CHAP7-CPTcodes50000-59999_final103116.doc
Revision Date: 1/1/2017

CHAPTER VII
SURGERY: URINARY, MALE GENITAL, FEMALE GENITAL, MATERNITY CARE AND DELIVERY SYSTEMS
CPT CODES 50000 - 59999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

Current Procedural Terminology (CPT) codes, descriptions and other data only are copyright 2016 American Medical Association. All rights reserved.

CPT® is a registered trademark of the American Medical Association.

Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

TABLE OF CONTENTS

Chapter VII - Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems (CPT Codes 50000 – 59999)

A. Introduction VII-2
B. Evaluation and Management (E&M) Services VII-2
C. Urinary System VII-4
D. Male Genital System VII-10
E. Female Genital System VII-11
F. Laparoscopy VII-12
G. Maternity Care and Delivery VII-14
H. Medically Unlikely Edits (MUEs) VII-15
I. General Policy Statements VII-16

Chapter VII
Surgery: Urinary, Male Genital, Female Genital, Maternity Care, and Delivery Systems
CPT Codes 50000 - 59999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 50000-59999. 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. 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 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. Urinary System

1. Insertion of a urinary bladder catheter is a component of the global surgical package. Urinary bladder catheterization (CPT codes 51701, 51702, and 51703) is not separately reportable with a surgical procedure when performed at the time of or just prior to the procedure.

Additionally, many procedures involving the urinary tract include the placement of a urethral/bladder catheter for postoperative drainage. Because this is integral to the procedure, placement of a urinary catheter is not separately reportable.

2. Cystourethroscopy, with biopsy(s) (CPT code 52204) includes all biopsies during the procedure and should be reported with one unit of service.

3. Some lesions of the genitourinary tract occur at mucocutaneous borders. The *CPT Manual* contains integumentary system (CPT codes 10000-19999) and genitourinary system (CPT codes 50000-59899) codes to describe various procedures such as biopsy, excision, or destruction. A single code from one of these two sections of the *CPT Manual* that best describes the biopsy, excision, destruction, or other procedure performed on one or multiple similar lesions at a mucocutaneous border should be reported. Separate codes from the integumentary system and genitourinary system sections of the *CPT Manual* may only be reported if separate procedures are performed on completely separate lesions on the skin and genitourinary tract. Modifier 59 should be utilized to indicate that the procedures are on separate lesions. The medical record should accurately describe the precise locations of the lesions.

4. If an irrigation or drainage procedure is necessary and integral to complete a genitourinary or other procedure, only the more extensive procedure should be reported. The irrigation or drainage procedure is not separately reportable.

5. The CPT code descriptor for some genitourinary procedures includes a hernia repair. A HCPCS/CPT code for a hernia repair is not separately reportable unless the hernia repair is performed at a different site through a separate incision. In the latter case, the hernia repair may be reported with modifier 59.

6. In general, multiple methods of performing a procedure (e.g., prostatectomy) cannot be performed at the same patient encounter. (See general policy on mutually exclusive services.) Therefore, only one method of accomplishing a given procedure may be reported. If an initial approach fails and is followed by an alternative approach, only the completed or last uncompleted approach may be reported.

7. If a diagnostic endoscopy leads to the performance of a laparoscopic or open procedure, the diagnostic endoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic endoscopy and non-endoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic endoscopy. However, if an endoscopic procedure is performed as an integral

part of an open procedure, only the open procedure is reportable. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a separate diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be reported separately with a diagnostic or surgical endoscopy code.

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.

8. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical endoscopy nor a diagnostic endoscopy code should be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

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

10. When multiple endoscopic procedures are performed at the same patient encounter, the most comprehensive code accurately describing the service(s) performed should be reported. If several procedures not included in a more comprehensive code are performed at the same endoscopic session, multiple HCPCS/CPT codes may be reported with modifier 51. (For example, if renal endoscopy is performed through an established nephrostomy with biopsy, fulguration of a lesion, and foreign body (calculus) removal, the appropriate CPT coding would be CPT codes 50557 and 50561-51, <u>not</u> CPT codes 50551, 50555, 50557, and 50561.) This policy applies to all endoscopic procedures, not only those of the genitourinary system.

11. CPT code 51700 (bladder irrigation, simple, lavage and/or instillation) is used to report irrigation with therapeutic agents or as an independent therapeutic procedure. It is not separately reportable if bladder irrigation is part of a more comprehensive service such as to gain access to or visualize the urinary system. Irrigation of a urinary catheter is included in the global surgical package. CPT code 51700 should not be misused to report irrigation of a urinary catheter.

12. CPT codes 51784 and 51785 describe diagnostic electromyography (EMG). When EMG is performed as part of a biofeedback session, neither CPT code 51784 nor 51785 should be reported unless a significant, separately identifiable diagnostic EMG service is provided. If either CPT code 51784 or CPT code 51785 is reported for a diagnostic electromyogram, a separate report must be available in the medical record to indicate this service was performed for diagnostic purposes.

13. When endoscopic visualization of the urinary system involves several regions (e.g., kidney, renal pelvis, calyx, and ureter), the appropriate CPT code is defined by the approach (e.g., nephrostomy, pyelostomy, ureterostomy, etc.) as indicated in the CPT descriptor. When multiple endoscopic approaches at the same patient encounter are medically reasonable and necessary (e.g., renal endoscopy through a nephrostomy and cystourethroscopy) to perform different procedures, they may be separately reported appending modifier 51 to the less extensive procedure codes. However, when multiple endoscopic approaches are utilized to attempt the same procedure, only the completed approach should be reported.

14. Endoscopic procedures include all minor related functions performed at the same encounter. Although CPT codes may exist to describe these functions, they should not be reported separately. For example, transurethral resection of the prostate includes meatotomy, urethral calibration and/or dilation, urethroscopy, and cystoscopy. Codes for the included procedures should not be reported separately.

15. When urethral catheterization or urethral dilation (e.g., CPT codes 51701-51703) is necessary to complete a more extensive procedure, the urethral catheterization/dilation is not separately reportable.

16. Ureteral anastomosis procedures are described by CPT codes 50740-50825, and 50860. In general, they represent mutually exclusive procedures that are not reported together. If one type of anastomosis is performed on one ureter, and a different type of anastomosis is performed on the contralateral ureter, the appropriate modifier (e.g., LT, RT) should be reported with the CPT code to describe the service performed on each ureter. For example, the procedure described by CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive with the procedures described by CPT codes 50800-50830 (e.g., ureteroenterostomy, ureterocolon conduit,

urinary undiversion) unless performed on contralateral ureters in which case anatomic modifiers should be reported.

17. CPT codes 53502-53515 describe urethral repair codes for urethral wounds or injuries (urethrorrhaphy). When an urethroplasty is performed, codes for urethrorrhaphy should not be reported in addition since “suture to repair wound or injury” is included in the urethroplasty service.

18. CPT code 78730 (Urinary bladder, residual study) is a nuclear medicine procedure requiring use of a radio-pharmaceutical. This CPT code should not be utilized to report measurement of residual urine in the urinary bladder determined by other methods.

19. CPT code 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent) describes insertion of a self-retaining indwelling stent during cystourethroscopy with ureteroscopy and/or pyeloscopy and should not be reported to describe insertion and removal of a temporary ureteral stent during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy (e.g., CPT codes 52320-52330, 52334-52355). The insertion and removal of a temporary ureteral catheter (stent) during these procedures is not separately reportable and should not be reported with CPT codes 52005 (Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;) or 52007 (Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis).

CPT codes 52332 and 52005 are not separately reportable for the same ureter for the same patient encounter.

20. Prostatectomy procedures (CPT codes 55801-55845) include cystoplasty or cystourethroplasty as a standard of surgical practice. CPT code 51800 (cystoplasty or cystourethroplasty...) should not be reported separately with prostatectomy procedures.

21. CPT code 50650 (ureterectomy, with bladder cuff (separate procedure)) should not be reported with other procedures on the ipsilateral ureter. Since CPT code 50650 includes the “separate procedure” designation, CMS does not allow

additional payment for the procedure when it is performed with other procedures in an anatomically related area.

22. The code descriptors for CPT codes 52310 and 52315 (cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure)...) include the “separate procedure” designation. Per CMS payment policy for procedures with the “separate procedure” designation, these codes should not be reported with other cystourethroscopy CPT codes for the same patient encounter.

23. 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.

24. Cystourethroscopy and transurethral procedures include fluoroscopy when performed. CPT codes describing fluoroscopy or fluoroscopic guidance (e.g. 76000, 76001, 77002) should not be reported separately with a cystourethroscopy or transurethral procedure CPT code.

25. A ureteral stent is commonly inserted at the site of an anastomosis of a ureter and another structure in order to maintain patency of the ureter. A ureteral stent is also often inserted into a ureter if the ureter is incised during a procedure (e.g., nephrectomy, cystectomy, ureteral anastomosis). With these procedures, insertion of the ureteral stent is integral to the procedure and is not separately reportable. For example, CPT code 50605 (Ureterotomy for insertion of indwelling stent, all types) should not be reported with CPT codes describing cystectomy, urinary diversion, or ureteral anastomosis for insertion of a ureteral stent to maintain patency at the site of a ureteral anastomosis.

26. 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).

27. CPT code 50398 describes change of a nephrostomy or pyelostomy tube. If the tube change occurs in a patient without new symptoms related to the tube, CPT code 50394 (injection procedure for pyelography through a nephrostomy or pyelostomy

tube) should not be reported separately for the tube check. However, if the patient has new symptoms related to the tube, the provider may separately report CPT code 50394 with an NCCI-associated modifier for the tube check. (CPT codes 50394 and 50398 were deleted January 1, 2016.)

28. CPT codes 52317 and 52318 describe litholapaxy (crushing/fragmentation and removal) of calculus in the urinary bladder. These codes may be reported for crushing/fragmentation with removal of calculi originating de novo in the urinary bladder. These codes should not be reported for crushing/fragmentation and removal of calculi in the urinary bladder that result from a procedure to remove, manipulate, and/or fragment calculi higher up in the urinary tract.

D. Male Genital System

1. Transurethral drainage of a prostatic abscess (e.g., CPT code 52700) is included in male transurethral prostatic procedures and should not be reported separately.

2. The puncture aspiration of a hydrocele (e.g., CPT code 55000) is included in services involving the tunica vaginalis and proximate anatomy (e.g., scrotum, vas deferens) and in inguinal hernia repairs and should not be reported separately.

3. The *CPT Manual* contains many codes (CPT codes 52601-52649, 53850-53855, 55801-55845, 55866) which describe various methods of removing or destroying prostate tissue. These procedures are mutually exclusive, and two codes from these code ranges should not be reported together.

4. Scrotal exploration (CPT code 55110) is not separately reportable with procedures of the scrotum, scrotal sac, or its contents including the testes and epididymis. Exploration of the surgical field is not separately reportable.

5. If a prostatectomy procedure necessitates reconstruction of the bladder neck, the bladder neck reconstruction is not separately reportable. For example, CPT code 51800 (cystoplasty or cystourethroplasty, plastic operation on bladder and/or vesical neck...) should not be reported with a prostatectomy CPT code where the cystoplasty or cystourethroplasty is necessitated by the prostatectomy procedure.

E. Female Genital System

1. When a pelvic examination is performed in conjunction with a gynecologic procedure, either as a necessary part of the procedure or as a confirmatory examination, the pelvic examination is not separately reportable. A diagnostic pelvic examination may be performed for the purpose of deciding to perform a procedure. This examination is included in the evaluation and management service at the time the decision to perform the procedure is made.

2. All surgical laparoscopic, hysteroscopic or peritoneoscopic procedures include diagnostic procedures. Therefore, CPT code 49320 is included in CPT codes 38120, 38570-38572, 43280, 43651-43653, 44180-44227, 44970, 47562-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, and 60650. CPT code 58555 is included in CPT codes 58558-58565.

3. Pelvic examination under anesthesia (CPT code 57410) is included in all major and most minor gynecological procedures and is not separately reportable. This procedure represents routine evaluation of the surgical field.

4. Dilation of vagina or cervix (CPT codes 57400 or 57800) in conjunction with vaginal approach procedures is not separately reportable unless the CPT code descriptor states “without cervical dilation”.

5. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a “scout” procedure to confirm a lesion or to assess the surgical field prior to a surgical procedure. A diagnostic colposcopy resulting in the decision to perform a non-colposcopic procedure may be reported separately with modifier 58 appended to the non-colposcopic procedure code. Diagnostic colposcopies (CPT codes 56820, 57420, 57452) are not separately reportable with other colposcopic procedures.

6. 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).

7. CPT code 57250 describes posterior colporrhaphy for repair of rectocele including perineorrhaphy if performed. If a vaginal hysterectomy is accompanied by additional dissection to repair a rectocele (with perineorrhaphy if performed), both the vaginal hysterectomy CPT code and CPT code 57250 may be reported together with an NCCI-associated modifier.

8. CPT code 57240 describes anterior colporrhaphy for repair of cystocele including repair of urethrocele if performed. If a vaginal hysterectomy is accompanied by additional dissection to repair a cystocele (with repair of urethrocele if performed), both the vaginal hysterectomy CPT code and CPT code 57240 may be reported together with an NCCI-associated modifier.

9. CPT code 57260 describes a combined anteroposterior colporrhaphy. If a vaginal hysterectomy is accompanied by additional dissection to repair a rectocele (with perineorrhaphy if performed) and repair a cystocele (with repair of urethrocele if performed), both the vaginal hysterectomy CPT code and CPT code 57260 may be reported together with an NCCI-associated modifier.

10. A vaginal hysterectomy normally includes fixation of the vagina to surrounding tissues. It is a misuse of CPT code 57282 (Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)) or 57283 (Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)) to report this fixation of the vagina to describe the fixation that routinely occurs during a vaginal hysterectomy. If a more extensive colpopexy consistent with the requirements of CPT code 57282 or 57283 is performed, CPT codes 57282 or 57283 may be reported with the vaginal hysterectomy CPT code utilizing an NCCI-associated modifier.

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.

G. Maternity Care and Delivery

1. The total obstetrical packages (e.g., CPT codes 59400 and 59510) include antepartum care, the delivery, and postpartum care. They do not include other services such as ultrasound, amniocentesis, special screening tests for genetic disorders, visits for unrelated conditions (incidental to pregnancy), or additional frequent visits due to high risk conditions.

2. CPT codes 59050 and 59051(fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT codes 59400 (routine obstetric care, vaginal delivery), 59409 (vaginal delivery only), 59410 (vaginal delivery and postpartum care), 59510 (routine obstetric care, cesarean delivery), 59514 (cesarean delivery only), 59515 (cesarean delivery and postpartum care), 59610 (routine obstetric care, vaginal delivery, after previous cesarean delivery), 59612 (vaginal delivery only after previous cesarean delivery), 59614 (vaginal delivery and postpartum care after previous cesarean delivery), 59618 (routine obstetric care, cesarean delivery, after previous cesarean delivery), 59620 (cesarean delivery only after previous cesarean delivery), and 59622 (cesarean delivery and postpartum care after previous cesarean delivery). They are not separately reportable.

3. Antepartum care includes urinalysis which is not separately reportable.

4. Maternity procedures are assigned a global period of MMM on the Medicare Physician Fee Schedule Database. Some of these procedures (e.g., Cesarean section) are similar to surgical procedures with a global period of 000, 010, or 090 days. These types of maternity procedures are subject to global surgery and anesthesia rules. The same HCPCS/CPT codes based on these rules are bundled into this subgroup of MMM procedures as are bundled into surgical procedures with a global period of 000, 010, or 090 days.

5. Wound repair CPT codes 12001-13153 should not be reported to describe closure of a surgical incision for codes with a global period of MMM.

H. 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 unit of service (UOS) for a procedure describing destruction or removal of renal system calculus(i) is one (1). The UOS is not each calculus. If a procedure for destruction or removal of renal system calculi is performed bilaterally, the CPT code may be reported with modifier 50 and one (1) UOS.

For example, CPT code 52353 (cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)) should be reported with only one unit of service (UOS) per ureter regardless of the number of calculi in the ureter. If the procedure is performed on bilateral ureters, it may be reported with modifier 50 and one UOS. This code should not be reported with a separate UOS for each calculus.

4. 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.

I. 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. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. A cystourethroscopy (*e.g.,* CPT code 52000) *or cystourethroscopy with ureteroscopy (e.g., CPT code 52351)* 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.