CHAP1-gencorrectcodingpolicies_final103116.doc
Revision Date: 1/1/2017

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

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LIST OF ACRONYMS

AA	Anesthesia Assistant
A/B MAC	A/B Medicare Administrative Contractor
ABN	Advanced Beneficiary Notice
AMA	American Medical Association
ASC	Ambulatory Surgical/Surgery Center
CBC	Complete Blood Count
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMT	Chiropractic Manipulative Treatment
CMV	Cytomegalovirus
CNS	Central Nervous System
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CT	Computed Tomography
CTA	Computed Tomographic Angiography
DME	Durable Medical Equipment
D.O.	Doctor of Osteopathy
DOJ	Department of Justice
ECG	Electrocardiogram
E/M or E&M	Evaluation & Management Services
EEG	Electroencephalogram
EMG	Electromyogram
FNA	Fine Needle Aspiration
HCPCS	Healthcare Common Procedure Coding System
HLA	Human Leukocyte Antigen
IPPB	Intermittent Positive Pressure Breathing
IVP	Intravenous Pyelogram
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
LT	Left Side
MAC	Monitored Anesthesia Care
MAI	MUE Adjudication Indicator
M.D.	Medical Doctor
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
PET	Positron Emission Tomography
PSC	Program Safeguard Contractor
PTP	Procedure-To-Procedure
RAC	Recovery Audit Contractor
RC	Right Coronary Artery

LIST OF ACRONYMS (Continued)

RT	Right Side
RS&I	Radiological Supervision and Interpretation
SPECT	Single Photon Emission Computed Tomography
SSA	Social Security Act
UOS	Unit(s) of Service
VAD	Ventricular Assist Device
WBC	White Blood Cell
ZPIC	Zoned Program Integrity Contractor

Chapter I

General Correct Coding Policies

A. Introduction

Healthcare providers utilize HCPCS/CPT codes to report medical services performed on patients to Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries (FIs). HCPCS (Healthcare Common Procedure Coding System) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA's) *CPT Manual* which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare & Medicaid Services (CMS) and are updated throughout the year as necessary. Changes in CPT codes are approved by the AMA CPT Editorial Panel which meets three times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific defining a single service (e.g., CPT code 93000 (electrocardiogram)) while other codes define procedures consisting of many services (e.g., CPT code 58263 (vaginal hysterectomy with removal of tube(s) and ovary(s) and repair of enterocele)). Because many procedures can be performed by different approaches, different methods, or in combination with other procedures, there are often multiple HCPCS/CPT codes defining similar or related procedures.

CPT and HCPCS Level II code descriptors usually do not define all services included in a procedure. There are often services inherent in a procedure or group of procedures. For example, anesthesia services include certain preparation and monitoring services.

The CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together. Prior to April 1, 2012, NCCI PTP edits were placed into either the "Column One/Column Two Correct Coding Edit Table" or the "Mutually Exclusive Edit Table". However, on April 1, 2012, the edits in the "Mutually Exclusive Edit Table" were moved to the "Column One/Column Two Correct Coding Edit Table" so that all the NCCI PTP edits are currently contained in this single table. Combining the two tables simplifies researching NCCI PTP edits and online use of NCCI tables.

Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment. (NCCI-associated modifiers and their appropriate use are discussed elsewhere in this chapter.)

When the NCCI was first established and during its early years, the “Column One/Column Two Correct Coding Edit Table” was termed the “Comprehensive/Component Edit Table”. This latter terminology was a misnomer. Although the column two code is often a component of a more comprehensive column one code, this relationship is not true for many edits. In the latter type of edit the code pair edit simply represents two codes that should not be reported together. For example, a provider should not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

In this chapter, Sections B–Q address various issues relating to NCCI PTP edits.

Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is one that allows the vast majority of appropriately coded claims to pass the MUE. More information concerning MUEs is discussed in Section V of this chapter.

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 [e.g., CMS *Internet-only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50(Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS

Internet-only Manual, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-only Manual* (*IOM*) instructions.

Physicians must report services correctly. This manual discusses general coding principles in Chapter I and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. There are certain types of improper coding that physicians must avoid.

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

- A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician should report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician should not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less;) plus CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)).

- A physician should not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician should report CPT code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code 46600(Anoscopy; diagnostic,...) plus CPT code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be utilized with an endoscopic procedure code.

- A physician should not unbundle a bilateral procedure code into two unilateral procedure codes. For example if a physician performs bilateral mammography, the physician

should report CPT code *77066* (*Diagnostic m*ammography... bilateral). The physician should not report CPT code *77065* (*Diagnostic m*ammography... unilateral) with two units of service or *77065*LT plus *77065*RT.

- A physician should not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician should not report CPT code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. For example if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider should report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician should not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must avoid upcoding. A HCPCS/CPT code may be reported only if all services described by that code have been performed. For example, if a physician performs a superficial axillary lymphadenectomy (CPT code 38740), the physician should not report CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. For example, some therapy codes are reported in fifteen minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A physician should not report a "per session" code using fifteen minute increments. CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.

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 should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

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

This chapter addresses general coding principles, issues, and policies. Many of these principles, issues, and policies are addressed further in subsequent chapters dealing with specific groups of HCPCS/CPT codes. In this chapter examples are often utilized to clarify principles, issues, or policies. The examples do not represent the only codes to which the principles, issues, or policies apply.

B. Coding Based on Standards of Medical/Surgical Practice

Most HCPCS/CPT code defined procedures include services that are integral to them. Some of these integral services have specific CPT codes for reporting the service when not performed as an integral part of another procedure. (For example, CPT code 36000 (introduction of needle or intracatheter into a vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein.) Other integral services do not have specific CPT codes. (For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.) Services integral to HCPCS/CPT code defined procedures are included in those procedures based on the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

Many NCCI PTP edits are based on the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. When integral component services have their own HCPCS/CPT codes, NCCI PTP edits place the comprehensive service in column one and the component service in column two. Since a component service integral to a comprehensive service is not separately reportable, the column two code is not separately reportable with the column one code.

Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration
- Insertion of urinary catheter
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia Services)
- Local, topical or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS unit
- Institution of Patient Controlled Anesthesia
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where CMS policy permits separate payment

Although other chapters in this Manual further address issues related to the standards of medical/surgical practice for the procedures covered by that chapter, it is not possible because of space limitations to discuss all NCCI PTP edits based on the principle of the standards of medical/surgical practice. However, there are several general principles that can be applied to the edits as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.

2. The component service is usually necessary to complete the comprehensive service.

3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Specific examples of services that are not separately reportable because they are components of more comprehensive services follow:

Medical:

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

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

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

Surgical:

1. Since a myringotomy requires access to the tympanic membrane through the external auditory canal, removal of impacted cerumen from the external auditory canal is not separately reportable.

2. A “scout” bronchoscopy to assess the surgical field, anatomic landmarks, extent of disease, etc., is not separately reportable with an open pulmonary procedure such as a pulmonary lobectomy. By contrast, an initial diagnostic bronchoscopy is separately reportable. If the diagnostic bronchoscopy is performed at the same patient encounter as the open pulmonary procedure and does not duplicate an earlier diagnostic bronchoscopy by the same or another physician, the diagnostic bronchoscopy may be reported with modifier 58 appended to the open pulmonary procedure code to indicate a staged procedure. A cursory examination of the upper airway during a bronchoscopy with the bronchoscope should not be reported separately as a laryngoscopy. However, separate endoscopies of anatomically distinct areas with different endoscopes may be reported separately (e.g., thoracoscopy and mediastinoscopy).

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Since a colectomy requires exposure of the colon, the laparotomy and adhesiolysis to expose the colon are not separately reportable.

C. Medical/Surgical Package

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work.

The component elements of the pre-procedure and post-procedure work for each procedure are included component services of that procedure as a standard of medical/surgical practice. Some general guidelines follow:

1. Many invasive procedures require vascular and/or airway access. The work associated with obtaining the required access is included in the pre-procedure or intra-procedure work. The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work.

Airway access is necessary for general anesthesia and is not separately reportable. There is no CPT code for elective endotracheal intubation. CPT code 31500 describes an emergency endotracheal intubation and should not be reported for elective endotracheal intubation. Visualization of the airway is a component part of an endotracheal intubation, and CPT codes describing procedures that visualize the airway (e.g., nasal endoscopy, laryngoscopy, bronchoscopy) should not be reported with an endotracheal intubation. These CPT codes describe diagnostic and therapeutic endoscopies, and it is a misuse of these codes to report visualization of the airway for endotracheal intubation.

Intravenous access (e.g., CPT codes 36000, 36400, 36410) is not separately reportable when performed with many types of procedures (e.g., surgical procedures, anesthesia procedures,

radiological procedures requiring intravenous contrast, nuclear medicine procedures requiring intravenous radiopharmaceutical). After vascular access is achieved, the access must be maintained by a slow infusion (e.g., saline) or injection of heparin or saline into a “lock”. Since these services are necessary for maintenance of the vascular access, they are not separately reportable with the vascular access CPT codes or procedures requiring vascular access as a standard of medical/surgical practice. CPT codes 37211-37214 (Transcatheter therapy with infusion for thrombolysis) should not be reported for use of an anticoagulant to maintain vascular access.

The global surgical package includes the administration of fluids and drugs during the operative procedure. CPT codes 96360-*96377* should not be reported separately. Under OPPS, the administration of fluids and drugs during or for an operative procedure are included services and are not separately reportable (e.g., CPT codes 96360-*96377*).

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

Insertion of a central venous access device (e.g., central venous catheter, pulmonary artery catheter) requires passage of a catheter through central venous vessels and, in the case of a pulmonary artery catheter, through the right atrium and ventricle. These services often require the use of fluoroscopic guidance. Separate reporting of CPT codes for right heart catheterization, selective venous catheterization, or pulmonary artery catheterization is not appropriate when reporting a CPT code for insertion of a central venous access device. Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 76001, 77002) should not be reported separately.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia services by the same physician performing a surgical or medical procedure. The physician performing a surgical or medical procedure should not report CPT codes 96360-*96377* for the administration of anesthetic agents during the procedure. If it is medically reasonable and necessary that a separate provider (anesthesia practitioner) perform anesthesia services (e.g., monitored anesthesia care) for a surgical or medical procedure, a

separate anesthesia service may be reported by the second provider.

Under OPPS, anesthesia for a surgical procedure is an included service and is not separately reportable. For example, a provider should not report CPT codes 96360-*96377* for anesthesia services.

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

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Many procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable. Examples of these services include cardiac monitoring, pulse oximetry, and ventilation management (e.g., 93000-93010, 93040-93042, 94760, 94761, 94770).

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

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

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

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

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

If a single lesion is biopsied multiple times, only one biopsy code may be reported with a single unit of service. If multiple lesions are non-endoscopically biopsied, a biopsy code may be reported for each lesion appending a modifier indicating that each biopsy was performed on a separate lesion. For endoscopic biopsies, multiple biopsies of a single or multiple lesions are reported with one unit of service of the biopsy code. If it is medically reasonable and necessary to submit multiple biopsies of the same or different lesions for separate pathologic examination, the medical record must identify the precise location and separate nature of each biopsy.

6. Exposure and exploration of the surgical field is integral to an operative procedure and is not separately reportable. For example, an exploratory laparotomy (CPT code 49000) is not separately reportable with an intra-abdominal procedure. If exploration of the surgical field results in additional procedures other than the primary procedure, the additional procedures may generally be reported separately. However, a procedure designated by the CPT code descriptor as a "separate procedure" is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

7. If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement, incision and drainage) is not separately reportable. *Types of procedures to which this principle applies include, but are not limited to, -ectomy, -otomy, excision, resection, -plasty, insertion, revision, replacement, relocation, removal or closure.* For example, debridement of skin and subcutaneous tissue at the site of an abdominal incision made to perform an intra-abdominal procedure is not separately reportable. (See Chapter IV, Section H (General Policy Statements), Paragraph #*11* for guidance on reporting debridement with open fractures and dislocations.)

8. If removal, destruction, or other form of elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure may be reported. For example, if an area of pilonidal disease contains an abscess, incision and drainage of the abscess during the procedure to excise the area of pilonidal disease is not separately reportable.

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

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

11. If a procedure utilizing one approach fails and is converted to a procedure utilizing a different approach, only the completed procedure may be reported. For example, if a laparoscopic hysterectomy is converted to an open hysterectomy, only the open hysterectomy procedure code may be reported.

12. If a laparoscopic procedure fails and is converted to an open procedure, the physician should not report a diagnostic laparoscopy in lieu of the failed laparoscopic procedure. For example, if a laparoscopic cholecystectomy is converted to an open cholecystectomy, the physician should not report the failed laparoscopic cholecystectomy nor a diagnostic laparoscopy.

13. If a diagnostic endoscopy is the basis for and precedes an open procedure, the diagnostic endoscopy may be reported with modifier 58 appended to the open procedure code. However, the medical record must document the medical reasonableness and necessity for the diagnostic endoscopy. A scout endoscopy to assess anatomic landmarks and extent of disease is not separately reportable with an open procedure. When an endoscopic procedure fails and is converted to another surgical procedure, only the completed surgical procedure may be reported. The endoscopic procedure is not separately reportable with the completed surgical procedure.

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

usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.

D. Evaluation and Management (E&M) Services

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

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP 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 preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the 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 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 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").

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

inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

E. Modifiers and Modifier Indicators

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

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicare restrictions are fulfilled. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU

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

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

It is very important that NCCI-associated modifiers only be used when appropriate. In general these circumstances relate to separate patient encounters, separate anatomic sites or separate specimens. (See subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have NCCI PTP

modifier indicators of “1” because the two codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations. However, if the two corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers generally should not be utilized.

The appropriate use of most of these modifiers is straight-forward. However, further explanation is provided about modifiers 25, 58, and 59. Although modifier 22 is not a modifier that bypasses an NCCI PTP edit, its use is occasionally relevant to an NCCI PTP edit and is discussed below.

a) **Modifier 22**: Modifier 22 is defined by the *CPT Manual* as “Increased Procedural Services”. This modifier should not be reported routinely but only when the service(s) performed is (are) substantially more extensive than the usual service(s) included in the procedure described by the HCPCS/CPT code reported.

Occasionally a provider may perform two procedures that should not be reported together based on an NCCI PTP edit. If the edit allows use of NCCI-associated modifiers to bypass it and the clinical circumstances justify use of one of these modifiers, both services may be reported with the NCCI-associated modifier. However, if the NCCI PTP edit does not allow use of NCCI-associated modifiers to bypass it and the procedure qualifies as an unusual procedural service, the physician may report the column one HCPCS/CPT code of the NCCI PTP edit with modifier 22. The Carrier (A/B MAC processing practitioner service claims) may then evaluate the unusual procedural service to determine whether additional payment is justified.

For example, CMS limits payment for CPT code 69990(microsurgical techniques, requiring use of operating microscope...) to procedures listed in the *Internet-only Manual* (*IOM*) (*Claims Processing Manual,* Publication 100-04, 12-§20.4.5). If a physician reports CPT code 69990 with two other CPT codes and one of the codes is not on this list, an NCCI PTP edit with the code not on the list will prevent payment for CPT code 69990. Claims processing systems do not determine which procedure is linked

with CPT code 69990. In situations such as this, the physician may submit his claim to the local carrier (A/B MAC processing practitioner service claims) for readjudication appending modifier 22 to the CPT code. Although the carrier (A/B MAC processing practitioner service claims) cannot override an NCCI PTP edit that does not allow use of NCCI-associated modifiers, the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

b) **Modifier 25**: The *CPT Manual* defines modifier 25 as a "significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service". Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.

c) **Modifier 58**: Modifier 58 is defined by the *CPT Manual* as a "staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period". It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI-associated modifiers.

If a diagnostic endoscopic procedure results in the decision to perform an open procedure, both procedures may be reported with modifier 58 appended to the HCPCS/CPT code for the open procedure. However, if the endoscopic procedure preceding an open procedure is a "scout" procedure to assess anatomic

landmarks and/or extent of disease, it is not separately reportable.

Diagnostic endoscopy is never separately reportable with another endoscopic procedure of the same organ(s) when performed at the same patient encounter. Similarly, diagnostic laparoscopy is never separately reportable with a surgical laparoscopic procedure of the same body cavity when performed at the same patient encounter.

If a planned laparoscopic procedure fails and is converted to an open procedure, only the open procedure may be reported. The failed laparoscopic procedure is not separately reportable. The NCCI contains many, but not all, edits bundling laparoscopic procedures into open procedures. Since the number of possible code combinations bundling a laparoscopic procedure into an open procedure is much greater than the number of such edits in NCCI, the principle stated in this paragraph is applicable regardless of whether the selected code pair combination is included in the NCCI tables. A provider should not select laparoscopic and open HCPCS/CPT codes to report because the combination is not included in the NCCI tables.

d) **Modifier 59:** Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. The *CPT Manual* defines modifier 59 as follows:

> **Modifier 59: “Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it

should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

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

Some examples of the appropriate use of modifier 59 are contained in the individual chapter policies.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe "different procedure or surgery". The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service.

There are several exceptions to this general principle about misuse of modifier 59 that apply to some code pair edits for procedures performed at the same patient encounter.

(1) When a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, that diagnostic procedure may be considered to be a separate and distinct procedure as long

as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure, it should not be reported separately. *For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service.*

(2) When a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a)it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

(3) There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two separate and distinct timed services are provided in separate and distinct time blocks, modifier 59 may be used to identify the services. The separate and distinct time blocks for the two services may be sequential to one another or split. When the two services are split, the time block for one service may be followed by a time block for the second service followed by another time block for the first service. All Medicare rules for reporting timed services are applicable. For example, the total time is calculated for all related timed services performed. The number of reportable units of service is based on the total time, and these units of service are allocated between the HCPCS/CPT codes for the individual services performed. The physician is not permitted to perform multiple services, each for the minimal reportable time, and report each of these as separate units of service. (e.g., A physician or therapist

performs eight minutes of neuromuscular reeducation (CPT code 97112) and eight minutes of therapeutic exercises (CPT code 97110). Since the physician or therapist performed 16 minutes of related timed services, only one unit of service may be reported for one, not each, of these codes.)

Use of modifier 59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. It does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site.

If the same procedure is performed at different anatomic sites, it does not necessarily imply that a HCPCS/CPT code may be reported with more than one unit of service (UOS) for the procedure. Determining whether additional UOS may be reported depends in part upon the HCPCS/CPT code descriptor including the definition of the code’s unit of service, when present.

Example #1: The column one/column two code edit with column one CPT code 38221 (bone marrow biopsy) and column two CPT code 38220(bone marrow, aspiration only) includes two distinct procedures when performed at separate anatomic sites or separate patient encounters. In these circumstances, it would be acceptable to use modifier 59. However, if both 38221 and 38220 are performed through the same skin incision at the same patient encounter which is the usual practice, modifier 59 should NOT be used. Although CMS does not allow separate payment for CPT code 38220 with CPT code 38221 when bone marrow aspiration and biopsy are performed through the same skin incision at a single patient encounter, CMS does allow separate payment for HCPCS level II code G0364 (bone marrow aspiration performed with bone marrow biopsy through same incision on the same date of service) with CPT code 38221 under these circumstances.

Example #2: The procedure to procedure edit with column one CPT code 11055 (paring or cutting of benign hyperkeratotic lesion ...) and column two CPT code 11720 (debridement of nail(s) by any method; 1 to 5) may be bypassed with modifier 59 only if the paring/cutting of a benign hyperkeratotic lesion is performed on a different digit (e.g., toe) than one that has nail debridement. Modifier 59 should not be used to bypass the edit if the two procedures are performed on the same digit.

e) **Modifiers XE, XS, XP, XU:** These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, physicians may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service.

XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"

XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"

XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

F. Standard Preparation/Monitoring Services for Anesthesia

With few exceptions anesthesia HCPCS/CPT codes do not specify the mode of anesthesia for a particular procedure. Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service HCPCS/CPT codes when performed in association with the anesthesia service. However, if the provider of the anesthesia service performs one or more of these services prior to and unrelated to the anticipated anesthesia service or after the patient is released

from the anesthesia practitioner's postoperative care, the service may be separately reportable with modifier 59.

G. Anesthesia Service Included in the Surgical Procedure

Under the CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical procedure. For example, separate payment is not allowed for the physician's performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. However, Medicare allows separate reporting for moderate conscious sedation services (CPT codes *99151-99153*) when provided by same physician performing a medical or surgical procedure.

CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia should not be reported in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician. Examples of improperly reported services that are bundled into the anesthesia service when anesthesia is provided by the physician performing the medical or surgical procedure include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), intravenous infusion/injection (CPT codes 96360-96368, 96374-*96377*) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042). However, if these services are not related to the delivery of an anesthetic agent, or are not an inherent component of the procedure or global service, they may be reported separately.

The physician performing a surgical or medical procedure should not report an epidural/subarachnoid injection (CPT codes *62320-62327*) or nerve block (CPT codes 64400-64530) for anesthesia for that procedure.

H. HCPCS/CPT Procedure Code Definition

The HCPCS/CPT code descriptors of two codes are often the basis of an NCCI PTP edit. If two HCPCS/CPT codes describe redundant services, they should not be reported separately. Several general principles follow:

1. A family of CPT codes may include a CPT code followed by one or more indented CPT codes. The first CPT code descriptor

includes a semicolon. The portion of the descriptor of the first code in the family preceding the semicolon is a common part of the descriptor for each subsequent code of the family. For example:

CPT code 70120 Radiologic examination, mastoids; less than 3 views per side
CPT code 70130 complete, minimum of 3 views per side

The portion of the descriptor preceding the semicolon ("Radiologic examination, mastoids") is common to both CPT codes 70120 and 70130. The difference between the two codes is the portion of the descriptors following the semicolon. Often as in this case, two codes from a family may not be reported separately. A physician cannot report CPT codes 70120 and 70130 for a procedure performed on ipsilateral mastoids at the same patient encounter. It is important to recognize, however, that there are numerous circumstances when it may be appropriate to report more than one code from a family of codes. For example, CPT codes 70120 and 70130 may be reported separately if the two procedures are performed on contralateral mastoids or at two separate patient encounters on the same date of service.

2. If a HCPCS/CPT code is reported, it includes all components of the procedure defined by the descriptor. For example, CPT code 58291 includes a vaginal hysterectomy with "removal of tube(s) and/or ovary(s)". A physician cannot report a salpingo-oophorectomy (CPT code 58720) separately with CPT code 58291.

3. CPT code descriptors often define correct coding relationships where two codes may not be reported separately with one another at the same anatomic site and/or same patient encounter. A few examples follow:

a) A "partial" procedure is not separately reportable with a "complete" procedure.

b) A "partial" procedure is not separately reportable with a "total" procedure.

c) A "unilateral" procedure is not separately reportable with a "bilateral" procedure.

d) A "single" procedure is not separately reportable with a "multiple" procedure.

e) A “with” procedure is not separately reportable with a “without” procedure.

f) An “initial” procedure is not separately reportable with a “subsequent” procedure.

I. *CPT Manual* and CMS Coding Manual Instructions

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

The *CPT Manual* also includes coding instructions which may be found in the “Introduction”, individual chapters, and appendices. In individual chapters the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow *CPT Manual* instructions unless CMS has provided different coding or reporting instructions.

The American Medical Association publishes *CPT Assistant* which contains coding guidelines. CMS does not review nor approve the information in this publication. In the development of NCCI PTP edits, CMS occasionally disagrees with the information in this publication. If a physician utilizes information from *CPT Assistant* to report services rendered to Medicare patients, it is possible that Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries may utilize different criteria to process claims.

J. CPT “Separate Procedure” Definition

If a CPT code descriptor includes the term “separate procedure”, the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the “separate procedure” designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifier 59 or a more specific modifier (e.g., anatomic modifier) may be appended to the “separate procedure” CPT code to indicate that it qualifies as a separately reportable service.

K. Family of Codes

The *CPT Manual* often contains a group of codes that describe related procedures that may be performed in various combinations. Some codes describe limited component services, and other codes describe various combinations of component services. Physicians must utilize several principles in selecting the correct code to report:

1. A HCPCS/CPT code may be reported if and only if all services described by the code are performed.

2. The HCPCS/CPT code describing the services performed should be reported. A physician should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed. There are limited exceptions to this rule which are specifically identified in this Manual.

3. HCPCS/CPT code(s) corresponding to component service(s) of other more comprehensive HCPCS/CPT code(s) should not be reported separately with the more comprehensive HCPCS/CPT code(s) that include the component service(s).

4. If the HCPCS/CPT codes do not correctly describe the procedure(s) performed, the physician should report a “not otherwise specified” CPT code rather than a HCPCS/CPT code that most closely describes the procedure(s) performed.

L. More Extensive Procedure

The *CPT Manual* often describes groups of similar codes differing in the complexity of the service. Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable. Several examples of this principle follow:

1. If two procedures only differ in that one is described as a “simple” procedure and the other as a “complex” procedure, the “simple” procedure is included in the “complex” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

2. If two procedures only differ in that one is described as a “simple” procedure and the other as a “complicated” procedure, the “simple” procedure is included in the “complicated” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

3. If two procedures only differ in that one is described as a “limited” procedure and the other as a “complete” procedure, the “limited” procedure is included in the “complete” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

4. If two procedures only differ in that one is described as an “intermediate” procedure and the other as a “comprehensive” procedure, the “intermediate” procedure is included in the “comprehensive” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

5. If two procedures only differ in that one is described as a “superficial” procedure and the other as a “deep” procedure, the “superficial” procedure is included in the “deep” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

6. If two procedures only differ in that one is described as an “incomplete” procedure and the other as a “complete” procedure, the “incomplete” procedure is included in the “complete” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

7. If two procedures only differ in that one is described as an “external” procedure and the other as an “internal” procedure, the “external” procedure is included in the “internal” procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

M. Sequential Procedure

Some surgical procedures may be performed by different surgical approaches. If an initial surgical approach to a procedure fails and a second surgical approach is utilized at the same patient

encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. If there are different HCPCS/CPT codes for the two different surgical approaches, the two procedures are considered “sequential”, and only the HCPCS/CPT code corresponding to the second surgical approach may be reported. For example, a physician may begin a cholecystectomy procedure utilizing a laparoscopic approach and have to convert the procedure to an open abdominal approach. Only the CPT code for the open cholecystectomy may be reported. The CPT code for the failed laparoscopic cholecystectomy is not separately reportable.

N. Laboratory Panel

The *CPT Manual* defines organ and disease specific panels of laboratory tests. If a laboratory performs all tests included in one of these panels, the laboratory may report the CPT code for the panel or the CPT codes for the individual tests. If the laboratory repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended.

O. Misuse of Column Two Code with Column One Code (Misuse of Code Edit Rationale)

CMS manuals and instructions often describe groups of HCPCS/CPT codes that should not be reported together for the Medicare program. Edits based on these instructions are often included as misuse of column two code with column one code.

A HCPCS/CPT code descriptor does not include exhaustive information about the code. Physicians who are not familiar with a HCPCS/CPT code may incorrectly report the code in a context different than intended. The NCCI has identified HCPCS/CPT codes that are incorrectly reported with other HCPCS/CPT codes as a result of the misuse of the column two code with the column one code. If these edits allow use of NCCI-associated modifiers (modifier indicator of “1”), there are limited circumstances when the column two code may be reported on the same date of service as the column one code. Two examples follow:

1. Three or more HCPCS/CPT codes may be reported on the same date of service. Although the column two code is misused if reported as a service associated with the column one code, the column two code may be appropriately reported with a third HCPCS/CPT code reported on the same date of service. For

example, CMS limits separate payment for use of the operating microscope for microsurgical techniques (CPT code 69990) to a group of procedures listed in the online *Claims Processing Manual* (Chapter 12, Section 20.4.5 (Allowable Adjustments)). The NCCI has edits with column one codes of surgical procedures not listed in this section of the manual and column two CPT code of 69990. Some of these edits allow use of NCCI-associated modifiers because the two services listed in the edit may be performed at the same patient encounter as a third procedure for which CPT code 69990 is separately reportable.

2. There may be limited circumstances when the column two code is separately reportable with the column one code. For example, the NCCI has an edit with column one CPT code of 80061 (lipid profile) and column two CPT code of 83721 (LDL cholesterol by direct measurement). If the triglyceride level is less than 400 mg/dl, the LDL is a calculated value utilizing the results from the lipid profile for the calculation, and CPT code 83721 is not separately reportable. However, if the triglyceride level is greater than 400 mg/dl, the LDL may be measured directly and may be separately reportable with CPT code 83721 utilizing an NCCI-associated modifier to bypass the edit.

Misuse of code as an edit rationale may be applied to procedure to procedure edits where the column two code is not separately reportable with the column one code based on the nature of the column one coded procedure. This edit rationale may also be applied to code pairs where use of the column two code with the column one code is deemed to be a coding error.

P. Mutually Exclusive Procedures

Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an “initial” service or a “subsequent” service. With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same patient encounter.

Q. Gender-Specific Procedures

The descriptor of some HCPCS/CPT codes includes a gender-specific restriction on the use of the code. HCPCS/CPT codes specific for

one gender should not be reported with HCPCS/CPT codes for the opposite gender. For example, CPT code 53210 describes a total urethrectomy including cystostomy in a female, and CPT code 53215 describes the same procedure in a male. Since the patient cannot have both the male and female procedures performed, the two CPT codes cannot be reported together.

R. Add-on Codes

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

Add-on codes permit the reporting of significant supplemental services commonly performed in addition to the primary procedure. By contrast, incidental services that are necessary to accomplish the primary procedure (e.g., lysis of adhesions in the course of an open cholecystectomy) are not separately reportable with an add-on code. Similarly, complications inherent in an invasive procedure occurring during the procedure are not separately reportable. For example, control of bleeding during an invasive procedure is considered part of the procedure and is not separately reportable.

In general, NCCI procedure to procedure edits do not include edits with most add-on codes because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure. (I.e., if an edit prevents payment of the primary procedure code, the add-on code should not be paid.) However, NCCI does include edits for some add-on codes when coding edits related to the primary procedures must be supplemented. Examples include edits with add-on HCPCS/CPT codes 69990 (microsurgical techniques requiring use of operating microscope) and 95940/95941/G0453 (intraoperative neurophysiology testing).

HCPCS/CPT codes that are not designated as add-on codes should not be misused as an add-on code to report a supplemental service. A HCPCS/CPT code may be reported if and only if all services described by the CPT code are performed. A HCPCS/CPT code should not be reported with another service because a portion of the service described by the HCPCS/CPT code was

performed with the other procedure. For example: If an ejection fraction is estimated from an echocardiogram study, it would be inappropriate to additionally report CPT code 78472 (cardiac blood pool imaging with ejection fraction) with the echocardiography (CPT code 93307). Although the procedure described by CPT code 78472 includes an ejection fraction, it is measured by gated equilibrium with a radionuclide which is not utilized in echocardiography.

S. Excluded Service

The NCCI does not address issues related to HCPCS/CPT codes describing services that are excluded from Medicare coverage or are not otherwise recognized for payment under the Medicare program.

T. Unlisted Procedure Codes

The *CPT Manual* includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes and are located at the end of each section or subsection of the manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service should be reported utilizing an unlisted procedure code. A physician should not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI generally does not include edits with these codes.

U. Modified, Deleted, and Added Code Pairs/Edits – Information moved to Introduction chapter, Section (Purpose), Page Intro-5 of this Manual

V. Medically Unlikely Edits (MUEs)

To lower the Medicare Fee-For-Service Paid Claims Error Rate, CMS has established units of service edits referred to as Medically Unlikely Edit(s) MUEs).

An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service.

The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE.

All practitioner claims submitted to Carriers (A/B MACs processing practitioner service claims), outpatient facility services claims (Type of Bill 13X, 14X, 85X) submitted to Fiscal Intermediaries (A/B MACs processing facility claims), and supplier claims submitted to Durable Medical Equipment (DME) MACs are tested against MUEs.

Prior to April 1, 2013, each line of a claim was adjudicated separately against the MUE value for the HCPCS/CPT code reported on that claim line. If the units of service on that claim line exceeded the MUE value, the entire claim line was denied.

In the April 1, 2013 version of MUE, CMS began introducing date of service (DOS) MUEs. Over time CMS will convert many, but not all, MUEs to DOS MUEs. Since April 1, 2013, MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the units of service (UOS) on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS MUE, all UOS on each claim line for the same date of service for the same HCPCS/CPT code are summed, and the sum is compared to the MUE value. If the summed UOS exceed the MUE value, all UOS for the HCPCS/CPT code for that date of service are denied. Denials due to claim line MUEs or DOS MUEs may be appealed to the local claims processing contractor. DOS MUEs are utilized for HCPCS/CPT codes where it would be extremely unlikely that more UOS than the MUE value would ever be performed on the same date of service for the same patient.

The MUE files on the CMS NCCI website display an “MUE Adjudication Indicator” (MAI) for each HCPCS/CPT code. An MAI of “1” indicates that the edit is a claim line MUE. An MAI of “2” or “3” indicates that the edit is a DOS MUE.

If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, appropriate use of CPT modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.

MUEs for HCPCS codes with an MAI of “2” are absolute date of service edits. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the HIPAA mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for CPT 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of “2” denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy.

MUEs for HCPCS codes with an MAI of “3” are “per day edits based on clinical benchmarks”. MUEs assigned an MAI of “3” are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If contractors have evidence (e.g., medical review) that UOS in excess of the MUE value were actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

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

(2) CPT code descriptors/CPT coding instructions in the *CPT Manual* may limit units of service. For example, a procedure described as the “initial 30 minutes” would have an MUE value of

“1” because of the use of the term “initial”.

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

reporting of bilateral procedures to a single unit of service reported with a bilateral modifier.

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

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

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

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

(5) The nature of a procedure/service may limit units of service and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).

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

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

(8) Prescribing information is based on FDA labeling as well as off-label information published in CMS approved drug compendia.

(9) Submitted claims data (100%) from a six month period is utilized to ascertain the distribution pattern of UOS typically billed for a given HCPCS/CPT code.

UOS denied based on an MUE may be appealed. Because a denial of services due to an MUE is a coding denial, not a medical

necessity denial, the presence of an Advanced Beneficiary Notice of Noncoverage (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, contractors should review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1”. CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider/ supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

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

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

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

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

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

(5) The MUE values for some drug codes are set to 0. The rationale for such values include but are not limited to: discontinued manufacture of drug, non-FDA approved compounded drug, practitioner MUE values for oral anti-neoplastic, oral anti-emetic, and oral immune suppressive drugs which should be billed to the DME MACs, outpatient hospital MUE values for inhalation drugs which should be billed to the DME MACs, and Practitioner/ASC MUE values for HCPCS C codes describing medications that would not be related to a procedure performed in an ASC.

Non-drug related HCPCS/CPT codes may be assigned an MUE of 0 for a variety of reasons including, but not limited to: outpatient hospital MUE value for surgical procedure only performed as an inpatient procedure, noncovered service, bundled service, or packaged service.

The MUE files on the CMS NCCI website display an “Edit Rationale” for each HCPCS/CPT code. Although an MUE may be based on several rationales, only one is displayed on the website. One of the listed rationales is “Data.” This rationale indicates that 100% claims data from a six month period of time was the major factor in determining the MUE value. If a physician appeals an MUE denial for a HCPCS/CPT code where the MUE is based on “Data,” the reviewer will usually confirm that (1) the correct code is reported; (2) the correct UOS is utilized; (3) the number of reported UOS were performed; and (4) all UOS were medically reasonable and necessary.

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

Many surgical procedures may be performed bilaterally. Instructions in the CMS *Internet-only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12

(Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 20.6.2 require that bilateral surgical procedures be reported using modifier 50 with one unit of service. If a bilateral surgical procedure is performed at different sites bilaterally (e.g., transforaminal epidural injections (CPT codes 64480, 64484)), one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

Some A/B MACs allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple units of service. If a provider reports services in this fashion, the provider should report the “from date” and “to date” on the claim line. Contractors are instructed to divide the units of service reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line.

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

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

supplier may choose to discuss these questions with the local

Medicare contractor or a national healthcare organization whose members frequently perform the procedure.

Most MUE values are published on the CMS MUE webpage (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html). However, some MUE values are not published and are confidential. These values should not be published in oral or written form by any party that acquires one or more of them.

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

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

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

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

W. Add-on Code Edit Tables

Add-on codes are discussed in Chapter I, Section R (Add-on Codes). CMS publishes a list of add-on codes and their primary codes annually prior to January 1. The list is updated quarterly based on the AMA's "CPT Errata" documents or implementation of new HCPCS/CPT add-on codes. CMS identifies add-on codes and

their primary codes based on *CPT Manual* instructions, CMS interpretation of HCPCS/CPT codes, and CMS coding instructions.

The NCCI program includes three Add-on Code Edit Tables, one table for each of three “Types” of add-on codes. Each table lists the add-on code with its primary codes. An add-on code, with one exception, is eligible for payment if and only if one of its primary codes is also eligible for payment.

The “Type I Add-on Code Edit Table” lists add-on codes for which the *CPT Manual* or HCPCS tables define all acceptable primary codes. Claims processing contractors should not allow other primary codes with Type I add-on codes. CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) is included as a Type I add-on code since its only primary code is CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes). For Medicare purposes, CPT code 99292 may be eligible for payment to a physician without CPT code 99291 if another physician of the same specialty and physician group reports and is paid for CPT code 99291.

The “Type II Add-on Code Edit Table” lists add-on codes for which the *CPT Manual* and HCPCS tables do not define any primary codes. Claims processing contractors should develop their own lists of acceptable primary codes.

The “Type III Add-on Code Edit Table” lists add-on codes for which the *CPT Manual* or HCPCS tables define some, but not all, acceptable primary codes. Claims processing contractors should allow the listed primary codes for these add-on codes but may develop their own lists of additional acceptable primary codes.

Although the add-on code and primary code are normally reported for the same date of service, there are unusual circumstances where the two services may be reported for different dates of service (e.g., CPT codes 99291 and 99292).

The first Add-On Code edit tables were implemented April 1, 2013. For subsequent years, new Add-On Code edit tables will be published to be effective for January 1 of the new year based on changes in the new year’s *CPT Manual*. CMS also issues quarterly updates to the Add-On Code edit tables if required due to publication of new HCPCS/CPT codes or changes in add-on codes or their primary codes. The changes in the quarterly update files

(April 1, July 1, or October 1) are retroactive to the implementation date of that year’s annual Add-On Code edit files unless the files specify a different effective date for a change. Since the first Add-On Code edit files were implemented on April 1, 2013, changes in the July 1 and October 1 quarterly updates for 2013 were retroactive to April 1, 2013 unless the files specified a different effective date for a change.