not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform a 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 contains many, but not 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.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional During a Postoperative Period").

Many non-surgical procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work *shall not* be reported as a separate E&M code. Other non-surgical procedures are not usually performed by a physician and have no physician work associated with them. A physician *shall not* report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most non-surgical

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 non-surgical procedure but cannot include any work inherent in the non-surgical procedure, supervision of others performing the non-surgical procedure, or time for interpreting the result of the non-surgical procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as a non-surgical procedure is correct coding.

C. NCCI Procedure-to-Procedure Specific Issues

1. CPT code 0183T is deleted effective January 1, 2014 and replaced by CPT code 97610. This paragraph was relocated to Chapter XI, Section P. (Physical Medicine and Rehabilitation), paragraph 7.

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). (CPT codes 0197T and 77421 were deleted on January 1, 2015)

D. Medically Unlikely Edits (MUEs)

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

2. Providers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. The MUEs were set so that such occurrences should be uncommon. If a provider does this frequently for any HCPCS/CPT code, the provider may be coding units of service incorrectly. The provider should consider contacting his/her national health care organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national health care organization, provider, 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. MUE values for surgical procedures that may be performed bilaterally are based on the NCCI coding principle that a bilateral surgical procedure should be reported on one line of a claim with modifier 50 and one (1) unit of service. This coding principle does not apply to non-surgical diagnostic and therapeutic procedures.

E. General Policy Statements

1. MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians *shall* not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

2. 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, or providers, 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 Medicaid 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.

3. 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 Medicaid 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*.

4. 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. 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*.

5. With the exception of moderate conscious sedation (see below), the NCCI program does not allow separate reporting of anesthesia for a medical or surgical procedure when it is provided by the physician performing the procedure. The physician shall not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the physician shall not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96377) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

The NCCI program allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when it is provided by the same physician performing a medical or surgical procedure.

Under the NCCI program, 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 shall not report CPT codes 96360-96376 for these services.

Under the NCCI program, postoperative pain management is not separately reportable when it is provided by the physician performing an operative procedure. CPT codes 36000, 36410, 62320-62327, 64400-64489, and 96360-96377 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 PTP-associated modifier if performed in a non-facility site of service.

6. The global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) *shall* not be reported with a surgical procedure.

7. Wound repair CPT codes 12001-13153 *shall* not be reported separately to describe closure of incisions for surgical procedures. Closure/repair of a surgical incision is included in the global surgical package.. Simple, intermediate, and complex wound repair codes may be reported with Mohs surgery (CPT codes 17311-17315). Intermediate and complex repair codes may be reported with excision of benign lesions (CPT codes 11401-11406, 11421-11426, 11441-11471) and excision of malignant lesions (CPT codes 11600-11646). Wound repair codes (CPT codes 12001-13153) *shall* not be reported with excisions of benign lesions with an excised diameter of 0.5 cm or less (CPT codes 11400, 11420, 11440).

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. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI PTP-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 PTP-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the 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 PTP-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.

12. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or Medicaid NCCI policy for a code indicates that the procedure includes radiologic guidance, a physician *shall* not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI PTP-associated modifier if appropriate.

13. *CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device". CPT code 36592 describes "collection of blood specimen using an established central or peripheral venous catheter, not otherwise specified". These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.*

14. *CPT code 96523 describes "irrigation of implanted venous access device for drug delivery system". This code may be reported only if no other service is reported for the patient encounter.*