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

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

A. Introduction

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

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

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

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

B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

1. The HCPCS/CPT codes 90760-90779 and C8957 describe services involving hydration, therapeutic, or diagnostic injections and infusions of non-chemotherapeutic drugs. The 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. The CPT codes 90760, 90765, 90774, 96409, and 96413 represent “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 vascular access sites. To

report two different “initial” service codes use NCCI-associated modifiers.

3. Because the placement of peripheral vascular access devices is integral to vascular (intravenous, intra-arterial) infusions and injections, the CPT codes for placement of these devices are not to be separately reported. Accordingly, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 90760-90768, 90774-90779, 96409-96417) should not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, these services may be reported separately. Because intra-arterial infusion often involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes may be reported separately.

4. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 90760-90779. If the sole purpose of fluid administration (e.g., saline, D_5W, 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. CPT codes 90760-90779, 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”.

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

7. 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.

8. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery.

The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 should NOT be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration. CPT codes 96522 and 96523 (irrigation of implanted venous access device for drug delivery system) should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

CPT code 96522 (refilling and maintenance of implantable pump or reservoir 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)).

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

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

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration,

and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 90760-90775 for these services.

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

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

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

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

13. CPT codes 90761 and 90766 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 general and special diagnostic services as well as a variety of therapeutic services. By *CPT Manual* definition, therapeutic services (e.g., HCPCS/CPT codes 90804-90829) include psychotherapy and continuing medical diagnostic evaluation; therefore, CPT codes 90801 and 90802 are not reported with these services.

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

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

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

D. Biofeedback

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

E. Dialysis

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

F. Gastroenterology

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

G. Ophthalmology

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

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

For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye

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

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

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

H. Otorhinolaryngologic Services

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

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

3. Treatment of swallowing dysfunction and/or oral function for feeding (CPT code 92526) may utilize electrical stimulation. HCPCS code G0283 (electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) should not be reported with CPT code 92526 for

electrical stimulation during the procedure. The NCCI edit (92526/G0283) for Medicare Carriers does not allow use of NCCI-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit in OCE for Fiscal Intermediaries does allow use of NCCI-associated modifiers because two separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the two procedures for different purposes at different patient encounters on the same date of service.

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

I. Cardiovascular Services

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

1. 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. In keeping with the policies outlined previously, procedures routinely performed as part of a comprehensive service are included in the comprehensive service and not separately

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

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

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

6. 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.

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

8. Routine monitoring of EKG rhythm and review of daily hemodynamics including cardiac output are part of critical care evaluation and management services. Separate reporting of EKG rhythm strips and cardiac output measurements (e.g., CPT codes

93040-93042, 93561, 93562) with critical care evaluation and management services is inappropriate. An exception to this may include a sudden change in patient status associated with a change in cardiac rhythm requiring a return to the ICU or telephonic transmission to review a rhythm strip. If reported separately, time included for this service is not included in the critical care time calculated for the critical care service.

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

10. 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.

11. Many Pacemaker/Pacing Cardioverter-Defibrillator procedures (HCPCS/CPT codes 33202-33249, G0297-G0300) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes are not separately reportable with the procedures described by HCPCS/CPT codes 33202-33249, G0297-G0300, and 93600-93662. Similarly, ultrasound guidance is not separately reportable with these HCPCS/CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by HCPCS/CPT codes 33202-33249, G0297-G0300, or 93600-93662.

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

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

14. 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.

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

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

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

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 as HCPCS code G0269. Providers should not report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

19. 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.

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

21. 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.

J. Pulmonary Services

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

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

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

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

4. Complex pulmonary stress testing (e.g., CPT code 94621) is a comprehensive stress test with a number of component tests separately defined in the *CPT Manual*. It is inappropriate to separately code venous access, EKG monitoring, spirometric parameters performed before, during and after exercise, oximetry, O_2 consumption, CO_2 production, rebreathing cardiac output calculations, etc., when performed as part of a complex pulmonary

stress test. It is also inappropriate to bill for a cardiac stress test and the component codes used to perform a simple pulmonary stress test (CPT code 94620), when a complex pulmonary stress test is performed. If using a standard exercise protocol, serial electrocardiograms are obtained, and a separate report describing a cardiac stress test (professional component) is included in the medical record, the professional components for both a cardiac and pulmonary stress test may be reported. Modifier -59 should be reported with the secondary procedure. Both tests must satisfy the requirement for medical necessity. (Since a complex pulmonary stress test includes electrocardiographic recordings, the technical components for both the cardiac stress test and the pulmonary stress test should not be reported separately.)

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

6. The procedure described by CPT code 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour) does not include any physician work 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, 99251-99255, 99281-99285, 99289-99300, 99304-99318, and 99324-99337 unless the physician supervises the performance of the procedure at a separate patient encounter on the same date of service outside the facility where the physician does have practice expenses related to the procedure.

7. CPT code 94640 (pressurized or nonpressurized 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 is divided into codes that include preparation of the antigen when it is administered at the same session and when it is prepared but delivered for immunotherapy by a different physician. Several specific issues are identified regarding allergy testing and immunotherapy.

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

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

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

L. Neurology and Neuromuscular Procedures

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

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

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

3. Continuous electroencephalographic monitoring services (CPT codes 95950-95962) represent different services than those provided during sleep testing; accordingly these codes are only to be reported when a separately identifiable service is performed and documented. Additionally, billing standard EEG services would only be appropriate if a significant, separately identifiable service is provided. These codes are to be reported with modifier -59 to indicate that a different service is clearly documented.

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

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

6. The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 95900 of this NCCI edit is only appropriate if the two procedures are performed on different nerves or in separate patient encounters.

M. Central Nervous System Assessments/Tests

1. Neurobehavioral status exam (CPT code 96116) should not be reported when a mini-mental status examination is performed. CPT code 96116 may never be reported with psychiatric diagnostic examinations (CPT codes 90801 or 90802). CPT code 96116 may be reported with other psychiatric services or evaluation and management services only if a complete neurobehavioral status exam is performed. If a mini-mental status examination is performed by a physician, it is included in the evaluation and management service.

2. CPT codes 96101-96103 describe psychological testing differing by method of performance and interpretation. Two or more codes from this code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different psychological tests. Similarly, CPT codes 96118-96120 describe neuropsychological testing differing by method of performance and interpretation. Two or more codes from this latter code range may be reported on the same date of service if and only if the differing testing techniques are utilized for different neuropsychological tests.

N. Chemotherapy Administration

1. The CPT codes 90760, 90765, 90774, 96409, and 96413 represent “initial” service codes. For a 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 vascular access sites. To report two different “initial” service codes use NCCI-associated modifiers.

2. CPT codes 90760-90779, 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. These codes should NOT be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

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

6. A concurrent intravenous infusion of an antiemetic or other non-chemotherapeutic drug with intravenous infusion of chemotherapeutic agents may be reported separately as CPT code 90768 (concurrent intravenous infusion). CPT code 90768 may be reported with a maximum of one unit of service per patient encounter regardless of the number of concurrently infused drugs or the length of time for the concurrent infusion(s).

7. Prior to January 1, 2005, the NCCI edits with column one CPT codes 96408 (Intravenous chemotherapy administration by push technique) and 96410 (Intravenous chemotherapy administration by infusion technique, up to one hour) each with column two CPT code 90780 (Therapeutic or diagnostic intravenous infusion up to one hour) were often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 90780 of these NCCI edits was only appropriate if the 90780 procedure was for hydration, antiemetic, or other non-chemotherapy drug administered before, after, or at different patient encounters than the chemotherapy. Modifier -59 should not have been used for “keep open” infusion for the chemotherapy.

O. 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

With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. (The only exception involves a “supervised modality” defined by CPT codes 97010-97028 which may be reported for the same fifteen minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI edits pair a “timed” CPT code with another “timed” CPT code or a non-timed CPT code. These edits may be bypassed with modifier -59 if the two procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter. NCCI does not include all edits pairing two physical medicine and rehabilitation services (excepting “supervised modality” services) even though they should never be reported for the same fifteen minute time period.

NCCI contains edits with column one codes of the physical medicine and rehabilitation therapy services and column two codes

of the physical therapy and occupational therapy re-evaluation CPT codes of 97002 and 97004 respectively. The re-evaluation services should not be routinely reported during a planned course of physical or occupational therapy. However, if the patient's status should change and a re-evaluation is warranted, it may be reported with modifier -59 appended to CPT code 97002 or 97004 as appropriate.

The procedure coded as CPT code 97755 (assistive technology assessment...direct one-on-one contact by provider, with written report, each 15 minutes) is intended for use on severely impaired patients requiring adaptive technology. For example, a patient with the use of only one or no limbs might require the use of high level adaptive technology.

The NCCI edit with column one CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column two CPT code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 97530 of this NCCI edit is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.

Q. 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.

R. 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.

S. Miscellaneous Services

1. When CPT code 99175 is reported, observation time provided exclusively to monitor the patient for a response to an emetogenic agent is not to be included in other timed codes (e.g., critical care, office visits, prolonged services, etc.).

2. If hypothermia (e.g., CPT code 99185) is accomplished by regional infusion techniques, separate services for chemotherapy administration should not be reported unless chemotherapeutic agents are also administered at the same session.

3. Therapeutic phlebotomy services (e.g., CPT code 99195) are not to be reported with transfusion service codes (e.g., CPT codes 86890, 86891), plasmapheresis codes, or exchange transfusion codes. Services necessary to perform the phlebotomy (e.g., CPT codes 36000, 36410, 90760-90775) are included in the procedure.

T. Evaluation and Management (E&M) Services

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

Rules governing the reporting of more than one E&M code for a patient on the same date of service are very complex and are not described herein. However, the NCCI contains numerous edits based on several principles including, but not limited to:

1. A physician may report only one “new patient” code on a single date of service.

2. A physician may report only one code from a range of codes describing an initial E&M service on a single date of service.

3. A physician may report only one “per diem” E&M service from a range of per diem codes on a single date of service.

4. A physician should not report an “initial” per diem E&M service with the same type of “subsequent” per diem service on the same date of service.

5. E&M codes describing observation/inpatient care services with admission and discharge on same date (CPT codes 99234-99236) should not be reported on the same date of service as initial hospital care per diem codes (99221-99223), subsequent hospital care per diem codes (99231-99233), or hospital discharge day management codes (99238-99239).

The prolonged physician service with direct face-to-face patient contact E&M codes (CPT codes 99354-99357) may be reported in conjunction with other evaluation and management codes. These prolonged service E&M codes are add-on codes that may generally be reported with the E&M codes listed in the CPT instruction following each CPT code in the code range 99354-99357.
Other E&M services are described by codes based on the duration of the encounter (e.g., critical care services).

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 the evaluation and management services. Certain procedural services that arise directly from the evaluation and management service are included as part of the evaluation and management service. For example, cleansing of traumatic lesions, closure of lacerations with adhesive strips, dressings, counseling and educational services are included in evaluation and management services.

Digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an evaluation and management code. CMS published this policy in the *Federal Register*, November 2, 1999, page 59414 as follows:

> “As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only

a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

Because of the intensive nature of caring for critically ill patients, certain services beyond patient history, examination and medical decision making are included in the overall evaluation and management associated with critical 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 (EKGs, blood pressures, hematologic data), gastric intubation (CPT code 91105), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94002-94004, 94660, 94662), and vascular access procedures (CPT codes 36000, 36410, 36600) are included in critical and intensive care services and should not be reported separately.

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 have incorporated codes describing specialty-specific services which primarily involve evaluation and management services. When codes for these services are reported, a separate evaluation and management service described by the range of CPT codes 99201-99499 is not to be reported on the same date of service. Examples of these codes include general and special ophthalmologic services and general and special diagnostic and therapeutic psychiatric services.

Procedural services involve some degree of physician involvement or supervision which is integral to the service. Separate evaluation and management services are not reported unless a significant, separately identifiable service is provided. Examples of such procedures include allergy testing and immunotherapy, osteopathic manipulative treatment, physical therapy services, neurologic and vascular testing procedures.

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

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

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

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

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. 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&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.

U. 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.

V. General Policy Statements

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

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

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

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

Under Medicare Global Surgery Rules, drug administration services (CPT codes 90760-90775) are not separately reportable by the

physician performing a procedure for drug administration services related to the procedure.

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

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

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

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

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

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

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

8. 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.