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CHAPTER VI
SURGERY: DIGESTIVE SYSTEM
CPT CODES 40000 - 49999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter VI
Surgery: Digestive System
CPT Codes 40000 - 49999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 40000-49999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

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

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

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

B. 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. Endoscopic Services

Endoscopic services may be performed in many places of service (e.g., office, outpatient, ambulatory surgical centers (ASC)). Services that are an integral component of an endoscopic procedure are not separately reportable. These services include, but are not limited to, venous access (e.g., CPT code 36000), infusion/injection (e.g., CPT codes 96360-*96377*), non-invasive oximetry (e.g., CPT codes 94760 and 94761), and anesthesia provided by the surgeon.

1. Per *CPT Manual* instructions, surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code should not be reported with a surgical endoscopy code.

2. If multiple endoscopic services 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 HCPCS/CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended

to the secondary HCPCS/CPT code. Only medically necessary services may be reported. Incidental examination of other areas should not be reported separately.

3. If the same endoscopic procedure (e.g., polypectomy) is performed multiple times at a single patient encounter in the same region as defined by the *CPT Manual* narrative, only one CPT code may be reported with one unit of service.

4. Gastroenterological procedures included in CPT code ranges 43753-43757 and 91010-91299 are frequently complementary to endoscopic procedures. Esophageal and gastric washings for cytology when performed are integral components of an esophagogastroduodenoscopy (e.g., CPT code 43235). Gastric or duodenal intubation with or without aspiration (e.g., CPT codes 43753, 43754, 43756) should not be separately reported when performed as part of an upper gastrointestinal endoscopic procedure. Gastric or duodenal stimulation testing (e.g., CPT codes 43755, 43757) may be facilitated by gastrointestinal endoscopy (e.g., procurement of gastric or duodenal specimens). When performed concurrent with an upper gastrointestinal endoscopy, CPT code 43755 or 43757 should be reported with modifier 52 indicating a reduced level of service was performed.

5. If an endoscopy or enteroscopy is performed as a common standard of practice when performing another service, the endoscopy or enteroscopy is not separately reportable. For example, if a small intestinal endoscopy or enteroscopy is performed during the creation or revision of an enterostomy, the small intestinal endoscopy or enteroscopy is not separately reportable.

6. A “scout” endoscopy to assess anatomic landmarks or assess extent of disease preceding another surgical procedure at the same patient encounter is not separately reportable. However, an endoscopic procedure for diagnostic purposes to decide whether a more extensive open procedure needs to be performed is separately reportable. In the latter situation, modifier 58 may be utilized to indicate that the diagnostic endoscopy and more extensive open procedure were staged procedures.

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.

7. If a non-endoscopic esophageal dilation (e.g., CPT codes 43450, 43453) fails and is followed by an endoscopic esophageal dilation procedure (e.g., CPT codes 43213, 43214, 43233), only the endoscopic esophageal dilation procedure may be reported. The physician should not report the failed procedure.

8. If it is necessary to perform diagnostic or surgical endoscopy of the hepatic/biliary/pancreatic system utilizing different methodologies (e.g., biliary T-tube endoscopy, ERCP) multiple CPT codes may be reported. Modifier 51 indicating multiple procedures were performed at the same patient encounter should be appended.

9. Intubation of the gastrointestinal tract (e.g., percutaneous placement of G-tube) includes subsequent removal of the tube. CPT codes such as 43247 (upper gastrointestinal endoscopic removal of foreign body(s)) should not be reported for removal of previously placed therapeutic devices. If a previously placed therapeutic device must be removed endoscopically because it cannot be removed by a non-endoscopic procedure, a CPT code such as 43247 may be reported for the endoscopic removal.

10. Rules for reporting biopsies performed at the same patient encounter as an excision, destruction, or other type of removal are discussed in Section H (General Policy Statements) (paragraph 21).

11. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. For example, if a provider performs endoscopic band ligation(s) by flexible sigmoidoscopy (CPT code 45350) or colonoscopy (CPT code 45398), control of bleeding is not separately reportable with CPT codes 45334 (flexible sigmoidoscopic control of bleeding) or 45382 (colonoscopic control of bleeding) respectively.

If it is necessary to repeat an endoscopy to control bleeding at a separate patient encounter on the same date of service, the HCPCS/CPT code for endoscopy for control of bleeding is separately reportable with modifier 78 indicating that the procedure required return to the operating room (or endoscopy suite) for a related procedure during the postoperative period.

12. Only the more extensive endoscopic procedure may be reported for a patient encounter. For example if a sigmoidoscopy

is completed and the physician also performs a colonoscopy during the same patient encounter, only the colonoscopy may be reported.

13. If an endoscopic procedure fails and is converted into an open procedure at the same patient encounter, only the open procedure is reportable. Neither a surgical endoscopy nor diagnostic endoscopy procedure code should be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

14. If a transabdominal colonoscopy via colostomy and/or standard sigmoidoscopy or colonoscopy is performed as a necessary part of an open procedure (e.g., colectomy), the endoscopic procedure(s) is (are) not separately reportable. However, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the endoscopic procedure may be reported separately. Modifier 58 may be utilized to indicate that the diagnostic endoscopy and the open procedure were staged or planned services. (CPT code 45355 was deleted January 1, 2015.)

15. If the larynx is viewed through an esophagoscope or upper gastrointestinal endoscope during endoscopy, a laryngoscopy CPT code cannot be reported separately. However, if a medically necessary laryngoscopy is performed with a separate laryngoscope, both the laryngoscopy and esophagoscopy (or upper gastro-intestinal endoscopy) CPT codes may be reported with NCCI-associated modifiers.

16. 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. For example, fluoroscopy (e.g., CPT code 76000) is not separately reportable with CPT codes describing gastrointestinal endoscopy for foreign body removal (e.g., 43194, 43215, 43247, 44390, 45332, 45379).

D. Esophageal Procedures

1. 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 an esophageal procedure. These codes may be reported separately if mediastinal drainage, removal

of foreign body, or biopsy is performed. However, these codes should not be reported separately for removal of foreign body with CPT code 43020 (esophagotomy, cervical approach, with removal of foreign body) or CPT code 43045 (esophagotomy, thoracic approach, with removal of foreign body).

E. Abdominal Procedures

1. During an open abdominal procedure exploration of the surgical field is routinely performed to identify anatomic structures and disease. An exploratory laparotomy (CPT code 49000) is not separately reportable with an open abdominal procedure.

2. Hepatectomy procedures (e.g., CPT codes 47120-47130, 47133-47142) include removal of the gallbladder based on anatomic considerations and standards of practice. A cholecystectomy CPT code is not separately reportable with a hepatectomy CPT code.

3. A medically necessary appendectomy may be reported separately. However, an incidental appendectomy of a normal appendix during another abdominal procedure is not separately reportable.

4. If a hernia repair is performed at the site of an incision for an open or laparoscopic abdominal procedure, the hernia repair (e.g., CPT codes 49560-49566, 49652-49657) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and should not be reported separately.

5. If a recurrent hernia requires repair, a recurrent hernia repair code may be reported. A code for incisional hernia repair should not be reported in addition to the recurrent hernia repair code unless a medically necessary incisional hernia repair is performed at a different site. In the latter case, modifier 59 should be appended to the incisional hernia repair code.

6. CPT code 49568 is an add-on code describing implantation of mesh or other prosthesis for incisional or ventral hernia repair. This code may be reported with incisional or ventral hernia repair CPT codes 49560-49566. Although mesh or other prosthesis may be implanted with other types of hernia repairs, CPT code 49568 should not be reported with these other hernia repair codes. If a provider performs an incisional or

ventral hernia repair with mesh/prosthesis implantation as well as another type of hernia repair at the same patient encounter, CPT code 49568 may be reported with modifier 59 to bypass edits bundling CPT code 49568 into all hernia repair codes other than the incisional or ventral hernia repair codes.

7. Removal of excessive skin and subcutaneous tissue (panniculectomy) at the site of an abdominal incision for an open procedure including hernia repair is not separately reportable. CPT code 15830 should not be reported for this type of panniculectomy. However, an abdominoplasty which requires significantly more work than a panniculectomy is separately reportable. In order to report an abdominoplasty in 2007, CPT requires the physician to report an infraumbilical abdominal panniculectomy (CPT code 15830 in 2007) plus the add-on CPT code 15847 for the abdominoplasty. Since NCCI bundles CPT code 15830 (in 2007) into abdominal wall hernia repair CPT codes, a provider should report CPT codes 15830 plus 15847 with modifier 59 appended to CPT code 15830 in order to report an abdominoplasty with an abdominal hernia repair CPT code.

8. Open enterolysis (CPT code 44005) and laparoscopic enterolysis (CPT code 44180) are defined by the *CPT Manual* as “separate procedures”. They are not separately reportable with other intra-abdominal or pelvic procedures. However, if a provider performs an extensive and time-consuming enterolysis in conjunction with another intra-abdominal or pelvic procedure, the provider may append modifier 22 to the CPT code describing the latter procedure. The local carrier (A/B MAC processing practitioner service claims) will determine whether additional payment is appropriate.

9. If an iatrogenic laceration/perforation of the small or large intestine occurs during the course of another procedure, repair of the laceration/perforation is not separately reportable. Treatment of an iatrogenic complication of surgery such as an intestinal laceration/perforation is not a separately reportable service. For example CPT codes describing suture of the small intestine (CPT codes 44602, 44603) or suture of large intestine (CPT codes 44604, 44605) should not be reported for repair of an intestinal laceration/perforation during an enterectomy, colectomy, gastrectromy, pancreatectomy, hysterectomy, or oophorectomy procedure.

10. A Whipple type pancreatectomy procedure (CPT codes 48150-48154) includes removal of the gallbladder. A

cholecystectomy (e.g., CPT codes 47562-47564, 47600-47620) should not be reported separately.

11. If closure of a fistula requires excision of a portion of an organ into which the fistula passes, excision of that tissue should not be reported separately. For example, if closure of an enterocolic fistula requires removal of a portion of adjacent small intestinal tissue and a portion of adjacent colonic tissue, closure of the enterocolic fistula (CPT code 44650) includes the removal of the small and large intestinal tissue. The excision of the small intestinal or colonic tissue should not be reported separately.

12. Pelvic exenteration procedures (CPT codes 45126, 51597, 58240) include extensive removal of structures from the pelvis. Physicians should not separately report codes for the removal of pelvic structures (e.g., colon, rectum, urinary bladder, uterine body and/or cervix, fallopian tubes, ovaries, lymph nodes, prostate gland).

13. Liver allotransplantation procedures include, if performed, biliary tract T-tube insertion/conversion/exchange/ removal, drainage, or stent procedures (e.g., CPT codes 47533-47540). CPT codes such as 47510, 47511, 47525, 47530, or 47801 should not be reported with a liver allotransplantation procedure. (CPT codes 47510, 47511, 47525, and 47530 were deleted January 1, 2016.)

14. CPT code 47544 (removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous...) is a Type I add-on code. The primary codes are defined by the CPT Manual and include CPT codes 47531-47540 (percutaneous biliary tract procedures). The CPT Manual also includes a separate instruction stating that CPT code 47544 should not be reported with CPT codes 47531-47540 for incidental removal of debris. Thus, CPT code 47544 may be reported with CPT codes 47531-47540 only for percutaneous removal of calculi or non-incidental debris.

F. Laparoscopy

1. Surgical laparoscopy includes diagnostic laparoscopy which is not separately reportable. If a diagnostic laparoscopy leads to a surgical laparoscopy at the same patient encounter, only the surgical laparoscopy may be reported.

2. If a laparoscopy is performed as a “scout” procedure to assess the surgical field or extent of disease, it is not

separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. *CPT code 49321 describes a laparoscopic biopsy. If this procedure is performed for diagnostic purposes and the decision to proceed with an open or laparoscopic –ectomy procedure is based on this biopsy, CPT code 49321 may be reported in addition to the CPT code for the –ectomy procedure. However, if the laparoscopic biopsy is performed for a different purpose such as assessing the margins of resection, CPT code 49321 is not separately reportable.*

4. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code should be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

5. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

6. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code should not be reported for an incidental laparoscopic appendectomy.

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

8. A diagnostic laparoscopy includes “washing”, infusion and/or removal of fluid from the body cavity. A physician should not report CPT codes 49082-49083 (abdominal paracentesis) or 49084 (peritoneal lavage) for infusion and/or removal of fluid from the body cavity performed during a diagnostic or surgical laparoscopic procedure.

9. Injection of air into the abdominal or pelvic cavity is integral to many laparoscopic procedures. Physicians should not separately report CPT code 49400 (injection of air or contrast into peritoneal cavity (separate procedure)) for this service.

10. CPT codes 43281 and 43282 describe laparoscopic paraesophageal hernia repair with fundoplasty, if performed, without or with mesh implantation respectively. These codes should not be reported for a figure-of-eight suture often performed during gastric restrictive procedures.

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. 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.

4. Gastrointestinal endoscopy CPT codes describing dilation of stricture(s) (e.g., CPT codes 43213, 45340, 45386)

include dilation of all strictures dilated during the endoscopic procedure. These codes should not be reported with more than one (1) unit of service if more than one stricture is dilated.

5. The unit of service (UOS) for CPT code 43277 (Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct) is each duct. One UOS includes trans-endoscopic balloon dilation of one or more strictures within each duct. Dilation of one or more strictures in the pancreatic duct including the major and minor ductal branches is reported as a single UOS. Similarly, dilation of one or more strictures in each of the following ducts may be reported as a single UOS for each duct: common bile duct, cystic duct, right hepatic duct, and left hepatic duct.

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. The vagotomy CPT codes (e.g., 43635-43641, 64755-64760) are not separately reportable with esophageal or gastric procedures that include vagotomy as part of the service. For example, the esophagogastrostomy procedure described by CPT code 43320 includes a vagotomy if performed. The vagotomy procedures are mutually exclusive, and only one vagotomy procedure code may be reported at a patient encounter.

7. If closure of an enterostomy or fistula involving the intestine requires resection and anastomosis of a segment of intestine, the resection and anastomosis of the intestine are not separately reportable.

8. If multiple services are utilized to treat hemorrhoids at the same patient encounter, only one HCPCS/CPT code describing the most extensive procedure may be reported. If an abscess is drained during the treatment of hemorrhoids, the incision and drainage is not separately reportable unless the incision and

drainage is at a separate site unrelated to the hemorrhoids. In the latter case, the incision and drainage code may be reported appending an anatomic modifier or modifier 59.

9. Diagnostic anoscopy (CPT code 46600) is not separately reportable with an open or endoscopic procedure of the anus (e.g., 46020-46942, 0184T, 0249T, 0377T). The diagnostic anoscopy (CPT code 46600) is an included service that is not separately reportable. It is a misuse of CPT codes describing diagnostic proctosigmoidoscopy (CPT code 45300), sigmoidoscopy (CPT code 45330), or colonoscopy (CPT code 45378) to report an examination limited to the anus. If the physician performs a complete diagnostic proctosigmoidoscopy, sigmoidoscopy, or colonoscopy, the procedure may be reported separately.

10. The *CPT Manual* contains groups of codes describing different approaches or methods to accomplish similar results. These codes are generally mutually exclusive of one another. For example CPT codes 45110-45123 describe different proctectomy procedures and are mutually exclusive of one another. Other examples include groups of codes for colectomy (CPT codes 44140-44160), gastrectomy (CPT codes 43620-43635), and pancreatectomy (CPT codes 48140-48155).

11. An enterostomy closure HCPCS/CPT code should not be reported with a code for creation or revision of a colostomy. Closure of an enterostomy is mutually exclusive with the creation or revision of the colostomy.

12. If an excised section of intestine includes a fistula tract, a fistula closure code should not be reported separately. Closure of the fistula is included in the excision of intestine.

13. The mouth and anus 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) or as a digestive system procedure (CPT codes 40000-49999). 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 digestive 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.

14. If a physician must drain an abscess in order to complete a sialolithotomy procedure, the drainage of the abscess is not separately reportable. If a definitive surgical procedure requires access through diseased tissue, treatment of the diseased tissue for this access is not separately reportable.

15. An open cholecystectomy includes an examination of the abdomen through the abdominal wall incision. If this examination is performed laparoscopically, it is not separately reportable as CPT code 49320 (diagnostic laparoscopy).

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

17. CPT codes 43770-43774 describe laparoscopic gastric restrictive procedures. Only one of these procedure codes may be reported for a single patient encounter. If a patient develops a complication during the postoperative period of the initial procedure requiring return to the operating room for a different laparoscopic gastric restrictive procedure to treat the complication, the second procedure should be reported with modifier 78.

18. 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. 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.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. The NCCI PTP edit with column one CPT code 45385 (Flexible colonoscopy with removal of tumor(s), polyp(s), or lesion(s) by snare technique) and column two CPT code 45380 (Flexible colonoscopy with single or multiple biopsies) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 45380 of this NCCI PTP edit is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.