NCCI Manual Overview

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The Basics

- Developed by CMS
- Prevents inappropriate payment for procedures that should not be reported together:
  - Either the column 2 code is a component of the column 1 code or
  - The 2 procedures simply should not be reported together
- Uses Column One/Column Two Table
- Unless medical necessity permits, a column one code will be eligible for payment and the column two code will be denied
- With appropriate medical necessity documented, a modifier may be reported to allow payment for both codes

The Basics

- Mutually exclusive procedure cannot be reported together
- Gender-specific CPT codes should not be reported for a patient of the opposite gender
- Unlisted procedure codes are usually listed as the last code of a section in the CPT book and are not included in the NCCI manual

MUE Edits

- Medically Unlikely Edits (MUE) also a part of the NCCI manual
- Limits the number/quantity of a service provided
- HCPCS/CPT codes are given an MUE value
- The MUE is the maximum number of units that can be billed on the same DOS
- All claims submitted to MAC's are subjected to MUE
- Denials may be appealed

MUE Edits: Claims Processing

MUEs are adjudicated as claim line or DOS edits

- Claim line edits:
  - Units of service on each claim line are matched to the MUE value
  - All units of service are denied on that claim line if the MUE value is over the maximum

- DOS edits:
  - Used when it's highly unlikely that more units than the MUE value would be performed on a given DOS
  - All units of service on each claim line for the same DOS for the same HCPCS/CPT code are totaled
  - If this total exceeds the maximum, all units are denied for that HCPCS/CPT code for that DOS

MUE Adjudication Indicator (MAI)

- 1- Claim line MUE
  - With the use of a modifier (59 or X{EPSU}, 76, 77, 91 or anatomic modifier), each line with the HCPCS/CPT code will be separately adjudicated
  - Some HCPCS/CPT codes limit the use of these modifiers

MUE Adjudication Indicator (MAI)

- 2-DOS MUE
  - These are fixed DOS edits
    - Considered impossible for units to exceed the MUE value on the same DOS due to being contrary to statute, regulation or sub-regulatory guidance
    - Correct coding limitations and/or anatomical limitations preclude reporting more than the designated number of units on a given DOS

Examples:

- Reporting multiple units of CPT 44950 (appendectomy)
  - Anatomical consideration is the limiting factor for this edit
  - There is only one appendix in the human body, so only one unit can ever be reported
- Reporting multiple units of CPT 16000 (initial treatment 1st degree burn…)
  - The code descriptor is the limiting factor for this edit
  - There can only be one "initial" treatment of the burn so reporting more than one unit would go against correcting coding based on the code descriptor

MUE Adjudication Indicator (MAI)

- 3-DOS MUE
- These are based on clinical benchmarks
  - It's possible but not likely, that more units would be performed during one DOS
  - Contractors may bypass the MUE edit if presented evidence that the number of units reported were correctly coded and medically necessary

Examples:

- CPT 48020 (Removal of pancreatic calculus)
  - Clinically, it would be highly unlikely to perform this procedure more than once per DOS
- CPT 49060 (Drainage of retroperitoneal abscess, open)
- The MUE on this procedure is 2
  - While it would be possible to perform a drainage procedure more than twice per day, it is highly unlikely

MUE Denials

- Providers may appeal denials based on MUE's
- Documentation is key appealing an MUE denial
  - Contractors will ask questions to decide on overriding a denial:
    - Did the provider actually perform more units that allowed by the MUE?
    - Were these service medically reasonable and necessary?
  - Denials may be appealed for an MAI of "1" or "3"
  - It is not appropriate to have beneficiaries sign an ABN in order to bill the patient for an MUE denial
  - These denials are not based on statutory provisions, thus making an ABN inappropriate

Coding Instructions

- HCPCS/CPT code descriptions should be referenced before reporting codes together, as some codes include redundant services, and those codes should not be reported separately
- Code descriptors often define correct coding - coders should start with the CPT code description to determine if two codes should be reported together
- Coding instructions are included prior to each chapter and in the appendices of the CPT book
- Instructions can also be found prior to the subsection of the chapter or after individual codes
- CPT instructions should be followed unless CMS provides specific coding or reporting directives
- The AMA also publishes “CPT Assistant” with coding rules as an additional tool
  - Sometimes CMS doesn’t agree with “CPT Assistant” advice
  - MAC’s may process claims differently than the advice from “CPT Assistant”

Comprehensive Codes

- All codes should be reported with the most comprehensive CPT code available
- Do not report multiple HCPCS/CPT codes if a single code describes the services performed
  - Example:
    - Provider performs a laparoscopic cholecystectomy with cholangiography
      - It is inappropriate to report the Lap Chole code 47562 with 47563 (Lap Chole with Cholangiogram)
      - The more inclusive code 47563 should be reported and includes the basic Lap Chole services in addition to the Cholangiography

- Do not break up a procedure into component parts
  - Example:
    - Provider performs a colonoscopy with biopsy
      - It is inappropriate to report 60650 (adrenalectomy) with 50545 (radical nephrectomy)
      - The parenthetical description with CPT 50545 lists adrenalectomy as a component of the nephrectomy

Comprehensive Codes

- Do not unbundle bilateral procedures:
  - If a bilateral procedure is performed, do not report the unilateral procedure with 2 units or on two lines with RT/LT modifiers

  Example:
    - Provider performs bilateral venous thrombosis imaging, venogram
      - DO NOT report 78457 with 2 units nor 78457-RT, 78457-LT
      - Instead, report 76858

- Do not unbundle services that are integral to a comprehensive procedure:
  - Certain services are integral to a more comprehensive procedure and should not be unbundled

Family of Codes

- Group of related codes
  - May describe component services
  - May describe various combinations of components
- All services included in the code must be performed in order to report a CPT code
- Multiple codes should not be reported for component services when a more comprehensive code exist
  - The NCCI manual does have limited exceptions
- A code describing the component service should not be reported with the comprehensive code
- If a codes doesn't exist to describe services provided, a "not otherwise specified" code should be reported
  - DO NOT use a code that is "close" to the service provided

More Extensive Procedure

- Group of similar codes, differing in complexity only
- Less complex code is included in the more complex code unless:
  - The services are performed at a separate encounter
  - The services are performed on different anatomical sites
- Simple procedures are included in complex/complicated
- Limited procedures are included in complete
- Intermediate procedures are included in comprehensive
- Superficial procedures are included in deep
- Incomplete procedures are included in complete
- External procedures are included in internal

“Separate Procedure”

- CPT codes defined as a “separate procedure” cannot be reported with a related procedure
- Coders are unable to report the “separate procedure” code performed in the anatomically related region
  - Often through the same incision, orifice or surgical approach
- A modifier may be reported for certain circumstances
  - i.e. unrelated anatomical location through a separate incision at the same encounter

Downcoding and Upcoding

- A less comprehensive code should not be reported in place of a more inclusive code
  - Example:
    - Physician performs Arthrocentesis of subacromial bursa with ultrasound guidance
      - DO NOT report CPT 20610 (arthrocentesis w/o ultrasound guidance) and CPT 76942
      - Instead report CPT 20611 (arthrocentesis with ultrasound guidance)
- Do not report a more comprehensive code if all services described by the code isn't completed
  - Example:
    - Provider performs a simple I&D of pilonidal cyst
      - DO NOT report CPT 10081 (I&D of pilonidal cyst, complicated)
      - Instead, only report CPT 10080 (I&D of pilonidal cyst, simple)
- Report Units of Service correctly:
  - Providers should be familiar with the criteria of what constitutes a unit of service
    - Some codes are reported per a time increments (CPT 97110 - therapeutic procedure, 1 or more areas, each 15 minutes) and some are per session (CPT 92507 - Treatment of speech disorder)

Medical/Surgical Package General Guidelines

- Most procedures include pre-procedure, intra-procedure and post-procedure work
- Vascular And/or Airway Access:
  - Work associated with gaining access is included in the pre- or intra-procedure work
  - Work associated with getting the patient back to the suitable post-procedure state is included in the post-procedure work
  - Airway access is essential for general anesthesia, therefore, not separately reportable
  - Intravenous access is not reportable with many types of procedures
  - Access must also be maintained by slow infusion and is not reportable
  - If a procedure requires more invasive vascular access, the more invasive procedure maybe reported if it isn't included in the valuation of the procedure
- Anesthesia:
  - Services by the same provider performing the surgical or medical procedure
  - If it is reasonable and necessary for another provider to give the anesthesia service, these services may be reported by the other provider
  - Do not unbundle components of anesthesia and report them in lieu of anesthesia services that are not reportable

Medical/Surgical Package General Guidelines

- Endoscopic procedure performed with a non-endoscopic procedure in order to make sure no injury occurred or to confirm the procedure was correctly performed, the endoscopic procedure is not reportable
- If Cardiopulmonary monitoring is integral to the procedure performed, it is not reportable separately
- Biopsies:
  - A biopsy performed at the same time as another extensive procedure
  - If a biopsy is performed on a separate lesion, modifier XS or 59 is allowed in order to report the separate lesion
  - If a biopsy is used to assess margins or resectability, it is not reportable
  - If a biopsy is submitted for Pathology that will be completed after the more extensive procedure, it is not separately reported
- Exposure and exploration of the surgical field is integral to the procedure and not reportable

Medical/Surgical Package General Guidelines

- If access through a diseased tissue is required in order to perform a definitive procedure, services for that access is not reportable
- If elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure is reported
- Excision and removal includes the incision and opening
  - A code for an –otomy should not be reported with an –ectomy for the same organ
- Multiple approaches for the same procedure are mutually exclusive
- When a laparoscopic procedure fails and is converted to an open procedure, only the open procedure should be reported
- If diagnostic endoscopy precedes an open procedure, the diagnostic procedure may be reported with modifier 58 reported on the open procedure code

Medical/Surgical Package General Guidelines

- Complications
  - Reportable with limitations
  - OR procedures include services that are normally a usual and necessary part of the procedure
  - Post-operative services that do not require a return to the OR are included in the global package
- Complications are NOT reportable when:
  - The services are normally provided in the OR during the procedure
  - The complication occurs during the post-op course but doesn't require a return to the OR

Example:

- Control of post-op bleeding that can be treated with out a return to the OR is not reportable
- Control of post-op bleeding that DOES require a return to the OR IS reportable

Evaluation and Management (E&M)

In order to determine if an E/M service is reportable at the same time as a surgical procedure, coders will need to know the global period of the procedure being performed

- All procedures have a global period assigned
  - The categories are 000, 010, 090, XXX (global period doesn't apply), YYY (global period determined by MAC), ZZZ (related to another procedure- global period determined by the related procedure) or MMM (maternity procedures)
  - A global period of 090 is defined as a major procedure
    - E/M services performed the day of or the day before are only reported if that encounter is for the purpose of deciding to perform the surgical procedure- modifier 57 should be reported with the E/M code
    - E/M services performed the day of or the day before for other reasons are not reportable
  - A global period of 000 or 010 is defined as a minor procedure
    - Generally, E/M services on the same day as a minor procedure is included in the procedure
    - Unlike major procedures, the decision to perform a minor procedure is included in the procedure
    - A significate, separately identifiable E/M service is separately reportable- modifier 25 should be reported with the E/M code
    - A separate Dx is not required
    - Same rule applies for new or established patient

Evaluation and Management (E&M)

Postoperative E&M services are included in both major and minor procedures during the global period

Complications are also included during the global period, unless the complication requires a return to the OR

E/M services during the PO period for an unrelated diagnosis can be reported with modifier 24 appended to the E/M code

Global Surgery Indicator “XXX”

Usual pre- intra and post- procedure work performed is included in the procedure and these services should not be reported as an E/M service

Some XXX procedures are not typically performed by a physician thus have no work RVU’s.

A separate E/M is **NOT** reported for:

- The supervision of others performing the procedure
- Interpretation of the procedure

A separate E/M **MAY** be reported:

- If the physician performs a separate, identifiable E/M services on the same day as the procedure
- A separate diagnosis isn’t required, but it can’t include work inherent in the XXX procedure, supervision of the performance of the XXX procedure or time interpreting the results
- Modifier 25 should be appended to a qualifying E/M code

Modifiers

- Only append modifiers if it's clinically appropriate to do so
- Modifier should NEVER be used solely to bypass an NCCI edit
- Medicare restrictions should be reviewed before appending a modifier
- Modifiers available for bypass of an NCCI PTP edit:
  - Anatomical: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
  - Global Surgery: 24, 25, 57, 58, 78, 79
  - Others: 27, 59, 91, XE, XS, XP, XU
- "Repeat procedure" modifiers 76 and 77 are not NCCI PTP modifiers and will not bypass an edit

Modifiers

- Most paired organs or structures have NCCI PTP modifier indicators of “1”
- Procedures performed on the contralateral organ or structure for a paired organ/structure
- Code pairs should not be reported with a modifier when performed on the ipsilateral organ or structure unless a specific coding rationale to bypass the edit
- Modifiers should only be reported when appropriate!

Generally, modifiers are appropriate to report:

- A separate patient encounter
- A separate anatomic site
- A separate Specimen

Modifiers

Let's review a few modifiers that impact NCCI PTP Edits: **Modifier 22**

- Although not a modifier that will bypass an edit, it is addressed in the Manual as it can be relevant to an edit
- Increased Procedural Services Modifier
- Services performed must be substantially more extensive than what is usually included in the HCPCS/CPT description
- Two procedures performed that should not be reported together based on an NCCI edit:
  - If the edit allows a modifier and clinical circumstances supports the use of a modifier, report the two procedure codes with the modifier
  - If the edit does not allow a modifier and the procedure meets the definition above modifier 2 may be appended to the column one code

Modifiers

Modifier 25

"CPT Manual" definition:

"Significant, Separately Identifiable Evaluation and Management Service by the Sam Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service"

- Append to a separate, identifiable E/M service on the same DOS
- Reported with minor procedures
- The work associated with the decision to perform a minor procedure is included in the procedure performed
- The patient designation of new or established has no baring on whether to report a separate E/M

Modifiers

Modifier 58

"CPT Manual" definition:

"Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period"

- Second procedure performed during the PO period of a prior procedure
  - Second procedure either:
    - Planned prospectively
    - More extensive that the first procedure
    - Therapy after a diagnostic procedure
- Diagnostic endoscopic procedure results in the decision to perform an open procedure, modifier 58 is reported on the open procedure
  - If the endoscopic procedure is a "scout" to access anatomic landmarks, it is NOT reportable
- At the same encounter:
  - A diagnostic endoscopy of the same organ or anatomic region is not reportable with another endoscopy procedure
  - A diagnostic laparoscopic and a surgical laparoscopic of the same body cavity is never reportable

Modifiers

Modifier 58

"CPT Manual" definition:

"Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period"

- Planned laparoscopic procedure fails and converted to open
  - Only the open procedure is reported
  - This statement is applicable whether there is an NCCI edit or not
  - There are more bundling possibilities that the number of NCCI edits
  - Just because the specific combination isn't included in the NCCI edit table, both a failed laparoscopic and open procedure should not be reported together

Modifiers

Modifier 59

"CPT Manual" definition:

"Distinct Procedural Service"

- Very mis-used modifier!!
  - Documentation must support two procedures that are not normally performed together qualify to be reported separately:
    - Different anatomic site
    - Different patient encounter
- Modifier 59 should **only** be used when no other modifier can more accurately describe the situation
- Not reported on E/M codes
- Modifier 59 should NOT be used simply to override the edit
- Documentation MUST support the use of modifier 59

Modifiers

Modifier 59

"CPT Manual" definition:

"Distinct Procedural Service"

- Two codes of an edit indicates two procedures can't be reported together if the same anatomical site and same encounter
- Modifier 59 isn't supported based on the two codes being different procedures
- If the two procedures are performed at separate anatomic sites or separate encounter for the same DOS, modifier 59 may be reported to appropriately bypass the edit

Modifiers

Modifier 59

"CPT Manual" definition:

"Distinct Procedural Service"

Exceptions:

- Diagnostic procedure can be reported if it precedes, and is the basis, to decide to perform a therapeutic procedure:
  - Not interspersed with services required for the therapeutic procedure
  - Clearly provides information to decide to proceed with the therapeutic procedure
  - Is not a service that would have been required during the therapeutic procedure
- Diagnostic procedures cannot be reported if the procedure is an essential component of the therapeutic procedure

Modifiers

Modifier 59

"CPT Manual" definition:

"Distinct Procedural Service"

Exceptions:

- Diagnostic procedure can be considered separate and distinct if:
  - Occurs after the therapeutic procedure and isn't interspersed with services required only for the therapeutic procedure
  - Not a service that is required during the therapeutic procedure

- A post-procedure diagnostic procedure is NOT separately reportable if the diagnostic procedure is essential or otherwise included in the therapeutic procedure

Modifiers

Modifier 59

"CPT Manual" definition:

"Distinct Procedural Service"

- For time-based codes, modifier 59 can be used to report two separate services provided in two distinct time blocks
- Providers are not allowed to report multiple services for the minimal time and report each as separate units of service
- All related timed services performed are totaled and the total time is used to calculate the number of units reported

Modifiers

Modifier 59

"CPT Manual" definition:

"Distinct Procedural Service"

- Different diagnosis are not required to report modifier 59
- Different diagnoses alone doesn't support the use of modifier 59
- Different anatomic sites:
  - Different organs
  - Different anatomic regions
  - Different lesions in the same organ
  - DOES NOT include connecting structures in the same organ or region
- Code descriptions should be evaluated to determine if additional units of services are allowed to be reported when a procedure is performed on different anatomical sites

Modifiers

Modifiers XE, XS, XP, XU

"CPT Manual" definition:

- Provide greater specificity when modifier 59 was previously reported
- Effective 1/1/2015 but not required, but will be required in the future
- XE- "Separate Encounter, A service that is distinct because it occurred during a separate encounter."
- XS- "Separate Structure, A service that is distinct because it was performed on a separate organ/structure."
- XP- "Separate Practitioner, A service that is distinct because it was performed by a different practitioner."
- XU- "Unusual, Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service."

Anesthesia

- Preparation and monitoring services are not reportable separately with the anesthesia service
- Separately reportable if:
  - Services are performed by the same anesthesia provider prior to and unrelated to the anticipated anesthesia service
  - After the patient is released from the anesthesia provider's post-op care
  - Report with modifier 59- or X{EU}

- Generally, payment for anesthesia provided by the provider who also performed the surgical procedure isn't allowed
- An exception is for moderate conscious sedation
- If services are not related to the delivery of an anesthetic agent or not inherent to the procedure, they may be reported separately
- Surgeon not allowed to report epidural/subarachnoid injection or nerve blocks

Add-On Code Edit Table

- Add-On codes are never reported alone; there must be a primary code reported
- Incidental services needed to perform the primary procedure should not be reported with an add-on code
- NCCI generally doesn't include edits for add-on codes
  - Some add-on code edits are included when primary procedure edits must be supplemented
- CPT codes not designated as add-on codes cannot be used as an add-on code
  - All services included in a CPT code must be performed in order to report the code

Anesthesia Services
CPT codes 00000-01999

- Included in Anesthesia services:
  - Pre-Op Evaluation
  - Administration of Anesthetic
  - Medications, blood and fluids
  - Monitoring
  - Supportive services
- Codes are broken down by anatomic area and includes several surgical procedures
  - Only one Anesthesia code should be reported
    - Exception- Add-on codes per CPT instructions
- Time units are used to report Anesthesia services
  - Starts when provider begins to prepare the patient for anesthesia
  - Ends when provider is no longer providing care to the patient
  - Any interruptions of care should not be counted in the time
- CPT codes also have an associated based unit
- If post-op pain management is requested by a surgeon, that surgeon must document the reason for this request in order for the anesthesia provider to be able to report these services. CMS global surgery rules state the performing provider is responsible for post-op pain treatment

Surgery: Integumentary System CPT Codes 10000-19999

- Wound closures using steri-strips or tape are not reported with a “closure” code, rather this service is included in the E&M (outside of an operative procedure)
- Suture removal and dressing change
  - Not reported if the patient requires anesthesia for a related procedure
  - Dressing change code 15852 should not be reported with any primary procedure
- Closure of a surgical wound is included in the procedure except:
  - Simple, intermediate and complex wound repair codes can be reported with MOHS surgery
  - Intermediate and complex repair codes may be reported with excision of benign or malignant lesions
  - Wound repair codes are not reportable with excision of a benign lesion with a diameter of 0.50 cm or less
- FNA cannot be reported with a biopsy of the same lesion
- Do not report tangential, punch or incisional biopsy with destruction of a benign or premalignant lesion unless the procedures are performed on separate lesions or at a separate patient encounter
- Do not report trimming of nondystrophic nails with debridement of nails unless the procedures are performed on separate nails or at a separate patient encounter

Surgery: Musculoskeletal System CPT Codes 20000-29999

- Diagnostic arthroscopy is included in a therapeutic arthroscopic procedure
- If a diagnostic arthroscopy leads to the decision to perform an open procedure, the diagnostic can be reported with modifier 58
- If a more extensive procedure is performed after a “clean up” synovectomy, the synovectomy isn’t reportable
- Coders and providers of Spine procedures are encouraged to review section F of this chapter, as it includes a lot of instructions
- Removal of external immobilization devices by the same physician/group who placed it are not reportable
- Casting/splinting/strapping codes are not reported if a definitive procedure is also performed for the same anatomical area
- Casting/splinting/strapping codes are minor procedure and include E&M services, unless a separate, identifiable service is provided
- Closed, percutaneous and open repair codes for the same anatomical area are mutually exclusive

Surgery: Respiratory, Cardiovascular, Hemic and Lymphatics Systems CPT Codes 30000-39999

- Respiratory:
  - For procedures performed at or near a mucocutaneous margin, the code that best describes the procedure should be reported; either a code from the Integ, nasal or oral section
  - For a biopsy performed with a more extensive nasal/sinus procedure should not be reported
  - The most comprehensive endoscopic code should be reported for services provided
  - Flexible and direct laryngoscopy aren't reportable for the same encounter
- Cardiovascular:
  - Bypass procedures using venous grafts include the obtaining of the graft
  - CP bypass requires insertion of cannulas into the venous and arterial circulation
  - Open or percutaneous vascular procedures include the repair and closure unless the CPT description states the repair is reported separately
  - Venous access codes should not be reported when the access is normally obtained while performing another procedure

Surgery: Respiratory, Cardiovascular, Hemic and Lymphatics Systems CPT Codes 30000-39999

- Hemi and Lymphatics:
  - Abdominal lymphadenectomy should not be reported for the excision of lymph nodes in the operative field of another procedure
  - Iatrogenic laceration of the spleen that occurs during another procedure, repair of the laceration with or without splenectomy is not separately reportable

- Mediastinum:
  - Mediastinotomy codes (39000, 39010) should not be reported with another procedure on the mediastinal structures for exploration

Surgery: Digestive System
CPT Codes 40000- 49999

- Services integral to an endoscopic procedure are not separately reportable
- The same endoscopic performed more than one time at a single encounter in the same region cannot be reported with multiple units
- Endoscopy or enteroscopy performed as a standard of practice performing another service should not be reported
- Only a more extensive endoscopic procedure should be reported for a patient encounter
- An incidental Appendectomy during the course of another procedure is not reportable
- Insertion of Mesh (49568+) is only reported for incisional or ventral hernia repairs
- Laparoscopic LOA (44180 or 58660)not separately reported with other surgical services

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

- Urinary System:
  - Insertion of a bladder catheter is included in the global surgical package
  - Placement of a urethral/bladder catheter for post-op drainage may not be reported if it is integral to the procedure
  - Some genitourinary procedures include a hernia repair
  - All minor related functions performed at the same endoscopic encounter are included in the endoscopy

- Male Genital System:
  - Two codes from the code ranges for various methods of removing or destroying prostate tissue cannot be reported together
  - If prostatectomy necessitates reconstruction of the bladder neck, the reconstruction is not reportable

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

- Female Genital System:
  - A pelvic exam performed in conjunction with a GYN procedure should not be separately reportable
  - A pelvic EUA is included in all major GYN procedures and is not reportable

- Maternity Care and Delivery:
  - Total obstetrical package includes antepartum, delivery and postpartum care
  - Other services may be reportable
  - Antepartum care includes a urinalysis

Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems

- Nervous System:
  - Burr hole cannot be reported unless performed at a separate site unrelated to a cranial procedure performed
  - General exploration of the filed is always included in craniotomies and craniectomies
- Ophthalmology:
  - Iridectomy done n order to complete a cataract extraction is included in the cataract procedure and not separately reportable
  - CPT codes for repair of retinal detachment (67101-67113) are mutually exclusive
    - Reportable for ipsilateral eye
  - Correction of Trichiasis is per eye and not per eyelid
- Auditory System:
  - Myringotomy procedures include tympanoplasty or tympanostomy procedures
  - Labyrinthotomy includes vestibular function testing or monitoring during the procedure

Radiology Services
CPT Codes 70000-79999

- Scout radiographs before the admin of contrast are not separately reported
- A chest X-Ray done to check the location after central venous catheter insertion is not separately reported
- Fluoroscopy is integral to may procedures and therefore not reportable
- Medically reasonable and necessary diagnostic CT may be separately reportable with an acceptable modifier
- Some brachytherapy procedures include calculations described by CPT 77300
- Radiologic guidance codes are reported as one unit of service per patient encounter

Pathology/ Laboratory Services CPT Codes 80000-89999

- CPT code descriptions in the Lab section include testing done as panels
  - If all tests of the panel are performed, the panel should be reported
  - Edits are in place for panel lab test and the individual tests included in the panel
- Diagnostic bone marrow aspiration is performed without biopsy, the procedure is reported with 38220. Interpretation of the aspirate smear(s) reported as 85097. If the same provider does both services, both can be reported
- Blood products are described by HCPCS Level II P codes. CPT 86945 can't be reported separately since the P code includes the irradiation of the blood product
- CPT codes 88321-88325 are surgical pathology consultations
  - Not reported for a second opinion also examined by another pathologist in the same group

Medicine Evaluation and Management Services CPT Codes 90000-99999

There are guidelines in the NCCI manual for each section within the Medicine section of the “CPT Manual” including:

- Therapeutic or Diagnostic Infusions/Injections and Immunizations
- Psychiatric Services
- Biofeedback
- Dialysis
- Ophthalmology
- Otorhinolaryngologic Services
- Cardiovascular Services
- Pulmonary Services
- Allergy Testing and Immunotherapy
- Central Nervous System Assessments/Tests
- Chemotherapy Administration
- Special Dermatological Procedures
- Physical Medicine and Rehabilitation
- Medical Nutrition Therapy
- Osteopathic Manipulative Treatment
- Chiropractic Manipulative Treatment
- Miscellaneous Services

Medicine Evaluation and Management Services CPT Codes 90000-99999

Evaluation and Management Services (E&M)

- Medicare doesn't recognize consultation codes (99241-99255)
  - For consultations reported to Medicare, the code for the site of service should be reported
- E&M services are usually cognitive services and do not include significant procedures
  - Some procedures that arise from the E&M are included- for example, dressings, counseling and educational services
- For Hospital DC services (99238, 99239)
  - Not reported with initial hospital care services 99221-99223
  - Not reported with initial hospital care services 99218-99220
  - If initial hospital or initials OBS and DC are performed on the same DOS, report 99234-99236
  - DC services includes all services provided to the patient on the DOS
  - No other E&M services (99201-99215, 99281-99285) should be reported on the same DOS

Supplemental Services
HCPCS Level II Codes A0000-V9999

- The previous principles discussed at the beginning of this presentation also apply to the HCPCS Level II codes
- HCPCS Level II are alpha-numeric codes developed to compliment the “CPT Manual”
- Includes services not included in the “CPT Manual”
- There are many issues addressed in Chapter 12 of the NCCI Manual specifically for HCPCS Level II codes
- Some CPT codes have similar HCPCS codes and the same rules apply
  - Example- 99408/99409 (non-screening) and G0396/G0397 (screening)
- Be very careful when reporting drug codes (J codes)
  - Make sure the units of service are correct based on the amount of the drug given
  - If the drug code description states “per dose” only one unit can be reported
- Double-check the MEU section of this chapter for lots of information!!

Category III Codes
CPT Codes 0001T-0999T

- The previous principles discussed at the beginning of this presentation also apply to the HCPCS Level III codes
- Category III codes are for emerging technologies, services and procedures
- Category III codes are referenced with codes from the “CPT Manual”
- The most specific HCPCS/CPT code should be reported for the service provided even if that code is a category III code

References

- https://www.cms.gov/medicare/national-correct-coding-initiative-edits/ncci-policy-manual-medicare

- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE

- https://www.cms.gov/medicare/national-correct-coding-initiative-edits/ncci-faqs