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CHAPTER V
SURGERY: RESPIRATORY, CARDIOVASCULAR, HEMIC AND LYMPHATIC SYSTEMS
CPT CODES 30000-39999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 30000-39999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

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

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

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

Open procedures of the thorax include the approach and exploration. CPT code 32100 (thoracotomy, major; with exploration and biopsy) should not be reported separately with open thoracic procedures to describe the approach and exploration. CPT code 32100 may be separately reportable with an open thoracic procedure if: (1) it is performed on the contralateral side; (2) it is performed on the ipsilateral side through a separate skin incision; or (3) it is performed to obtain a biopsy at a different site than the other open thoracic procedure.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules. All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, 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.

C. Respiratory System

1. The nose and mouth have mucocutaneous margins. Numerous procedures (e.g., biopsy, destruction, excision) have CPT codes that describe the procedure as an integumentary procedure (CPT codes 10000-19999), a nasal procedure (CPT codes 30000-30999), or an oral procedure (CPT codes 40000-40899). If a procedure is performed on a lesion at or near a mucocutaneous margin, only one CPT code which best describes the procedure may be reported. If

the code descriptor of a CPT code from the respiratory system (or any other system) includes a tissue transfer service (e.g., flap, graft), the CPT codes for such services (e.g., transfer, graft, flap) from the integumentary system (e.g., CPT codes 14000-15770) should not be reported separately.

2. A biopsy performed in conjunction with a more extensive nasal/sinus procedure is not separately reportable unless the biopsy is examined pathologically prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the result of the pathologic examination.

Example: If a patient presents with nasal obstruction, sinus obstruction and multiple nasal polyps, it may be reasonable to perform a biopsy prior to, or in conjunction with, polypectomy and ethmoidectomy. A separate biopsy code (e.g., CPT code 31237 for nasal/sinus endoscopy) should not be reported with the removal nasal/sinus endoscopy code (e.g., CPT code 31255) because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic or surgical endoscopy of the respiratory system is performed, it is a standard of practice to evaluate the access regions. A separate HCPCS/CPT code should not be reported for this evaluation of the access regions. For example, if an endoscopic anterior ethmoidectomy is performed, a diagnostic nasal endoscopy should not be reported separately simply because the approach to the ethmoid sinus is transnasal. Similarly, fiberoptic bronchoscopy routinely includes an examination of the nasal cavity, pharynx, and larynx. A separate HCPCS/CPT code should not be reported with the bronchoscopy HCPCS/CPT code for this latter examination whether it is limited (“cursory”) or complete.

If medically reasonable and necessary endoscopic procedures are performed on two regions of the respiratory system with different types of endoscopes, both procedures may be separately reportable. For example, if a patient requires diagnostic bronchoscopy for a lung mass with a fiberoptic bronchoscope and a separate laryngoscopy for a laryngeal mass with a fiberoptic laryngoscope at the same patient encounter, HCPCS/CPT codes for both procedures may be reported separately. It must be medically reasonable and necessary to utilize two separate endoscopes to report both codes.

If the findings of a diagnostic endoscopy lead to the decision to perform a non-endoscopic surgical procedure at the same patient

encounter, the diagnostic endoscopy may be reported separately. However, if a “scout” endoscopic procedure to evaluate the surgical field (e.g., confirmation of anatomic structures, assess extent of disease, confirmation of adequacy of surgical procedure such as tracheostomy) is performed at the same patient encounter as an open surgical procedure, the endoscopic procedure is not separately reportable.

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.

A diagnostic endoscopy is not separately reportable with a surgical endoscopy per *CPT Manual* instructions. If an endoscopic procedure fails and is converted into an open procedure, the endoscopic procedure is not separately reportable with the open procedure. Neither the surgical endoscopy nor diagnostic endoscopy code should be reported with the open procedure code when a surgical endoscopy is converted to an open procedure.

Example: A patient presents with aspiration of a foreign body. A bronchoscopy is performed identifying lobar foreign body obstruction, and an attempt is made to remove this obstruction during the bronchoscopy. It would be inappropriate to report CPT codes 31622 (diagnostic bronchoscopy) and 31635 (surgical bronchoscopy with removal of foreign body). Only the "surgical" endoscopy, CPT code 31635, may be reported. In this example, if the endoscopic effort fails and a thoracotomy is performed, the diagnostic bronchoscopy may be reported separately in addition to the thoracotomy. Modifier 58 may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. However, the CPT code for the surgical bronchoscopy to remove the foreign body is not separately reportable because the procedure was converted to an open procedure. If the surgeon decides to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, this confirmatory bronchoscopy is not separately reportable although the initial diagnostic bronchoscopy may still be reportable.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service may be reported. *CPT Manual* instructions indicate that surgical sinus endoscopy includes a sinusotomy (if appropriate) and a diagnostic sinus endoscopy. However, if the medically necessary procedure is a sinusotomy and

a sinus endoscopy is performed to evaluate adequacy of the sinusotomy and visualize the sinus cavity for disease, it may be appropriate to report the sinusotomy HCPCS/CPT code rather than the sinus endoscopy HCPCS/CPT code.

5. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. For example, control of nasal hemorrhage (CPT code 30901) is not separately reportable for control of bleeding due to a nasal/sinus endoscopic procedure. If bleeding occurs in the postoperative period and requires return to the operating room for treatment, a HCPCS/CPT code for control of the bleeding may be reported with modifier 78 indicating that the procedure was a complication of a prior procedure requiring treatment in the operating room. However, control of postoperative bleeding not requiring return to the operating room is not separately reportable.

Like CPT code 30901, CPT codes 30801 (ablation, soft tissue of inferior turbinates...; superficial), 30903 (control of hemorrhage, anterior...), 30905 (control of hemorrhage, posterior...), and 31238 (nasal/sinus endoscopy, surgical; with control of nasal hemorrhage) should not be reported separately for control of bleeding due to a nasal/sinus endoscopic procedure or other nasal procedure.

6. When endoscopic service(s) are performed, the most comprehensive code describing the service(s) rendered should be reported. If multiple services are performed and not adequately described by a single CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended to the secondary service CPT code(s). Additionally, only medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

7. CPT codes 31292, 31293, and 31294 describe nasal/sinus endoscopy with “medial or inferior orbital wall decompression”, “medial and inferior orbital wall decompression”, and “optic nerve decompression” respectively. These procedures include the following procedures which may not be reported separately when performed on the ipsilateral side: CPT codes 31256 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy;), 31267 (Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus), 31276 (Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus), 31287 (Nasal/sinus endoscopy, surgical, with sphenoidotomy;), and 31288 (Nasal/sinus

endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus). CPT code 30130 (Excision inferior turbinate, partial or complete, any method) is also included and not separately reportable if performed on the ipsilateral side to allow access to the ethmoid or other sinuses in order to perform the procedures described by CPT codes 31292-31294. However, CPT code 30130 may be reported separately, if performed on the ipsilateral side, for a purpose unrelated to allowing access to the sinuses to perform the procedures described by CPT codes 31292-31294. If any of the included procedures are performed on the contralateral side from the procedures described by CPT codes 31292-31294, they may be reported separately.

8. Lavage by cannulation of a respiratory accessory sinus (e.g., CPT codes 31000 (maxillary sinus), 31002(sphenoid sinus)) is an integral component when performed with a more definitive procedure on that sinus. Lavage by cannulation should not be reported separately with another code describing a more definitive sinus procedure (e.g., CPT codes 31256, 31267, 31295) when performed on the ipsilateral sinus at the same patient encounter.

9. If laryngoscopy is required for elective or emergency placement of an endotracheal tube, the laryngoscopy is not separately reportable. CPT code 31500 describes an emergency endotracheal intubation procedure and should not be reported when an elective intubation is performed. For example, if intubation is performed in a rapidly deteriorating patient who requires mechanical ventilation, a separate HCPCS/CPT code may be reported for the intubation with adequate documentation of the reasons for the intubation.

10. An emergency endotracheal intubation procedure (CPT code 31500) is normally followed by a chest radiologic examination to confirm proper positioning of the endotracheal tube. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

11. The descriptor for CPT code 31600 (Tracheostomy, planned (separate procedure)) includes the “separate procedure” designation. Therefore, pursuant to the CMS “separate procedure” policy, a tracheostomy is not separately reportable with laryngeal surgical procedures that frequently require tracheostomy (e.g., laryngotomy, laryngectomy, laryngoplasty).

12. If laryngoscopy is required for placement of a tracheostomy, the tracheostomy (CPT codes 31600-31610) may be reported. The laryngoscopy is not separately reportable.

13. CPT code 92511 (nasopharyngoscopy with endoscope) should not be reported separately when performed as a cursory examination with other respiratory endoscopic procedures.

14. A diagnostic thoracoscopy (CPT codes 32601, 32604, 32606) is not separately reportable with a surgical thoracoscopy on the ipsilateral side of the thorax.

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

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

15. A tube thoracostomy (CPT code 32551) may be performed for drainage of an abscess, empyema, or hemothorax. The code descriptor for CPT code 32551 defines it as a “separate procedure”. It is not separately reportable when performed at the same patient encounter as another open procedure of the thorax unless it is performed in the thoracic cavity contralateral to the one entered to perform the open thoracic procedure.

16. A *pleural drainage procedure (e.g., CPT codes 32556, 32557), thoracentesis procedure (e.g., CPT codes 32554, 32555), or* chest tube insertion procedure (e.g., CPT codes 32550, 32551) is often followed by a chest radiologic examination to confirm *adequacy of the procedure, lack of complications, or* the proper

location and positioning of the chest tube. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

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

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

19. A diagnostic biopsy(s) of the lung from an anatomic location removed during a more extensive procedure (e.g., segmentectomy, lobectomy, thoracoscopic (VATS) lobectomy) at the same patient encounter is not separately reportable with the more extensive procedure. This principle is applicable whether the lung biopsy(s) is examined pathologically during the intraoperative procedure or postoperatively. This principle is applicable whether the biopsy(s) is for purposes of diagnosis, determining whether the more extensive procedure should be performed, or determining the extent of the more extensive procedure. This principle is also applicable regardless of the surgical approach (i.e., open or thoracoscopic (VATS)) or technique (e.g., incisional, excisional, resection, stapled wedge) to perform the biopsy(s).

A diagnostic biopsy(s) of the lung is separately reportable with a more extensive lung procedure performed at the same patient encounter if the anatomic location of the biopsy is not included in the more extensive procedure.

D. Cardiovascular System

1. Coronary artery bypass procedures utilizing venous grafts (CPT codes 33510-33523) include procurement of the venous graft(s) as an integral component of the procedure. CPT codes 37700-37735 (ligation of saphenous veins) should not be reported separately for procurement of the venous grafts.

2. When a coronary artery bypass procedure is performed, the most comprehensive code describing the procedure should be reported. When venous grafting only is performed, only one code in the range of coronary artery bypass CPT codes 33510-33516 may be reported. No other bypass codes should be reported with these codes. One code in the range of CPT codes 33517-33523 (combined arterial-venous grafting) and one code in the range of CPT codes 33533-33536 (arterial grafting) may be reported together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, only one code in the range of CPT codes 33533-33536 may be reported.

3. During venous or combined arterial venous coronary artery bypass grafting procedures (CPT codes 33510-33523), it is occasionally necessary to perform epi-aortic ultrasound. This procedure may be reported with CPT code 76998 (ultrasonic guidance, intraoperative) appending modifier 59. CPT code 76998 should not be reported for ultrasound guidance utilized to procure the vascular graft.

4. Cardiopulmonary bypass requires insertion of cannulas into the venous and arterial circulation which is integral to the procedure. HCPCS/CPT codes for insertion of the cannulas into the venous and arterial circulation should not be reported separately.

5. CPT codes 33210 and 33211 describe insertion or replacement of temporary transvenous single and dual chamber respectively cardiac electrodes or pacemaker catheters. These codes should not be reported with open or percutaneous cardiac procedures performed at the same patient encounter.

6. Many of the code descriptors in the CPT code range 36800-36861 (hemodialysis access, intervascular cannulation, shunt insertion) include the “separate procedure” designation. Pursuant to the CMS “separate procedure” policy, these “separate procedures” are not separately reportable with vascular revision procedures at the same site/vessel.

7. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy, and/or bypass. When a thromboendarterectomy is performed at the site of an aneurysm repair or graft insertion, the thromboendarterectomy is not separately reportable. If a bypass procedure requires an endarterectomy to insert the bypass graft, only the code describing the bypass may be reported. The endarterectomy is not separately reportable. If both an aneurysm repair (e.g., after

rupture) and a bypass are performed at separate non-contiguous sites, the aneurysm repair code and the bypass code may be reported with an anatomic modifier or modifier 59. If a thromboendarterectomy is medically necessary due to vascular occlusion in a different vessel, the appropriate code may be reported with an anatomic modifier or modifier 59 indicating that the procedures were performed in non-contiguous vessels.

At a given site, only one type of bypass (venous, non-venous) code may be reported. If different vessels are bypassed with different types of grafts, separate codes may be reported. If the same vessel has multiple obstructions and requires bypass with different types of grafts in different areas, separate codes may be reported. However, it is necessary to indicate that multiple procedures were performed by using an anatomic modifier or modifier 59.

8. When an open or percutaneous vascular procedure (e.g., thromboendarterectomy) is performed, the repair and closure are included components of the vascular procedure. CPT codes 35201-35286 (repair of blood vessel including extensive repair) are not separately reportable in addition to the primary vascular procedure unless the CPT code descriptor states that repair or closure is separately reportable.

9. *Repair and closure of a blood vessel utilized for vascular access during the performance of a procedure is an included component of that procedure. Repair of the blood vessel (e.g., CPT codes 35201-35286) should not be reported separately.*

10. If a failed percutaneous vascular procedure is followed by an open procedure by the same physician at the same patient encounter (e.g., percutaneous transluminal angioplasty, thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the HCPCS/CPT code for the completed procedure, which is usually the more extensive open procedure may be reported. If a percutaneous procedure is performed on one lesion and a similar open procedure is performed on a separate lesion, the HCPCS/CPT code for the percutaneous procedure may be reported with modifier 59 only if the lesions are in distinct and separate anatomically defined vessels. If similar open and percutaneous procedures are performed on different lesions in the same anatomically defined vessel, only the open procedure may be reported.

11. The CPT codes 36000, 36406, 36410, etc. represent very common procedures performed to gain venous access for phlebotomy,

prophylactic intravenous access, infusion therapy, chemotherapy, hydration, transfusion, drug administration, etc. When intravenous access is routinely obtained in the course of performing other medical/diagnostic/surgical procedures or is necessary to accomplish the procedure (e.g., infusion therapy, chemotherapy), it is inappropriate to separately report the venous access services. CPT codes 96360-96361 should not be reported for infusions to maintain patency of a vascular access site.

12. When a non-coronary percutaneous intravascular interventional procedure is performed on the same vessel at the same patient encounter as diagnostic angiography (arteriogram/venogram), only one selective catheter placement code for the vessel may be reported. If the angiogram and the percutaneous intravascular interventional procedure are not performed in immediate sequence and the catheter(s) are left in place during the interim, a second selective catheter placement or access code should not be reported. Additionally, dye injections to position the catheter should not be reported as a second angiography procedure.

13. Open and percutaneous interventional vascular procedures include operative angiograms and/or venograms which should not be separately reported as diagnostic angiograms/venograms. The *CPT Manual* describes the circumstances under which a provider may separately report a diagnostic angiogram/venogram at the time of an interventional vascular procedure. A diagnostic angiogram/venogram may be separately reportable with modifier 59 if it satisfies *CPT Manual* guidelines, national Medicare guidelines, and local Medicare Administrative Contractor guidelines. If the code descriptor for a vascular procedure specifically includes diagnostic angiography, the provider should not separately report a diagnostic angiography code.

If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed prior to the date of the open or percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the open or percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier 59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 in addition to modifier 59 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed

tomographic) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the open or percutaneous intravascular interventional procedure.

14. If a median sternotomy is utilized to perform a cardiothoracic procedure, the repair of the sternotomy is not separately reportable. CPT codes 21820-21825 (treatment of sternum fracture) should not be reported for repair of the sternotomy.

If a cardiothoracic procedure is performed after a prior cardiothoracic procedure with sternotomy (e.g., repeat procedure, new procedure, treatment of postoperative hemorrhage), removal of embedded wires is not separately reportable.

15. If a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure. For example, if a reoperation for coronary artery bypass or valve procedures requires removal of previously inserted sternal wires, removal of these wires is not separately reportable.

16. When existing vascular access lines or selectively placed catheters are utilized to procure arterial or venous samples, reporting the sample collection separately is inappropriate. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling. CPT code 75893 includes concomitant venography if performed. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure.

17. Peripheral vascular bypass CPT codes describe bypass procedures with venous and other grafting materials (CPT codes 35501-35683). These procedures are mutually exclusive since only one type of bypass procedure may be performed at a site of obstruction. If multiple sites of obstruction are treated with different types of bypass procedures at the same patient encounter, multiple bypass procedure codes may be reported with anatomic modifiers or modifier 59. If a physician attempts a graft with one material but completes the graft with another

material, only the one code describing the completed procedure should be reported.

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

19. Vascular obstruction may be caused by thrombosis, embolism, atherosclerosis or other conditions. Treatment may include thrombectomy, embolectomy and/or endarterectomy. CPT codes describe embolectomy/thrombectomy (e.g., CPT codes 34001-34490), atherectomy (e.g., CPT codes 0234T-0238T, 37225, 37227, 37229, 37231, 37233, 37235), and thromboendarterectomy (e.g., CPT codes 35301-35390). Only the most comprehensive code describing the services performed at a given site/vessel may be reported. Therefore, for a given site/vessel, codes from more than one of the above code ranges should not be reported together. If a percutaneous interventional procedure fails (e.g., balloon thrombectomy) and the same physician performs an open procedure (e.g., thromboendarterectomy) at the same patient encounter, only the completed procedure, generally the more extensive open procedure, may be reported.

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

21. CPT codes 35800-35860 describe treatment of postoperative hemorrhage requiring return to the operating room. These codes should not be reported for the treatment of hemorrhage during the initial operative session nor treatment of postoperative hemorrhage not requiring return to the operating room. These codes should generally be reported with modifier 78 indicating that the procedure represents a return to the operating room for a related procedure in the postoperative period.

22. Many Pacemaker/Implantable Defibrillator procedures (CPT codes 33202-33249) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers under fluoroscopic guidance. Physicians should not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes (e.g., CPT codes 76000, 76001) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures may be reported separately. Additionally, ultrasound guidance is not separately reportable with these CPT codes. Physicians should not report CPT codes 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by CPT codes 3320*2*-33249 or 93600-93662.

Insertion or replacement of a temporary transvenous cardiac electrode or pacemaker catheter (CPT codes 33210, 33211) during a pacemaker/implantable defibrillator procedure (CPT codes 33202-33249) or intracardiac electrophysiology procedure (CPT codes 93600-93662) is not separately reportable. CPT codes 33210 and 33211 include the “separate procedure” designation in their code descriptors and are not separately reportable with another surgical procedure performed in the same anatomic area at the same patient encounter.

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

24. CPT codes 33218 and 33220 describe repair of single and two transvenous electrodes respectively for a permanent pacemaker or implantable defibrillator. These procedures include incising the skin pocket for the device, removing the device, repairing the lead, and reinserting the original device. CPT codes for device removal, insertion, or replacement or skin pocket revision should not be reported for the typical procedure when the original device is replaced. However, if a new device is used to replace the original device, CPT codes 33227-33229 or 33262-33264 may be reported additionally for replacement with a new device.

25. CPT code 37202 (transcatheter therapy, infusion other than for thrombolysis, any type...) describes an arterial infusion directly into an artery of a non-chemotherapeutic medication to treat the artery for disease (e.g., vasospasm) other than thrombolysis. This code should not be utilized to report intravenous infusions, arterial push injections (CPT code 96373), or chemotherapy infusions. It should not be reported for infusion for systemic therapy. This code should not be reported for infusion into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. This code may be reported separately when a catheter is inserted into a blood vessel for the purpose of the transcatheter therapy of the blood vessel. CPT code 75896 (Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary), radiological supervision and interpretation) may be reported for the radiological supervision and interpretation associated with the transcatheter therapy described by CPT code 37202.

Similarly CPT codes 37211-37214(transcatheter therapy with infusion for thrombolysis of non-coronary vessel) may be reported when a blood vessel is catheterized for the purpose of transcatheter infusion for thrombolysis of a non-coronary vessel. CPT code 75896 should not be reported for the radiological supervision and interpretation associated with CPT codes 37211-37214 since these codes include radiological supervision and interpretation. With the exception of lower extremity endovascular revascularization procedures (CPT codes 37220-37235), CPT codes 37211-37214 should not be reported for infusion of a thrombolytic agent into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. Thrombolysis in a lower extremity vessel may be reported separately with an endovascular revascularization procedure (CPT codes 37220-37235). *(CPT codes 37202 and 75896 were deleted January 1, 2016.)*

26. The procedure described by CPT code 37204 (transcatheter occlusion or embolization (eg, for tumor destruction)...) includes infusion of the occlusion/embolization agent. It is not appropriate to separately report CPT code 77750 (infusion or instillation of radioelement solution...) if the embolization agent is a radioelement solution. Similarly it is not appropriate to separately report CPT code 77778 (interstitial

radiation source application...) in addition to CPT code 37204 for infusion of the radioelement solution. (CPT code 37204 was deleted January 1, 2014.)(CPT codes 77776 and 77777 were deleted January 1, 2016.)

27. The *CPT Manual* defines primary and secondary percutaneous transluminal arterial mechanical thrombectomies. The *CPT Manual* contains an instruction which states: "Do not report 37184-37185 for mechanical thrombectomy performed for retrieval of short segments of thrombus or embolus evident during other percutaneous interventional procedures. See 37186 for these procedures." Based on this CPT instruction, the NCCI contains edits bundling the primary percutaneous transluminal mechanical thrombectomy (CPT code 37184) into all percutaneous arterial interventional procedures. These edits allow use of NCCI–associated modifiers if a provider performs a primary percutaneous transluminal arterial mechanical thrombectomy rather than a secondary percutaneous transluminal arterial mechanical thrombectomy (CPT code 37186) in conjunction with the other percutaneous arterial procedure.

28. CPT code 37215 describes an open or percutaneous transcatheter placement of intravascular stent(s) in the cervical carotid artery utilizing distal embolic protection. It includes all ipsilateral selective carotid arterial catheterization, all diagnostic imaging for ipsilateral cervical and cerebral carotid arteriography, and all radiological supervision and interpretation (RS&I). Physicians should not unbundle the RS&I services. For example a provider should not report CPT code 75962 (RS&I for transluminal balloon angioplasty of a peripheral artery) for angioplasty of the cervical carotid artery which is an included service in the procedure defined by CPT code 37215. Additionally since the carotid artery is not a peripheral artery, it is a misuse of CPT code 75962 to describe a carotid artery procedure. These same principles would apply to CPT code 37216, but it is currently a noncovered service code on the Medicare Physician Fee Schedule. *(CPT code 75962 was deleted January 1, 2017.)*

29. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

30. CPT code 36002 (injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm) should not be reported for vascular sealant of an arteriotomy site. It is bundled into vascular procedures and cardiopulmonary bypass procedures in which there is an arteriotomy. If the procedure described by CPT code 36002 is performed at a separate anatomic site unrelated to use of a vascular sealant or separate patient encounter on the same date of service, it may be reported separately with an NCCI-associated modifier.

31. Operative ablation procedures (CPT codes 33250-33266) include cardioversion as an integral component of the procedures. CPT codes 92960 or 92961 (elective cardioversion) should not be reported separately with the operative ablation procedure codes unless an elective cardioversion is performed at a separate patient encounter on the same date of service. If electrophysiologic study with pacing and recording is performed during an operative ablation procedure, it is integral to the procedure and should not be reported separately as CPT code 93624 (electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy...)

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

33. CPT codes 33203, 33265, and 33266 describe surgical endoscopic procedures (CPT code 33203 – insertion of epicardial electrodes; CPT codes 33265, 33266 – operative tissue ablation). CPT codes 32601 and 32604 describe diagnostic thoracoscopy of the pericardial sac. Since surgical endoscopy includes diagnostic endoscopy, CPT codes 32601 or 32604 should not be reported separately with CPT codes 33203/33265/33266 for the same patient encounter.

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

35. Effective January 1, 2010, CMS discontinued use of HCPCS codes G0392 and G0393 to report percutaneous transluminal balloon angioplasty for maintenance of a hemodialysis access. CPT code 35476 (Transluminal balloon angioplasty, percutaneous; venous) may be reported with one unit of service for percutaneous transluminal balloon angioplasty of all lesions in the venous outflow vessel of a hemodialysis access defined as the "vessel" originating at the arterial anastomosis through the venous outflow tract to the subclavian vein. CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) may be reported with one unit of service for percutaneous transluminal balloon angioplasty of all lesions in the arterial inflow tract. *(HCPCS codes G0392 and G0393 were deleted January 1, 2010.) (CPT codes 36475 and 36476 were deleted January 1, 2017.)*

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

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

38. A procedure to insert a central flow directed catheter (e.g., Swan-Ganz) (CPT code 93503) is often followed by a chest radiologic examination to confirm proper positioning of the flow directed catheter. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination.

39. CPT code 36147 describes introduction of a needle and/or catheter into an arteriovenous shunt created for dialysis (graft/fistula). The code descriptor states that the procedure includes "all necessary imaging for the arterial anastomosis and adjacent artery through entire venous outflow"...) *(CPT code 36147 was deleted January 1, 2017.)*

40. Open vascular procedures include exploration of the blood vessel. CPT codes 35701, 35721, 35741, and 35761 ("exploration (not followed by surgical repair)...") should not

be reported for a blood vessel on which an open vascular procedure is performed.

41. Diagnostic studies of the cervicocerebral arteries (CPT codes 36221-36227) include angiography of the thoracic aortic arch. Physicians should not separately report CPT codes 75600 or 75605 (thoracic aortography) for this examination unless it is medically reasonable and necessary to additionally examine the descending thoracic aorta. A physician should not report CPT codes 75600 or 75605 for the examination of the descending thoracic aorta with the runoff of the dye used to examine the thoracic aortic arch included in the diagnostic studies of the cervicocerebral arteries. Additionally, if an unexpected abnormality of the descending thoracic aorta is identified while examining the dye runoff in the descending aorta, CPT codes 75600 or 75605 should not be reported separately.

42. For vascular embolization procedures (CPT codes 37241-37244) physicians may separately report selective catheterization CPT codes. However, physicians should not separately report non-selective catheterization CPT codes for these procedures. Vascular embolization procedures include associated radiological supervision and interpretation, intra-procedural guidance, road-mapping, and imaging necessary to document completion of the procedure. Angiography may be a separately reportable procedure with modifier 59 only if it satisfies guidelines for diagnostic angiography included in the “Vascular Embolization and Occlusion” section of the CPT Manual, national Medicare guidelines, and local Medicare Administrative Contractor guidelines.

43. Transcatheter aortic valve or mitral valve replacement procedures include fluoroscopic and/or ultrasound guidance if performed. Physicians should not report fluoroscopy CPT codes (e.g.,76000, 76001, 77002) nor ultrasound CPT codes (e.g., 76942, 76998) for guidance during these procedures.

Transthoracic echocardiography CPT codes 93306-93308, transesophageal echocardiography CPT codes 93312-93314, and Doppler echocardiography CPT codes 93320-93325 are not separately reportable by the physician performing a transcatheter aortic valve and mitral valve replacement procedure.

44. Ligation procedures of the lower extremity (e.g., CPT codes 37700-37785) include application of a compression dressing, if performed. CPT codes 29581 and 29582 (application of multi-layer compression system) should not be reported for application of a compression dressing.

E. Hemic and Lymphatic Systems

1. When bone marrow aspiration is performed alone, the appropriate code to report is CPT code 38220. When a bone marrow biopsy is performed, the appropriate code is CPT code 38221 (bone marrow biopsy). This code cannot be reported with CPT code 20220 (bone biopsy). CPT codes 38220 and 38221 may only be reported together if the two procedures are performed at separate sites or at separate patient encounters. Separate sites include bone marrow aspiration and biopsy in different bones or two separate skin incisions over the same bone. When both a bone marrow biopsy (CPT code 38221) and bone marrow aspiration (CPT code 38220) are performed at the same site through the same skin incision, do not report the bone marrow aspiration, CPT code 38220, in addition to the bone marrow biopsy (CPT code 38221). HCPCS/CPT code G0364 may be reported to describe the bone marrow aspiration performed with bone marrow biopsy through the same skin incision on the same date of service.

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

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

F. Mediastinum

CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with “exploration, drainage, removal of foreign body, or biopsy”. Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 should not be reported separately for exploration of the mediastinum when performed with procedures on mediastinal

structures (e.g., esophagus, bronchi, aorta, heart) or structures accessed through the mediastinum (e.g., lungs, vertebrae). These codes may be reported separately if mediastinal drainage, removal of foreign body, or biopsy is performed.

G. Medically Unlikely Edits (MUEs)

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

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

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

If CPT code 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) is reported for percutaneous transluminal balloon angioplasty of one or more lesions in the arterial inflow tract of a hemodialysis access, it should be reported with only one (1) unit of service. *(CPT codes 36475 and 36476 were deleted January 1, 2017.)*

4. CPT codes 37211 and 37212 describe transcatheter therapy infusions for thrombolysis on the “initial treatment day”. Since each of these codes may only be reported once per day, the MUE value for each of these codes is one (1). CPT codes 37213 and 37214 describe transcatheter therapy infusions for thrombolysis “continued treatment on subsequent day”. Since each of these codes may only be reported once per day, the MUE value for each of these codes is one (1).

5. 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 requires that practitioners and outpatient hospitals report bilateral surgical procedures with modifier 50 and one (1) UOS on a single claim line. MUE values for surgical procedures that may be performed bilaterally are based on this reporting requirement. Since this reporting requirement does not apply to an ambulatory surgical center (ASC), an ASC should report a bilateral surgical procedure on two claim lines, each with one (1) UOS using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

H. General Policy Statements

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

2. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, 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.

3. 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.

4. 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.*

5. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

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

7. Open procedures of the thoracic cavity require a thoracotomy for the surgical approach. A physician should not report CPT code 32100 (thoracotomy, major; with exploration and biopsy) in addition to an open thoracic procedure CPT code.

8. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, *62320-62327*, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug

administration (CPT codes 96360-*96377*) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

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

Under Medicare Global Surgery Rules, drug administration services (CPT Codes 96360-*96377*) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-*96377* for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, *62320-62327*, 64400-64489, and 96360-*96377* describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

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

9. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with any procedure with a global period of 000, 010, or 090 days nor with some procedures with a global period of MMM.

10. Closure/repair of a surgical incision is included in the global surgical package. Wound repair CPT codes 12001-13153 should not be reported separately to describe closure of surgical

incisions for procedures with global surgery indicators of 000, 010, 090, or MMM.

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

12. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances except for lung biopsy(s) performed at the same patient encounter as a more extensive lung procedure removing the anatomic area of the biopsy(s). See Chapter V, Section C, paragraph 18 for rules regarding separate reporting of lung biopsy(s) performed at the same patient encounter as a more extensive procedure.

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.

13. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for

diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

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

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

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

17. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code

appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

18. A cystourethroscopy (CPT code 52000) performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.