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CHAPTER VIII
SURGERY: ENDOCRINE, NERVOUS, EYE AND OCULAR ADNEXA, AND AUDITORY SYSTEMS
CPT CODES 60000 - 69999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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Chapter VIII
Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems
CPT Codes 60000 - 69999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 60000-69999. 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. Nervous System

1. A burr hole is often necessary for intracranial surgery (e.g., craniotomy, craniectomy) to access intracranial contents, to alleviate pressure, or to place an intracranial pressure monitoring device. When this service is integral to the performance of other services, CPT codes describing this service are not separately reportable if performed at the same patient encounter. A burr hole is separately reportable with another cranial procedure only if performed at a separate site unrelated to the other cranial procedure or at a separate patient encounter on the same date of service.

In addition, taps, punctures, or burr holes accompanied by drainage procedures (e.g., hematoma, abscess, cyst, etc.)

followed by other procedures are not separately reportable unless performed as staged procedures. Modifier 58 may be reported to indicate staged or planned services. Many intracranial procedures include bone grafts by CPT definition, and these grafts should not be reported separately.

2. Biopsies performed in the course of Central Nervous System (CNS) surgery should not be reported as separate procedures.

3. Craniotomies and craniectomies always include a general exploration of the accessible field. An exploratory craniectomy or craniotomy (CPT code 61304 or 61305) should not be reported separately with another craniectomy/craniotomy procedure performed at the same anatomic site and same patient encounter.

4. A craniotomy is performed through a skull defect resulting from reflection of a skull flap. Replacing the skull flap during the same procedure is an integral component of a craniotomy procedure and should not be reported separately utilizing the cranioplasty CPT codes 62140 and 62141. A cranioplasty may be separately reportable with a craniotomy procedure if the cranioplasty is performed to replace a skull bone flap removed during a procedure at a prior patient encounter or if the cranioplasty is performed to repair a skull defect larger than that created by the bone flap.

5. If two procedures are performed at the same anatomic site and same patient encounter, one procedure may be bundled into the other (e.g., one procedure may be integral to the other). However, if the two procedures are performed at separate anatomic sites or at separate patient encounters, they may be separately reportable. Modifier 59 may be reported to indicate that the two procedures are distinct and separately reportable services under these circumstances.

Example: A patient with an open head injury and a contre-coup subdural hematoma requires an exploratory craniectomy for the open head injury and a burr hole drainage on the contralateral side for a subdural hematoma. The creation of a burr hole at the site of the exploratory craniectomy would be considered integral to the craniectomy. However, the contralateral burr hole drainage is a separate service not integral to the exploratory craniectomy. To correctly report the burr hole drainage for the contralateral subdural hematoma and the exploratory craniectomy, the burr hole should be reported with the appropriate modifier

(e.g., 59, RT, LT). In this example the correct coding would be CPT codes 61304 (exploratory craniectomy) with one unit of service and 61154-59 (burr hole with drainage of subdural hematoma) with one unit of service.

6. If a physician performs a craniectomy or craniotomy procedure and places a ventricular catheter, pressure recording device, or other intracerebral monitoring device through the same hole in the skull, the physician should not separately report CPT code 61107 (twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter...). CPT code 61107 may be reported separately with an NCCI-associated modifier if it is necessary to place a ventricular catheter, pressure recording device, or other intracerebral monitoring device through a different hole in the skull.

7. If a physician evacuates, aspirates, or drains an intracranial hematoma (e.g., CPT codes 61154, 61156, 61312-61315), the physician should not separately report a code for drainage of a hematoma in the overlying skin to access the intracranial hematoma. Access through diseased tissue to perform a more extensive definitive procedure is not separately reportable.

8. CPT codes 61781-61783 are add-on codes describing computer-assisted navigational procedures of the cranium or spine. CMS payment policy does not allow CPT code 69990 (microsurgical technique requiring use of operating microscope) to be reported with these codes unless CPT code 69990 is reported with another CPT code that meets the requirements of CMS *Internet-Only Manual*, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 20.4.5. This IOM section limits the separate payment for CPT code 69990 to a small number of procedures. In these situations, physicians may report modifier 59 with CPT code 69990 to indicate that the procedure described by CPT code 69990 was performed for a procedure other than the computer-assisted navigation on the same date of service.

9. The use of general intravascular access devices (e.g., intravenous lines), cardiac monitoring, oximetry, laboratory sample procurement, and other routine monitoring for patient safety during general anesthesia, monitored anesthesia care (MAC), or other anesthesia are included in the anesthesia service and are not separately reportable. For example, if a physician performing a spinal puncture for intrathecal injection

administers an anxiolytic agent, the vascular access and any appropriate monitoring is considered part of the spinal puncture procedure and is not separately reportable.

10. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure. The reporting of nerve block or facet block CPT codes for anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate.

11. If cerebrospinal fluid is withdrawn during a nerve block procedure, the withdrawal is not separately reportable (e.g., diagnostic lumbar puncture). It is integral to the nerve block procedure.

12. If a dural (cerebrospinal fluid) leak occurs during a spinal procedure, repair of the dural leak is integral to the spinal procedure. CPT code 63707 or 63709 (repair of dural/cerebrospinal fluid leak) should not be reported separately for the repair.

If a dural (cerebrospinal fluid) leak occurs during a skull base approach procedure, repair of the dural leak is integral to the skull base approach procedure. CPT code 61618 or 61619 (secondary repair of dura for cerebrospinal fluid leak) should not be reported separately for the repair.

If a dural (cerebrospinal fluid) leak occurs during a burr hole, craniotomy, or craniectomy procedure, repair of the dural leak is integral to the burr hole, craniotomy, or craniectomy procedure. CPT code 62100 (craniotomy for repair of dural/cerebrospinal fluid leak) should not be reported separately for the repair.

13. CPT code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. The procedure coded as CPT code 64721 includes the procedure coded as CPT code 29848 when performed on the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported.

14. Nerve repairs by suture (neurorrhaphies) (CPT codes 64831-64876) include suture and anastomosis of nerves when

performed to correct traumatic injury or anastomosis of nerves which are proximally associated (e.g., facial-spinal accessory, facial-hypoglossal, etc.). When neurorrhaphy is performed with a nerve graft (CPT codes 64885-64911), neuroplasty, transection, excision, neurectomy, excision of neuroma, etc., the neurorrhaphy is integral to the procedure and is not separately reportable.

15. Implantation of neurostimulator electrodes in an area of the cerebral cortex may not be reported with two codes describing different approaches. CPT code 61860 describes implantation by craniectomy or craniotomy. CPT code 61850 describes implantation by twist drill or burr hole(s).

16. The following information was revised and published April 1, 2012. CPT codes 61885, 61886, and 63685 describe “insertion or replacement” of cranial or spinal neurostimulator pulse generators or receivers. Reporting an “insertion or replacement” CPT code necessitates use of a new neurostimulator pulse generator or receiver. CPT codes 61888 and 63688 describe “revision or removal” of cranial or spinal neurostimulator pulse generators or receivers. If the same pulse generator is removed and replaced into the same or another skin pocket, the “revision” CPT code is the only CPT code that may be reported. The “replacement” CPT code which requires use of a new neurostimulator pulse generator or receiver should NOT be reported as this Manual previously indicated. If one pulse generator is removed and replaced with a different pulse generator into the same or another skin pocket, the “replacement” CPT code may be reported. The “removal” CPT code is not separately reportable. The “insertion or replacement” CPT code is separately reportable with a “revision or removal” CPT code only if two separate batteries/generators are changed. For example, if one battery/generator is replaced (e.g., right side) and another is removed (e.g., left side), CPT codes for the “insertion or replacement” and “revision or removal” could be reported together with modifier 59.

17. Because procedures necessary to perform a column one coded procedure are included in the column one coded procedure, column two CPT codes such as *62320-62327* (injection of diagnostic or therapeutic substances) are included in the codes describing more invasive spinal/back procedures.

18. A laminectomy includes excision of all the posterior vertebral components, and a laminotomy includes partial excision of posterior vertebral components. Since a laminectomy is a more

extensive procedure than a laminotomy, a laminotomy code should not be reported with a laminectomy code for the same vertebra. CPT codes 22100-22103 (partial excision of posterior vertebral component (e.g., spinous process, lamina, or facet) for intrinsic bony lesion) are not separately reportable with laminectomy or laminotomy procedures for the same vertebra.

19. Some spinal procedures may require manipulation of the spine which is integral to the procedure. CPT code 22505 (Manipulation of the spine requiring anesthesia, any region) should not be reported separately with a spinal procedure.

20. Fluoroscopy reported as CPT codes 76000 or 76001 should not be reported with spinal procedures unless there is a specific *CPT Manual* instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure.

21. CPT codes 62310-62319 describe injections of diagnostic or therapeutic substance(s) into the epidural or subarachnoid spaces at different spinal levels. Fluoroscopic guidance such as CPT code 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid))is included in these procedures and should not be reported separately with these codes.

On January 1, 2017, CPT codes 62310-62319 were replaced by CPT codes 62320-62327. CPT codes 62321, 62323, 62325, and 62327 describe these injections with fluoroscopic or CT guidance, and CPT codes 62320, 62322, 62324, and 62326 describe these injections without imaging guidance.

22. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a

physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an add-on code describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

23. A bone marrow aspiration (CPT code 38220) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code if the bone marrow aspiration is obtained from the surgical field. However, if the bone marrow aspiration is obtained from an anatomic site other than vertebrae on which the orthopedic/neurosurgical procedure is performed, it may be reported separately with an NCCI-associated modifier.

24. CPT codes 38230 (bone marrow harvesting for transplantation; allogeneic) and 38232 (bone marrow harvesting for transplantation; autologous) should not be reported separately with a spinal osteotomy, vertebral fracture repair,

spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code for procurement of bone marrow aspirate. CPT codes 38230 and 38232 are used to report the procurement of bone marrow for future bone marrow transplantation.

25. CMS payment policy does not allow separate payment for CPT codes 63042 (laminotomy...; lumbar) or 63047 (laminectomy...; lumbar) with CPT codes 22630 or 22633 (arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 appended to CPT code 63042 or 63047.

26. Since the code descriptor for CPT code 61576 (transoral approach to skull base...(including tracheostomy)) includes a tracheostomy in the code descriptor, a CPT code describing a tracheostomy should not be reported separately.

27. For reporting CPT code 69990 (operating microscope), the reader is referred to Chapter VIII, Section F (Operating Microscope).

28. CPT code 61623 (endovascular temporary balloon arterial occlusion...concomitant neurological monitoring,...) describes a procedure that includes prolonged neurologic assessment. This code should not be utilized to report the temporary arterial occlusion that is an inherent component of CPT code 61624 (transcatheter permanent occlusion or embolization...; central nervous system (intracranial, spinal cord)).

29. Muscle chemodenervation procedures coded as CPT codes 64612-64614 occasionally require needle electromyographic (EMG) guidance. From January 1 through December 31, 2005, CMS allowed CPT code 95870 to be reported for such guidance when medically reasonable and necessary. Effective January 1, 2006, needle EMG guidance for muscle chemodenervation procedures coded as CPT codes 64612-64614 may be reported with CPT code 95874. (CPT codes 64613 and 64614 were deleted January 1, 2014.)

30. Some procedures (e.g., intracranial, spinal) utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) should not be reported by the physician performing an operative procedure since it is included in the global package. The physician performing an operative procedure should not report

other CPT section 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., 92585, 95822, 95860-95870, 95907-95913, 95925, 95926, 95927, 95928, 95929, 95930-95937, 95938, 95939) since they are also included in the global package. However, when performed by a different physician during the procedure, intraoperative neurophysiology testing is separately reportable by the second physician.

31. 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.

32. Access to the brachial plexus for a neuroplasty or suture procedure often requires division of a scalene muscle. Since access to the surgical field to perform a surgical procedure is integral to the procedure, division of a scalene muscle is not separately reportable with a brachial plexus procedure.

33. If the injection procedure for discography (CPT codes 62290, 62291) is followed by postoperative pain, treatment of this pain is not separately reportable (e.g., CPT codes *62320-62323*). The injection procedure codes have a global surgical indicator of 000 days. Medicare Global Surgery Rules include treatment of postoperative pain in the global surgical package.

34. CPT code 61783 (stereotactic computer assisted (navigational) procedure; spinal...) should not be reported for a simple spinal decompression (e.g., CPT codes 63001-63051). Stereotactic navigational procedures are usually performed to identify anatomy for precise treatments and avoid vital structures which are not necessary for a simple spinal decompression procedure.

35. CPT code 64561 (percutaneous implantation of neurostimulator electrode array; sacral nerve...) is priced to include a “percutaneous neuro test stimulation kit”. This kit includes a “test stimulation lead”. HCPCS code A4290 (sacral nerve stimulation test lead, each) should not be reported with CPT code 64561.

D. Ophthalmology

1. When a subconjunctival injection (e.g., CPT code 68200) with local anesthetic is performed as part of a more extensive anesthetic procedure (e.g., peribulbar or retrobulbar block), the subconjunctival injection is not separately reportable. It is part of the anesthetic procedure and does not represent a separate service.

2. Iridectomy and/or anterior vitrectomy may be performed in conjunction with cataract extraction. If an iridectomy is performed in order to complete a cataract extraction, it is an integral part of the procedure and is not separately reportable. Similarly, the minimal vitreous loss occurring during routine cataract extraction does not represent a vitrectomy and is not separately reportable. If an iridectomy or vitrectomy that is separate and distinct from the cataract extraction is performed for an unrelated reason at the same patient encounter, the iridectomy and/or vitrectomy may be reported separately with an NCCI-associated modifier. The medical record must document the distinct medical necessity for each procedure.
A trabeculectomy is separately reportable with a cataract extraction if performed for a purpose unrelated to the cataract extraction. For example, if a patient with glaucoma requires a cataract extraction and a trabeculectomy is the appropriate treatment for the glaucoma, the trabeculectomy may be separately reportable. However, performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not separately reportable.

3. CPT codes describing cataract extraction (66830-66984) are mutually exclusive of one another. Only one code from this CPT code range may be reported for an eye.

4. There are numerous CPT codes describing repair of retinal detachment (e.g., 67101-67113). These procedures are mutually exclusive and should not be reported separately for the ipsilateral eye on the same date of service. Some retinal detachment repair procedures include some vitreous procedures which are not separately reportable. For example, the procedure described by CPT code 67108 includes the procedures described by CPT codes 67015, 67025, 67028, 67031, 67036, 67039, and 67040.

5. The procedures described by CPT codes 68020-68200 (incision, drainage, biopsy, excision, or destruction of the

conjunctiva) are included in all conjunctivoplasties (CPT codes 68320-68362). CPT codes 68020-68200 should not be reported separately with CPT codes 68320-68362 for the ipsilateral eye.

6. CPT code 67950 (canthoplasty) is included in repair procedures such as blepharoplasties (e.g., CPT codes 67917, 67924, 67961, 67966).

7. Correction of lid retraction (CPT code 67911) includes a full thickness graft (e.g., CPT code 15260) as part of the procedure. A full thickness graft code such as CPT code 15260 should not be reported separately with CPT code 67911 for the ipsilateral eye.

8. If it is medically reasonable and necessary to inject anti-sclerosing agents at the same patient encounter as surgery to correct glaucoma, the injection is included in the glaucoma procedure. CPT codes such as 67500, 67515, and 68200 for injection of anti-sclerosing agents (e.g., 5-FU, HCPCS code J9190) should not be reported separately with other pressure-reducing or glaucoma procedures.

9. Since visual field examination (CPT codes 92081-92083) would be performed prior to scheduling a patient for a blepharoplasty (CPT codes 15820-15823) or blepharoptosis (CPT codes 67901-67908) procedure, the visual field examination CPT codes should not be reported separately with the blepharoplasty or blepharoptosis procedure codes for the same date of service.

10. The CPT code descriptors for CPT code 67108 (repair of retinal detachment...) and 67113 (repair of complex retinal detachment...) include removal of lens if performed. CPT codes for removal of lens or cataract extraction (e.g., 66830-66984) should not be reported separately.

11. Medicare Anesthesia Rules prohibit the physician performing an operative procedure from separately reporting anesthesia for that procedure except for moderate conscious sedation for some procedures. CPT codes describing ophthalmic injections (e.g., CPT codes 67500, 67515, 68200) should not be reported separately with other ophthalmic procedure codes when the injected substance is an anesthetic agent. Since Medicare Global Surgery Rules prohibit the separate reporting of postoperative pain management by the physician performing the procedure, the same CPT codes should not be reported separately

by the physician performing the procedure for postoperative pain management.

12. CMS payment policy does not allow separate payment for a blepharoptosis procedure (CPT code 67901-67908) and blepharoplasty procedure (CPT codes 15822, 15823) on the ipsilateral upper eyelid.

13. CPT codes 65420 and 65426 describe excision of pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT codes 65780-65782 should not be reported separately with either of these codes for the ipsilateral eye.

14. CPT codes 92018 and 92019 (ophthalmological examination and evaluation, under general anesthesia...) are generally not separately reportable with ophthalmological surgical procedures. The examination and evaluation of an eye while a patient is under general anesthesia for another ophthalmological procedure is integral to the procedure. However, there are unusual circumstances when an adequate ophthalmological examination cannot be completed without anesthesia (e.g., uncooperative pediatric patient, severe eye trauma). In such situations CPT codes 92018 or 92019 may be separately reportable with appropriate documentation.

15. Procedures of the cornea should not be reported with anterior chamber “separate procedures” such as CPT codes 65800-65815 and 66020. CMS payment policy does not allow separate payment for procedures including the “separate procedure” designation in their code descriptor when the “separate procedure” is performed with another procedure in an anatomically related area.

16. Repair of a surgical skin or mucous membrane incision (CPT codes 12001-13153) is generally included in the global surgical package. For procedures of the eye requiring a skin or mucous membrane incision (e.g., eyelid, orbitotomy, lacrimal system), simple, intermediate, and complex repair codes should not be reported separately.

17. Repair of an incision to perform an ophthalmic procedure is integral to completion of the procedure. It is a misuse of the repair of laceration codes (CPT codes 65270-65286) to separately report closure of a surgical incision of the conjunctiva, cornea, or sclera.

18. CPT codes 65280 and 65285 describe repair of laceration of the cornea and/or sclera. These codes should not be reported to describe repair of a surgical incision of the cornea and/or sclera which is integral to a surgical procedure (e.g., 65710-65756).

19. Posterior segment ophthalmic surgical procedures (CPT codes 67005-67229) include extended ophthalmoscopy (CPT codes 92225, 92226), if performed during the operative procedure or post-operatively on the same date of service. Except when performed on an emergent basis, extended ophthalmoscopy would normally not be performed pre-operatively on the same date of service.

20. Injection of an antibiotic, steroid, and/or nonsteroidal anti-inflammatory drug during a cataract extraction procedure (e.g., CPT codes 66820-66986) or other ophthalmic procedure is not separately reportable. Physicians should not report CPT codes such as 66020, 66030, 67028, 67500, 67515, or 68200 for such injections.

21. CPT codes 67515 (injection into Tenon’s capsule) and 68200 (subconjunctival injection) should not be reported with a paracentensis (e.g., CPT code 65800-65815) since the injections,

if performed, are integral components of the paracentesis procedure.

22. Removal of corneal epithelium (e.g., CPT codes 65435, 65436) should not be reported with removal of corneal foreign body (e.g., CPT codes 65220, 65222) or repair of laceration of the cornea (e.g., CPT codes 65275-65285) for the ipsilateral eye.

23. Repair of entropion (CPT codes 67923, 67924) or repair of ectropion (CPT codes 67916, 67917) should not be reported with excision and repair of eyelid (CPT codes 67961, 67966) for the same eyelid. The latter codes include excision and repair of the eyelid involving lid margin, tarsus, conjunctiva, canthus, or full thickness and may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement. A repair of entropion or repair of ectropion CPT code may be reported with an excision and repair of eyelid CPT code only if the procedures are performed on different eyelids. Modifiers E1,

E2, E3, or E4 should be utilized to indicate that the procedures were performed on different eyelids.

24. CPT code 67028 (intravitreal injection of a pharmacologic agent (separate procedure)) should not be reported with CPT codes 65800-65815 (paracentesis of anterior chamber of the eye (separate procedure);...) when both procedures are performed on the same eye at the same patient encounter. Medicare policy does not allow two codes each defined as a “separate procedure” by its code descriptor to be reported together when performed in the same anatomic region at the same patient encounter.

25. CPT code 67028 describes intravitreal injection of a pharmacologic agent. CPT code 68200 (subconjunctival injection) performed on the ipsilateral side should not be reported separately with CPT code 67028.

E. Auditory System

1. If the code descriptor for a procedure of the auditory system includes a mastoidectomy (e.g., CPT codes 69530, 69910), an additional code describing a mastoidectomy (e.g., 69502-69511) is not separately reportable for the ipsilateral mastoid.

2. A myringotomy (e.g., CPT codes 69420, 69421) is included in a tympanoplasty or tympanostomy procedure and is not separately reportable.

3. If an otologic procedure requires a transcanal or endaural approach with incision of the tympanic membrane and access through the middle ear, exploration of the middle ear (CPT code 69440) and tympanic membrane procedures (e.g., CPT codes 69420, 69421, 69424, 69433, 69436, 69610, 69620) should not be reported separately.

4. A labyrinthotomy procedure includes vestibular function testing performed for monitoring during the procedure. Since diagnostic vestibular function testing would have been performed prior to the procedure on a different date of service, diagnostic vestibular function tests should not be reported separately with a labyrinthotomy procedure code on the same date of service.

F. Operating Microscope

1. The *Internet-Only Manual (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 20.4.5 (Allowable Adjustments) limits the reporting of use of an operating microscope (CPT code 69990) to procedures described by CPT codes 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64891 and 64905-64907. CPT code 69990 should not be reported with other procedures even if an operating microscope is utilized. CMS guidelines for payment of CPT code 69990 differ from *CPT Manual* instructions following CPT code 69990. The NCCI bundles CPT code 69990 into all surgical procedures other than those listed in the *Medicare Claims Processing Manual*. Most edits do not allow use of NCCI-associated modifiers. (CPT code 64870 was deleted January 1, 2015.)

2. If a physician performs two procedures utilizing the operating microscope but only one of the procedures is on the CMS list of procedures for which CPT code 69990 is separately payable, payment for CPT code 69990 may be denied because of an edit bundling CPT code 69990 into the other procedure not on the CMS list. (Claims processing systems do not identify which procedure is linked to CPT code 69990.) In these cases, physicians may submit the claim to the local carrier (A/B MAC processing practitioner service claims) appending modifier 22 to the CPT code for the procedure on which the operating microscope was used and a letter of explanation. Although the carrier (A/B MAC processing practitioner service claims) cannot override an NCCI PTP edit that does not allow use of NCCI-associated modifiers, the carrier (A/B MAC processing practitioner service claims) has discretion to adjust payment to include use of the operating microscope based on modifier 22.

G. 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.

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 MUE values for CPT code 63661 (removal of spinal neurostimulator electrode percutaneous array(s)...) and CPT code 63662 (removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy...) are one (1). Each code descriptor includes the removal of some or all electrode percutaneous arrays and some or all electrode plates/paddles for a neurostimulator pulse generator.

4. The MUE value for CPT code 64612 (chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm) is one (1). The unit of service for this code is all injections for chemodenervation into any and all muscles innervated by a facial nerve. A provider may separately report a unit of service for chemodenervation of any and all muscles innervated by the left facial nerve and a unit of service for chemodenervation of any and all muscles innervated by the right facial nerve. However, a provider should never report more than one unit of service for chemodenervation of one or more muscles innervated by a single facial nerve. If the procedure is performed bilaterally on the muscles of the left facial nerve and right facial nerve, it should be reported with modifier 50 and one (1) unit of service.

5. Bilateral ophthalmic procedures should be reported with modifier 50 and one (1) unit of service on a single claim line. Procedures performed on eyelids should be reported with modifiers E1-E4. The MUE values for many eyelid procedures are one (1) based on use of these modifiers for clinical scenarios in which the same procedure is performed on more than one eyelid.

6. CPT code 68840 describes probing of lacrimal canaliculi and includes probing of the lacrimal canaliculi of both the upper and lower eyelids of an eye. This code may only be reported with one (1) UOS for a single eye. If the procedure is performed bilaterally, it may be reported with modifier 50 and one (1) UOS on a single line of the claim.

7. The unit of service (UOS) for procedures to correct trichiasis (e.g., CPT codes 67820-67835) is the eye, not eyelid. The MUEs for these codes are one (1). If a procedure is performed bilaterally, it may be reported with modifier 50 and one (1) UOS.

8. CPT codes 64400-64530 describe injection of anesthetic agent for diagnostic or therapeutic purposes, the codes being distinguished from one another by the named nerve and whether a single or continuous infusion by catheter is utilized. All injections into the nerve including branches described (named) by the code descriptor at a single patient encounter constitute a single unit of service*(UOS)*. For example*:*

*(1) I*f a physician injects an anesthetic agent into multiple areas around the sciatic nerve at a single patient encounter, only one UOS of CPT code 64445 (injection, anesthetic agent; sciatic nerve, single) may be reported.

(2) If a physician injects the superior medial and lateral branches and inferior medial branches of the left genicular nerve, only one UOS of CPT code 64450 (Injection, anesthetic agent; other peripheral nerve or branch) may be reported regardless of the number of injections needed to block this nerve and its branches.

9. 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.