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CHAPTER XII
SUPPLEMENTAL SERVICES
HCPCS LEVEL II CODES A0000 - V9999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter XII
Supplemental Services
HCPCS Level II Codes A0000 - V9999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range A0000-V9999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

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

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

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

The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc. The general correct coding policies described in Chapter I apply to these codes as well as CPT codes. The correct coding edits and policy statements that follow address those HCPCS Level II codes that are reported to Medicare carriers and Fiscal Intermediaries for Part B services.

B. Evaluation and Management (E&M) Services

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

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

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

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

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. 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 day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

C. Medically Unlikely Edits (MUEs)

1 MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be

uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

D. General Policy Statements

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

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

3. HCPCS code M0064 is not to be reported separately from CPT codes 90801-90857 (psychiatric services). This code describes a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.

4. HCPCS code Q0091, for screening pap smears includes the services necessary to procure and transport the specimen to the laboratory. If an evaluation and management service is performed

at the same visit solely for the purpose of performing a screening pap smear, then the evaluation and management service is not reported separately. If a significant, separately identifiable evaluation and management service is performed to evaluate other medical problems, then both the screening pap smear and the evaluation and management service are reported. By appending the modifier -25 to the evaluation and management code, the provider is indicating that a significant, separately identifiable service was rendered.

5. HCPCS code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E&M) services under certain circumstances. If a Medicare covered E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported. However, if the Medicare covered E&M service and the screening services, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier -25 to the E&M service CPT code. Use of modifier -25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101.

6. HCPCS code G0102 (Prostate cancer screening; digital rectal examination) is not separately payable with an evaluation and management code (CPT codes 99201-99499). CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

> "As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

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

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

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

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

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

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

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

90760-90775) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

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

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

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

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

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

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

indicate that the biopsy and the more extensive procedure were planned or staged procedures.

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

12. 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.