PREMIER PATIENT CARE

Your Partner in Health

PROVIDER AUTHORIZATION MANUAL

Managed by:

PROCARE

MANAGEMENT SERVICES ORGANIZATION

TABLE OF CONTENTS

Appendix

INTRODUCTION

Premier Patient Care (PPCIPA) is committed in providing quality care to our members and improve health outcomes while preventing waste and abuse of unnecessary medical services that may be harmful to patients. PPCIPA aim to provide continuous quality improvement and appropriate utilization of resources to our members. Our Utilization Management infrastructure provide ongoing monitoring and evaluation of delegated medical management activities to address over/under utilization and coordination of medical resources; to support continuum- based case management activities, continuity-of- care; and, to maintain a systematic process for the education of our staff and providers regarding Utilization Management.

This Provider Authorization Manual offers Prior Authorization guidelines and Clinical Determination information.

The Procare/Premier Patient Care Web Authorization System (available through procaremso.quickcap.net) is available for Physician's offices to submit and view status of a referral request. A Provider Authorization Notification is also faxed to each office with authorization and patient details including specific reasons for the determination.

IPA Authorization Department Information/Healthplan Contact Information

Authorizations Department Phone (855) 548-0911

Fax: (888) 972-1931

UM Review Nurse Line: (657)-206-8700
Rosan Godoy, LVN (714) 837-9451
Josh Sleeper, RN (707)- 338-8440
Dana Lopez, LVN (760)-812-3256

Technical Support Line:
Daniel Hong, Provider Network Support (714)-837-9385

Local Provider Relations Liasion:
Martha West, Regional Provider Relations (760)-672-5885

Premier Patient Care IPA's Contracted Health plans:

Molina Healthcare- 1-855-322-4076

Healthnet- 1-800-929-9224 OR 1-800-646-5614

Brand New Day- 1-866-255-4795

Types of Referral/Authorizations

Routine authorizations are for services that are not-urgent.

Retrospective authorizations are medical services provided without prior authorization, can only be accepted within 48 hours of service rendered or up to 14 days if exception circumstances occurred, see page 26 for details.

Urgent means services that are required in order to prevent serious deterioration of a member's health that results from an unforeseen illness or injury. Urgent Authorizations that are not truly Urgent will be defaulted to Routine Status.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION:

Generally, authorizations are required for all services except for PCP-capitated services, Ob/Gyn visits, and some exceptions made by the IPA such as Direct Referral Authorizations (attached) such as Preventative services and Initial Consult to Specialist performed by IPA contracted providers.

Frequently Asked Questions:

What requires an authorization?

- PCP services beyond office visit and Carve out services that are more than one time per patient per month
- Follow-up visits for Specialist Services
- Specialist Procedure and test services
- Outpatient surgical services, Outpatient Dialysis services, ambulatory surgery, endoscopy, etc.
- Scheduled Inpatient hospital admissions and acute rehab admissions
- Physical Therapy, Occupational Therapy, Speech Therapy, Nutritional Services, Chemotherapy
- Adult Hep A and Hep B, Synagis, and other high- cost drugs and Injectables
- CT scans, MRIs, PETs and certain other radiology services when received as an outpatient and not an emergency
- Treadmill, Stress Echo, other Cardiology tests, and Holter Monitor, Apnea monitor, Sleep study services and testing
- HHC, DME, Orthotics, Prosthetics
- Out of network or non-contracted providers or facilities
- High cost and non-routine Lab services

The following **do NOT** require an authorization

- EKGs

- Cardiac Echo
- Routine Annual Lab and X-ray (Routine X-rays do not need an authorization through IPA designated Providers)
- Routine OB/Gyn Care, including well woman visits.
- Mammogram
- Colonoscopy
- Yearly Diabetes Retinal Screening
- Yearly Glaucoma Eye Exam Screening
- Yearly Foot Exam
- BMD Screening (women age 65 and older)
- Initial Specialist Consult/Office visit

All unlisted Medicare services require prior authorization.

Authorization Process Overview

You may submit referral authorizations using a standard Authorization Request Form or electronically through Procare Quickcap provider portal Contact Provider Services at (714) 837-9385 or email Daniel.H@procaremso.com to request login Provider portal access (contracted providers only) and/or additional copies of Authorization Request Forms.

The Authorizations Department fax number is **(888) 972-1931.**

AUTHORIZATION PROCESS FAQs:

Updating a request?

To update recently approved authorization requests, please fax PROCARE a written request with the reference authorization number with the requested change. We will be happy to assist you. Please note that updates to already Approved Authorizations can only be modified within 48 hours of last Approval notice.

Once an Authorization Request is received, how long does authorization determination take?

- **Routine requests** with complete supporting medical documents that justify the treatment request are completed within five business days from receipt of request. Although CMS allow up to 14 days to process Routine Authorizations.

- **Urgent requests** with complete supporting documentations are completed within 48 hours from receipt of request. CMS allow up to 72 Hours.

- **Retro request** with complete supporting documentation (please include reason why Prior Authorization Request was not done prior to rendering service, i.e system was down and we could not verify member's eligibility) are processed within 7 days for receipt.

How will we be notified of the determination?

A Fax Provider Notification will be faxed to the fax number we have on file for your office.

It is important to keep your fax machine on 24 hours a day, since we fax back daily notifications to you during and after typical business hours. Remember to check your incoming fax report before calling our office to inquire about status. You can also check our Web Authorization system on-line at procaremso.quickcap.net. If the fax number failed and unable to connect, we will contact you for a Secured email to email you the Determination Notification.

Further, Notification letters of determination will be sent to the member specific to their Health Plan's letter template. The Provider Notification is sent to both the requesting and requested provider, and the Primary care provider.

Prior Authorizations – Reminders

DO:

- Check fax notification DAILY for status and authorization number. This is typically sent immediately after the determination is made. (Keep fax machine ON!)
- Fill in the diagnosis (code), procedure (code), procedure description, member name and ID on each request, and reason for treatment along with supporting medical documentation including recent Physical exam with treatment plan, tried RX therapies, labs/pathology results, diagnostics results, and other pertinent test results that support the treatment).
- Combine requests if the requested services are for the same provider at the same site. Please Note: Unbundled service requests are not allowed per CMS/NCCI edits.
- Respond to a request for additional information (medical records/notes) from our medical review staff as soon as possible so that a determination can be made.
- Include clinical information pertinent to the request.
- Include/enter the Facility when appropriate (i.e. hospital, ambulatory surgery center, SNF, etc.)
- Use the Procare Premier Patient Care QUICKCAP web system to verify status of requests.
- Send two separate authorization/referral requests for office and hospital procedures

DO NOT:

- Send an additional new request to add a code, this will cause a duplication and result in Cancel request. Please contact us by phone or fax to request to modify an already approved authorization, within 48 hours only.
- Send Routine authorization requests as URGENT OR EMERGENCY. This will further delay the Authorization process. Requests not meeting the conditions for an urgent request as define below will be considered Routine. The federal regulations define an urgent request as:
  - Requires immediate action to prevent a serious deterioration of a member's health that results from an unforeseen illness or an injury, or
  - Could jeopardize the ability of the individual to regain maximum function based upon a prudent layperson's judgment, or
  - In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being

requested.

- Send multiple copies of the same request.
- Requests that are made to multiple providers within the same medical group cannot be on the same day of service. For cases that required other Specialist service in the same group for other services within in the same date of service, the PCP of the patient must be notified and share the treatment plan to coordinate care for optimal patient health outcomes. Please call UM Department for further details.
- Send a retro-authorization after 48 hours (or up to 14 days for special circumstances, i.e system was down, could not verify eligibility). After 14 days, a Retro request must be sent as a claim and medical review will be done through the claims review process. A retro authorization request cannot be used after a claim has been denied. No authorization will be given. This is considered a claims appeal and go through the claims process.
- PCPs: Send a referral to an OB/GYN as prior authorization is not required.

Additional Important Information

- With the Procare Provider portal Web Authorization request system, the Evaluation & Management code level is defaulted to level 3 unless the supporting clinical notes justify the higher level and there are no other bundled or inclusive codes with other services requested.
- Request for surgical supplies and trays, will not be prior authorized. These will be reviewed on a case-by-case basis by the Claims Department.
- Specialists can request follow-up visits and surgical procedures directly; however, the PCP will be notified of the request for Coordination of patient care to achieve safer and more effective care.
- If specialist has not seen member in last 3 months and is not under active treatment with the specialist, the patient/member needs to be redirect back to PCP for evaluation first.

Web Procare Quickcap Authorization System - Reminders

- Make sure the appropriate diagnosis codes and procedure codes are entered. The system will be cancelled for outdated codes or unlisted codes.
- Check the status of the requests daily in order to respond to request for information quickly.

• Providers who are not showing in the system are out-of-network providers and the service is required to an out of network provider for continuity of care, you can enter the out of network provider name and phone number under "NOTES" and we will contact that provider for a Letter of Agreement (LOA).

• Cancelled Notification will be sent for the following reasons:

- Duplicate request
- Member not eligible at the time of service
- Provider Request to cancel
- Carve out service with the Health Plan (these are services that are Health plan responsibility)

PCPS, EMERGENCY SERVICE, AND SPECIALIST AUTHORIZATIONS

The following describes basic information about authorizations for PCPs and Specialists.

Primary Care Providers (PCPs) are responsible for managing PPCIPA assigned members' primary, preventative, acute and chronic health care needs. PCPs focuses on preventative treatment and chronic care management by conservative medication therapy, health education, maintenance and promotion and serve as a gatekeeper for initiating and obtaining prior authorization to specialist referrals. PCPs should only refer to the Specialist when facing a complicated or perplexing diagnoses that conservative therapies tried and failed. Prior Authorization are required for non - routine labs and carve out procedures that require more than one time per patient per month.

Authorizations are NOT required for a referral from a PCP to a contracted Ob/Gyn Specialist for Ob/Gyn visits. Be sure to inform your patients! This information is KEY in coordinating timely care for your patients.

Ob/Gyns: You do not need to ask for a referral authorization for an office visit related to Ob/Gyn care when a member self refers. Continue to submit referral authorizations for anything beyond office visits, including procedure(s) and delivery.

Emergency Services

Primary Care Physicians are requested to notify the PROCARE UM immediately of all Emergency Department visits, including member visits to out-of-network facilities. ER services are periodically reviewed by PROCARE's UM department and/or the IPA's UM Committee. When ER services have been authorized by the PCP or other authorized representative of the IPA, but were later found through the UM review process not to meet medical necessity criteria, this information may be incorporated into targeted provider utilization history. The UM Department will periodically fax to PCPs their members that went to Emergency Department for services that could been seen at an Urgent Care. PCPs must educate their members to utilize PPCIPA contracted Urgent care as needed after hours. Our contracted Urgent Care:

Specialists (SPC): Specialty care is care focused on dealing with the diagnoses and treatment of specific non-routine conditions. Specialists are encouraged to communicate and sharing treatment options with the members' Primary Care Provider to coordinate and facility appropriate patient care for improved health outcomes. The

Initial consult is referred by a signed Direct Referral form by the PCP or a Faxed Approval Notification. The Specialist can request for Prior Authorization through the Procare Provider Portal or Fax the Treatment Authorization form (enclosed in Appendix). Please note: Initial office visit level 3 is defaulted to automatically approved. For higher level 4 or above, please submit clinical supporting documentation to justify the higher level and would require medical review.

For further treatment or services after the Initial Consult/Visit, Specialist must request Prior Authorization through the Procare/Premier Patient Care IPA Web Portal or by filling the Treatment Request Fax form. To prevent delay, please include Diagnoses and reason(s) for the treatment requested and attached the supporting medical documentations including Physical exam with treatment plan, recent History and Physical, Medications tried but failed, recent lab results relevant to the request, relevant diagnostic test results, and other relevant notes that support the Service/Procedure request.

SPC follow up visits: PPC IPA allow **two** auto approved SPC follow up visits per year for patients that has previous history of receiving care from the SPC. For more frequent follow up visits, patients must be under active treatment and continued Specialty care is medically necessary per UM Medical Review.

E/M codes with other Services: may be subject to CMS NCCI edits where when combination of certain codes is inclusive of each other.

SPCs are encouraged to refer PPCIPA members back to their PCP once treatment is completed and the members are stable for continued preventative care and medication therapy and management. Kindly fax the recent consult notes to the PCP for coordinated care improving patients' health outcomes.

Prior authorization requests that do not have a recent history with Specialist (not under active treatment) in the last six months, the patient must be redirected to his or her Primary Care Provider to evaluate first to determine the need for referral to Specialist.

Note: Services that are combined with Evaluation and Management may be subject to CMS NCCI edits where services are inclusive of each other. Unbundled services are not allowed per CMS. See Appendix for Chapter 1 General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services

Please note an Approved pre-authorization is not a guarantee of payment. SPC must check the patient's eligibility and Medicare benefit coverage prior to rendering services.

USING THE PROCARE QUICKCAP WEB PORTAL TO SUBMIT AUTHORIZATIONS

There are several benefits and advantages to using a paperless process. Not only are your requests received instantly by the UM Department, but you are also able to:

- ☐ Check the status of any request any time.
- ☐ Check eligibility.
- ☐ Receive the referral/reference number immediately.
- ☐ Check history of a referral related to the member.

If you don't have a Login User ID to the web portal, email the attached Provider Portal Login Request form to Daniel Hong at Daniel.h@procaremso.com or call Provider Services at 213-393-7520 to request a User ID, password and training.

Basic Instructions for Submitting Referral Authorizations Using the Web

For additional detailed instructions, please log on to **procaremso.quickcap.net** or refer to the provider portal document.

Launch a web browser of your choice (FireFox preferred) and go to procaremso.quickcap.net.

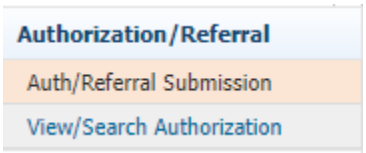
Click the IPA of choice. Enter your assigned username and password (case-sensitive).

Reminder: Always type the password using case-sensitive keys.

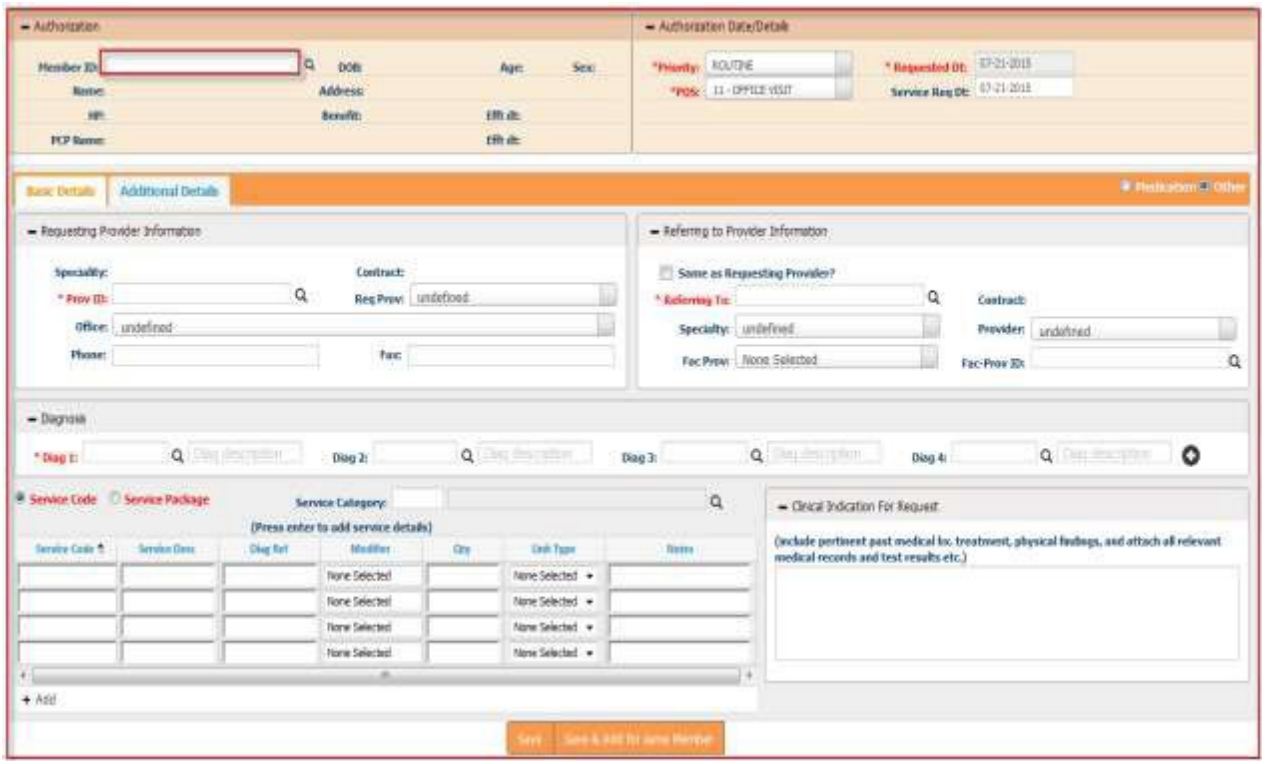
The Authorization/Referral module

Click on the Authorization/Referral module and select "Auth/Referral Submission".

-

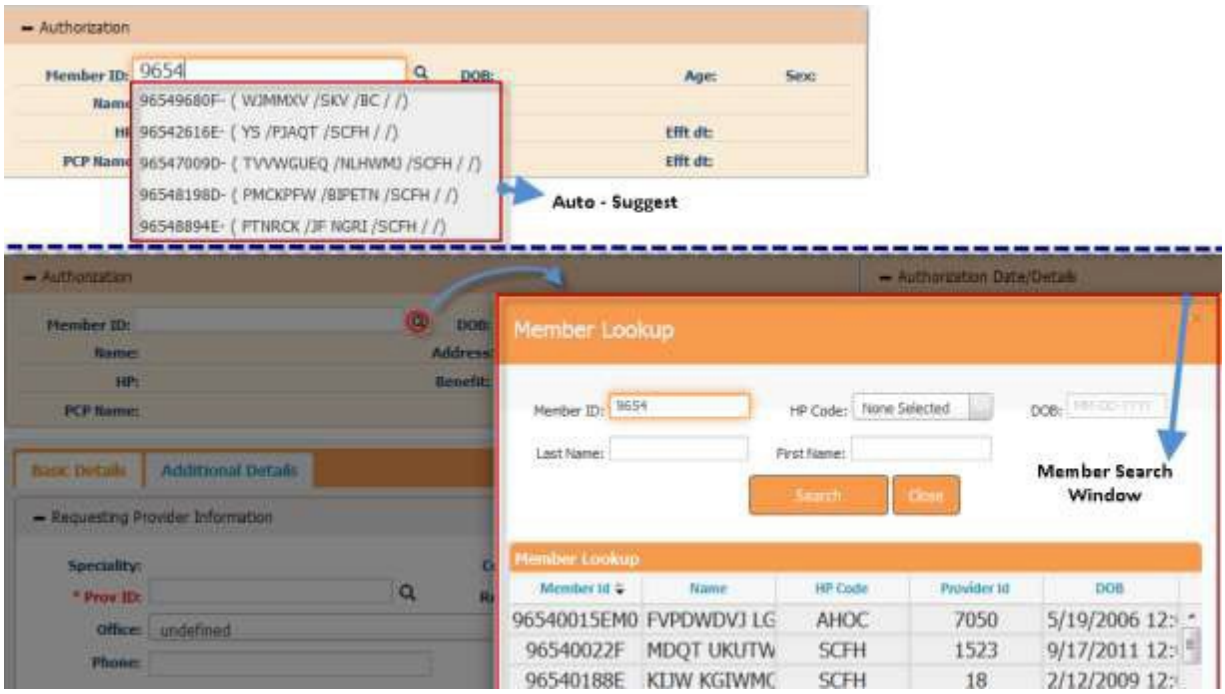


The screen will display as shown. On this screen, there are three subsections to add and submit an authorization.

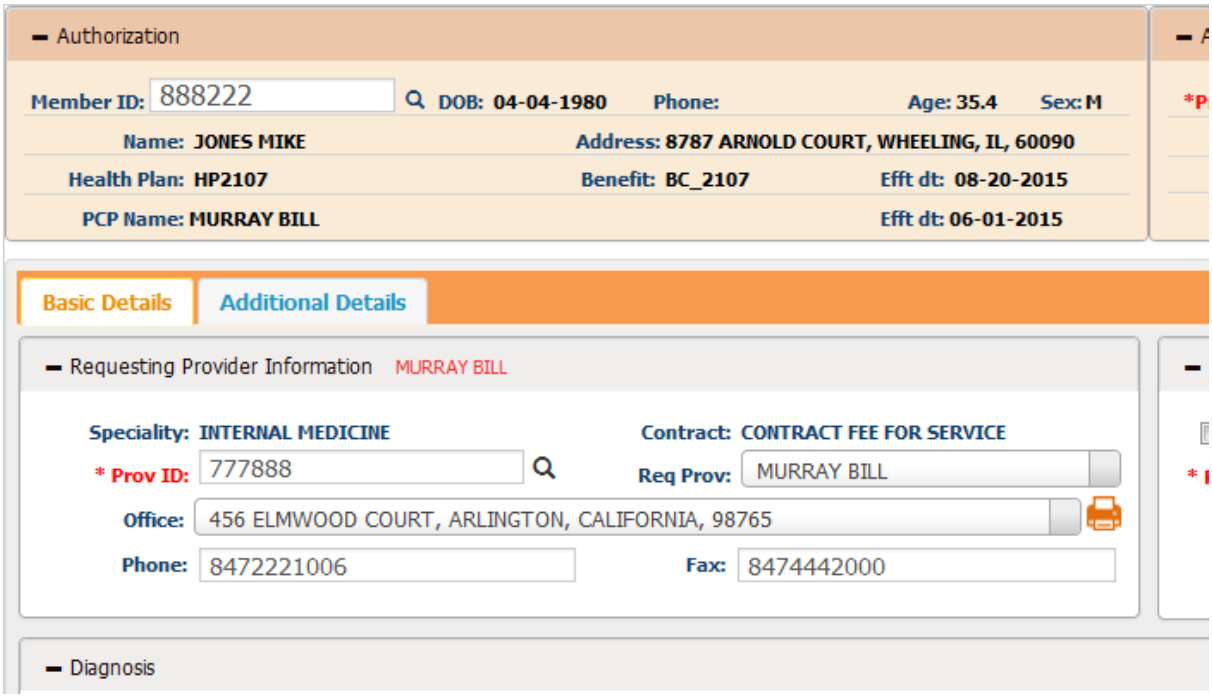


Step 3: The first section is the **Member Section.** Users can enter the member's information in one of two ways:

- ☐ Enter the **Member ID** for the specific member. The system will begin suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member's information to the screen.
- ☐ Users can click on the **Magnifying Glass** icon to search for the member. The -**Member Lookup** screen will open. From this screen, users can search using a combination of **Member ID, Health Plan**, **Name,** and **DOB** to find the record. Double click the correct record to add it to the authorization request.



Step 4: The details for the selected member will be populated on the screen. The system will default the **Requesting Provider** information matching the organization and provider logged in.

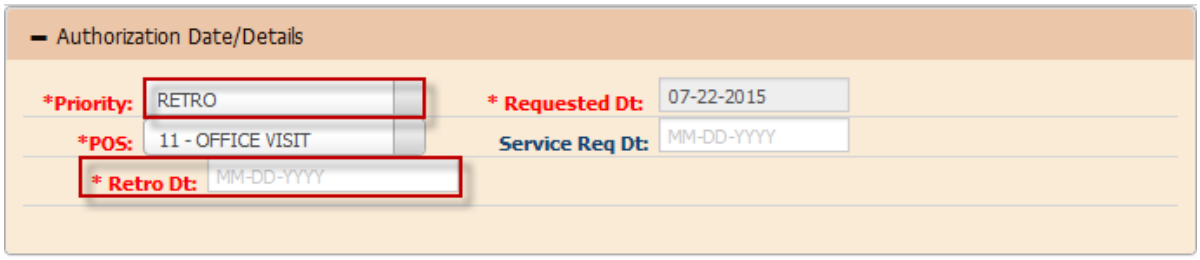


Step 5: The user can select the **Priority** and the **Place of Service** for the request.

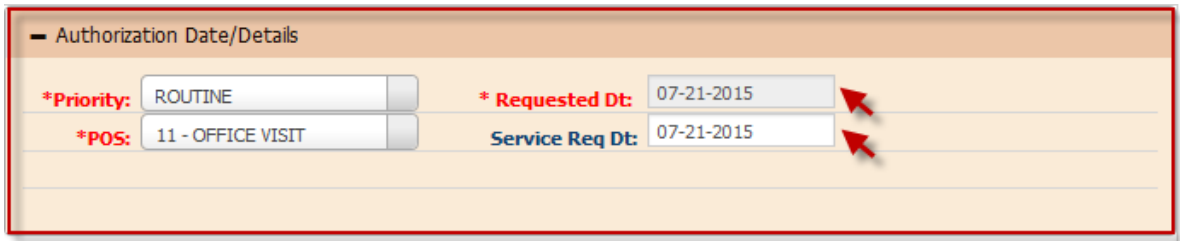
☐ Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear or additional options.

- **Urgent**: If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.

- **Retro**: If the services have already been provided, users should select **Retro.** A new field, **Retro Date,** will appear and require date entry.

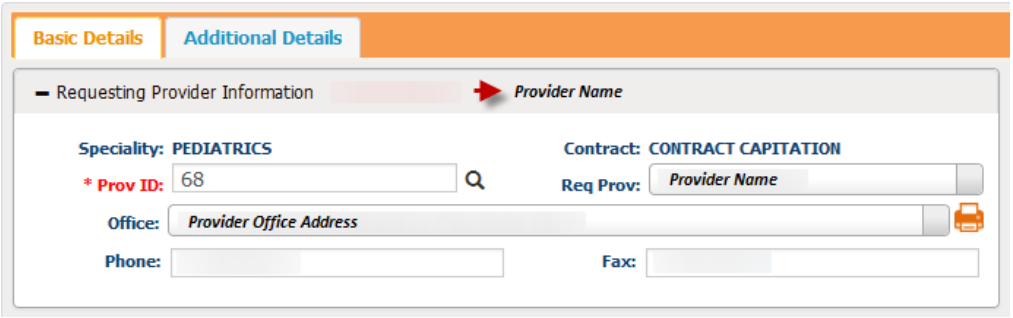


Step 6: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** is non-editable and will always default to the date of submission.

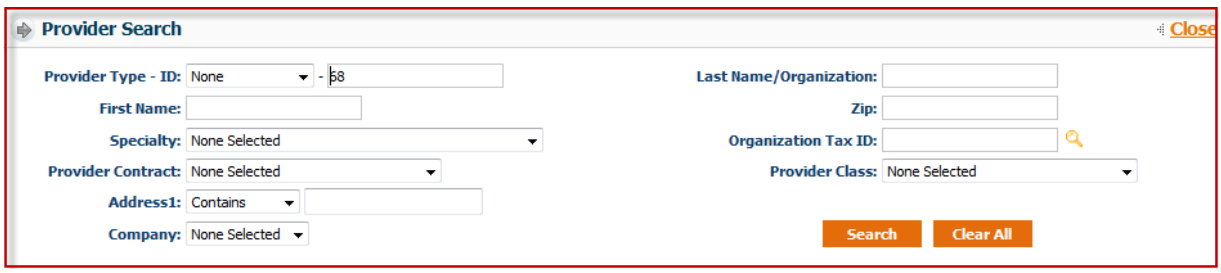


- ☐ The **Service Requested Date,** displayed in the **Service Req. Dt** field should be entered as the date that the service should be performed, scheduled for, or for the authorization to become effective. This date will be reviewed by Nivano Physicians internal staff and is subject to their discretion.

Step 7: The **Basic Details** tab displays the **Requesting Provider Information**. This screen includes **the Specialty, Contract Type, Provider ID**, **Requesting Provider Name**, and the contact information.



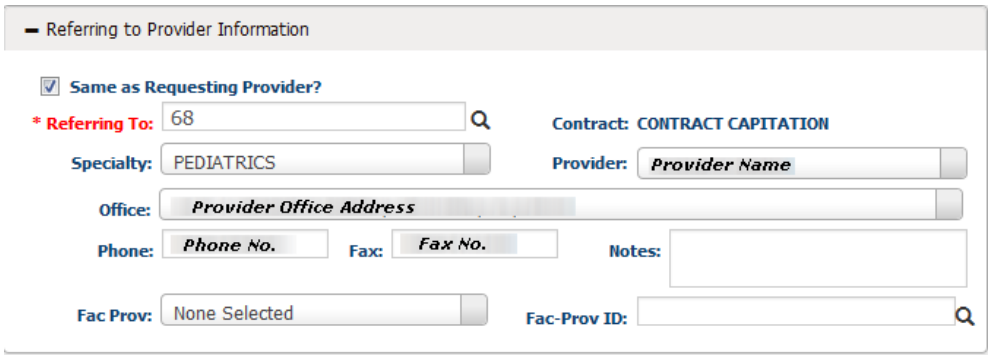
- ☐ Users can search for a requesting provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information. If you click on search without entering any parameter, all providers under your organization will show up.



☐ Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.
☐ If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 8: The next section, **Referring to Provider Information**, allows users to enter the information for the provider that member is being referred to.

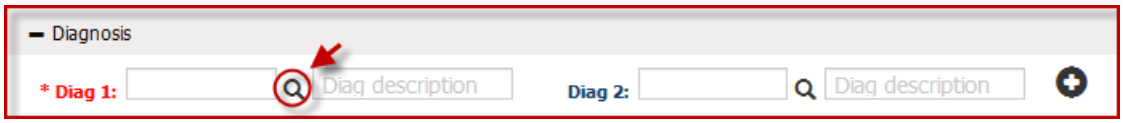
☐ For self-referrals, select the "Same as Requesting Provider" checkbox. This will auto-populate the information from the Requesting Provider screen.
☐ To search for a Referring To Provider, click the Magnifying Glass icon beside the Referring To field. The Provider Search screen will populate as shown in the above section. Users can search for the specific provider.
☐ Click the correct Provider ID to enter the details of the referring provider on the authorization request



☐ Then, select the **Referring to Office** from the dropdown menu.

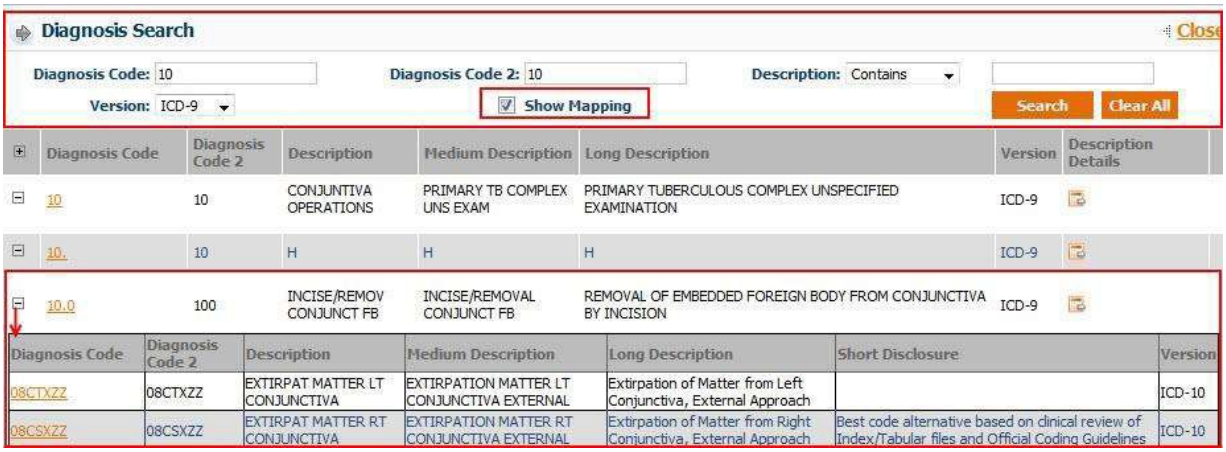
Step 9: This step is optional. Users can enter **Facility Provider Information** for the request, if needed.

Step 10: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.



☐ Enter all ICD codes related to the request in the **Diagnosis Code** field.

- If the user knows the ICD code, they can enter it into the field and press **tab** on their keyboard. The system will populate the description to the right in the **Diag. Description** field. The system will auto suggest codes if they are partially entered.
- To search for the diagnosis code, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.

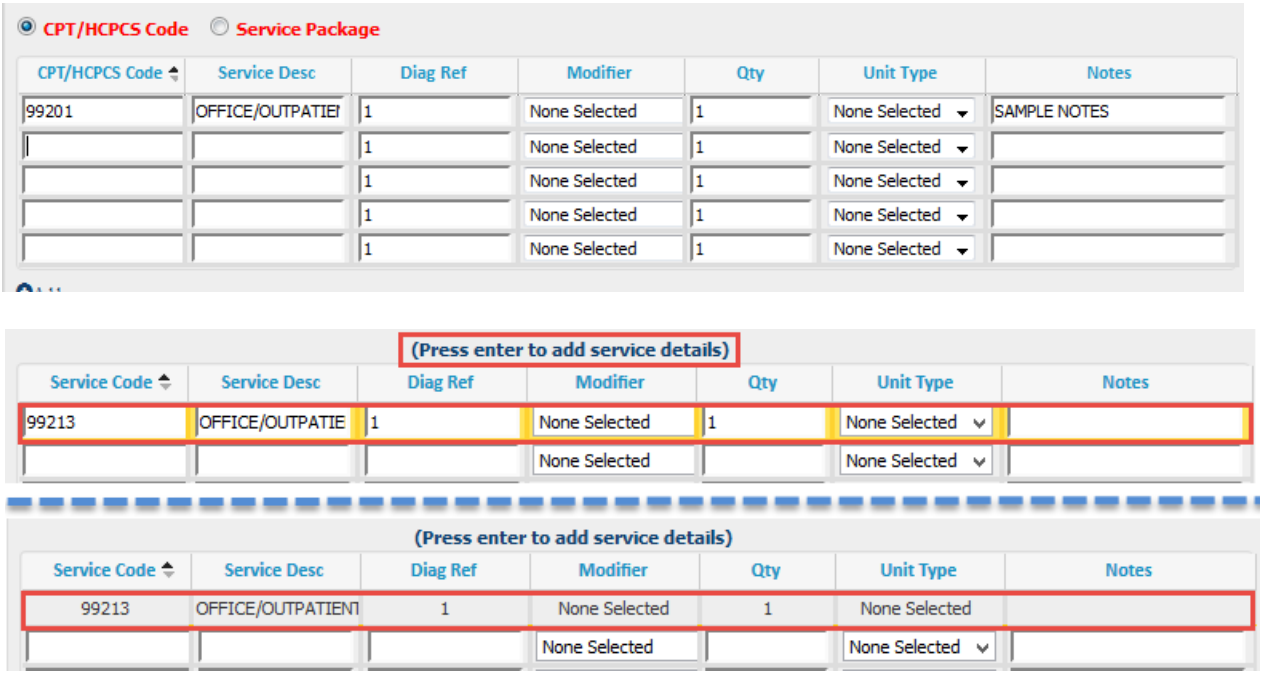


☐ From the **Diagnosis Search** screen:

- Enter either the diagnosis code or description to search for the code.
- Select the version of the code. ICD 9 codes will default. However, users can search for ICD 9, ICD 10, or for both codes.
- Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
- Click the **Search** button.
- Click the **+** icon to the left of each code to view the mapping.
- Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

Note: Users can add 12 distinct diagnosis codes.

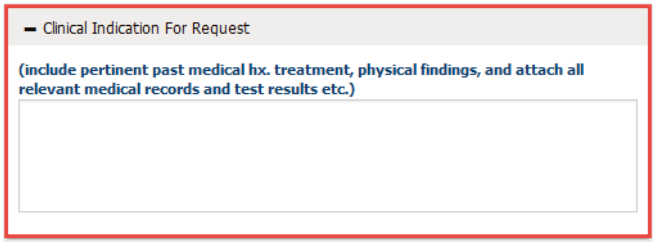
Step 11: The next section is used to enter the CPT/HCPCS codes for the requested services.



- ☐ The option for **CPT/HCPCS Code** defaults for entry; users can select **Service Package** if it is enabled. This will be described further below.
- ☐ To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard.
- ☐ If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated. This can be used to identify certain services such as Office Visits or Consultation visits.
- ☐ After the code is entered, the description will auto populate into the **Service Desc** field.
- ☐ Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.

- ☐ Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.
- ☐ Users can add any modifiers if needed. Modifiers can be selected from the dropdown menu or manually enter the code.
- ☐ Press **tab** on the keyboard to go to the next CPT (service) line.

Step 12: The next section is **Clinical Indication for Request**. In this section, users can add the member's past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.



Step 13: The second information tab is **Additional Details.** Within this tab, three more sections will appear.

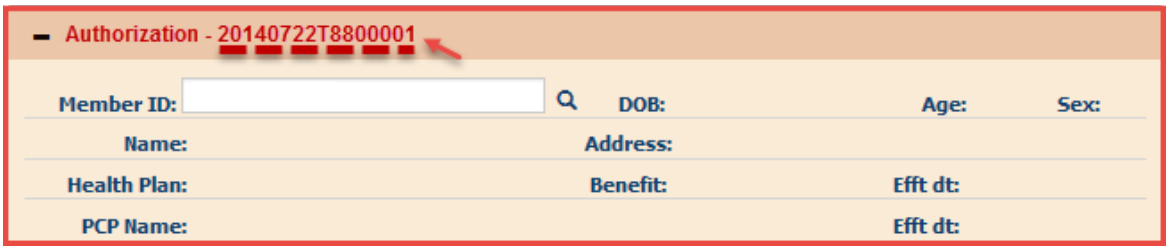
Step 14: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

- ☐ Select the **Category** and **Priority** of the document.
- ☐ Click **Browse** to find the file from the computer directory
- ☐ Upload documents in the following formats: .doc, .docx, .xls, .xlsx, .pptx, .xps, .psd, .htm, .pdf, .tiff, .rtf, and text.
- ☐ Click the **Add Additional Documents** button to add multiple documents.
- ☐ Once users click **Save**, the document will send with the referral automatically.

Step 15: After verifying the data entered, users can save the request.

- ☐ To submit the referral request, click **Save**.
- ☐ To submit the referral request and add another request for the same member, click **Save and Add for Same Member**.

Note: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.

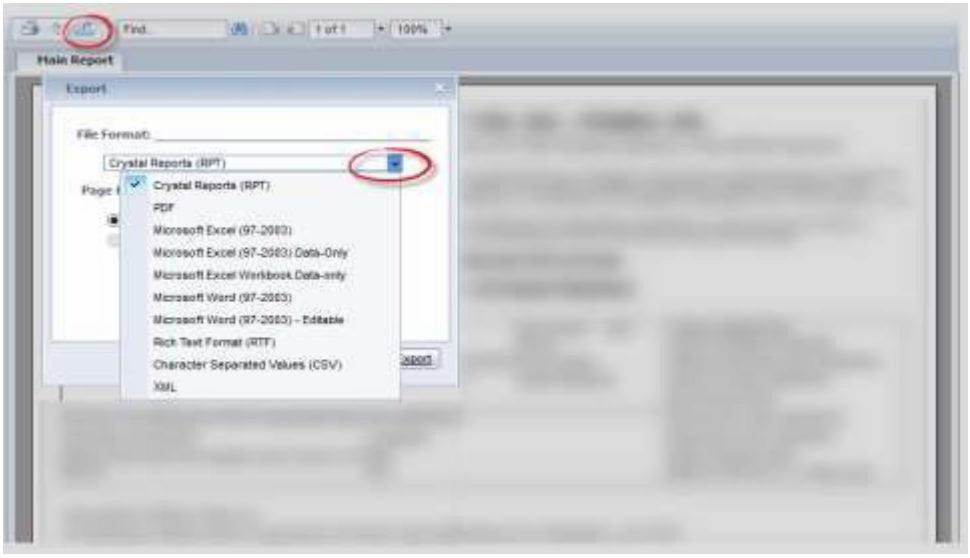


Step 16: Users have the option to **Print Auth** on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.

☐ **Export Options:** There are several options that the reports can be exported to:

- Crystal Reports (RPT)
- PDF
- Excel 97 – 2003
- Excel 97 – 2003 Data Only
- Excel Workbook Data Only
- Word 97 – 2003
- Word 97 – 2003 Editable
- Rich Text Format (RTF)
- Character Separated Values (CSV)

- XML



☐ CHECKING THE STATUS OF AN AUTHORIZATION

To verify the status of an authorization, follow these steps:

Step 1: From the **Authorization/Referral** list, select **View/Search Authorization**.

Step 2: The **Authorization/Referral Status Search** screen will display as shown below:

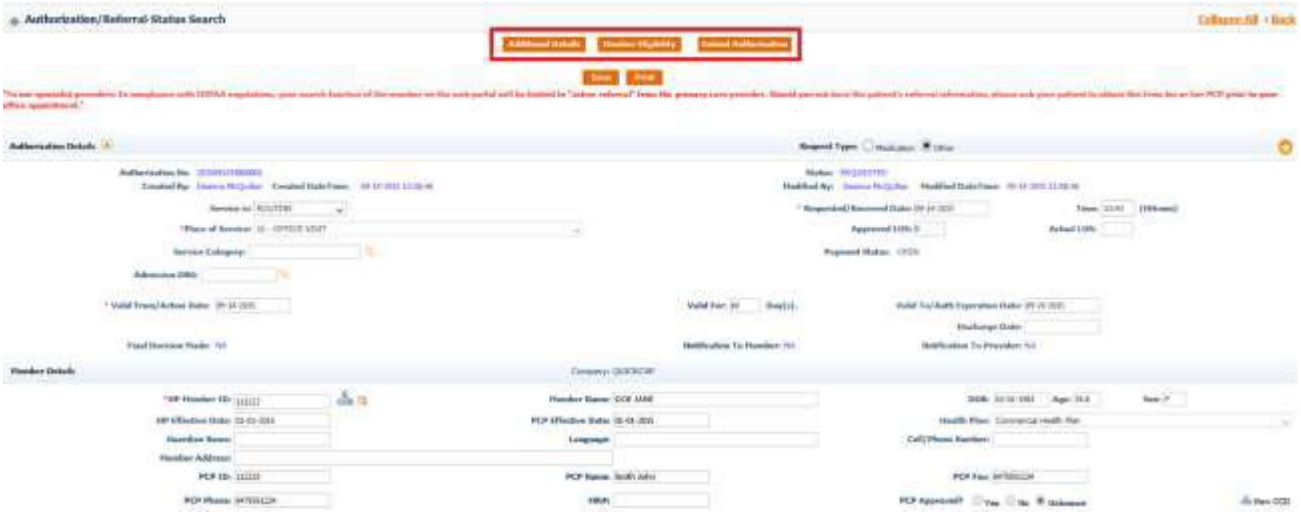
Step 3: The first section is where users search for authorizations. Enter search criteria in any of the available fields. The search results will display in the results section below.

Step 4: Click the (**+**) icon to view the services requested in the authorization. The service information will be visible.

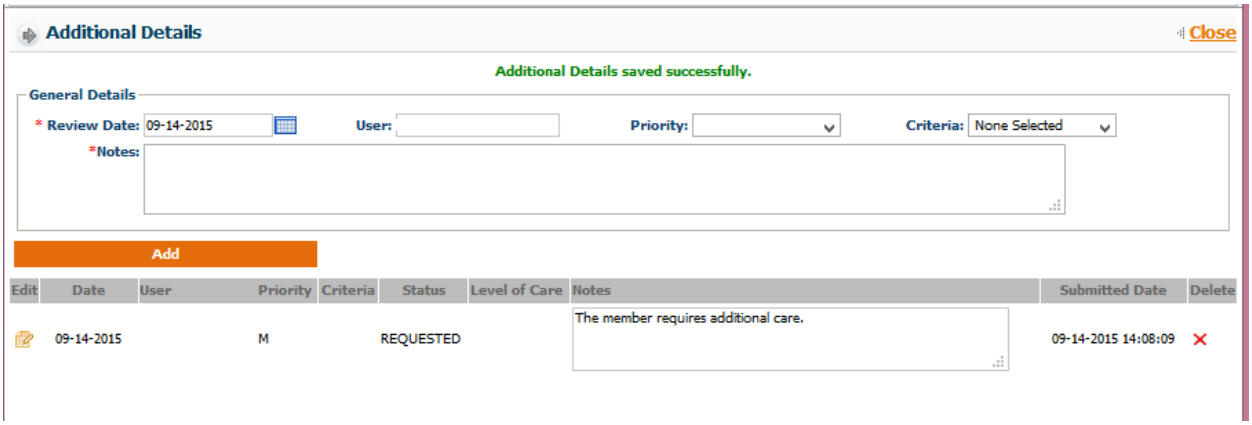
Step 5: The status of the authorization (requested, approved, denied) is displayed in the **Authorization No. Status** column.

Step 6: To view all of the information for a specific authorization, click on the row for the authorization. This will redirect users to the **Authorization/Referral Status Search** screen with all of the authorization details.

Note: This screen is only for viewing purposes. Only a few sections are enabled.

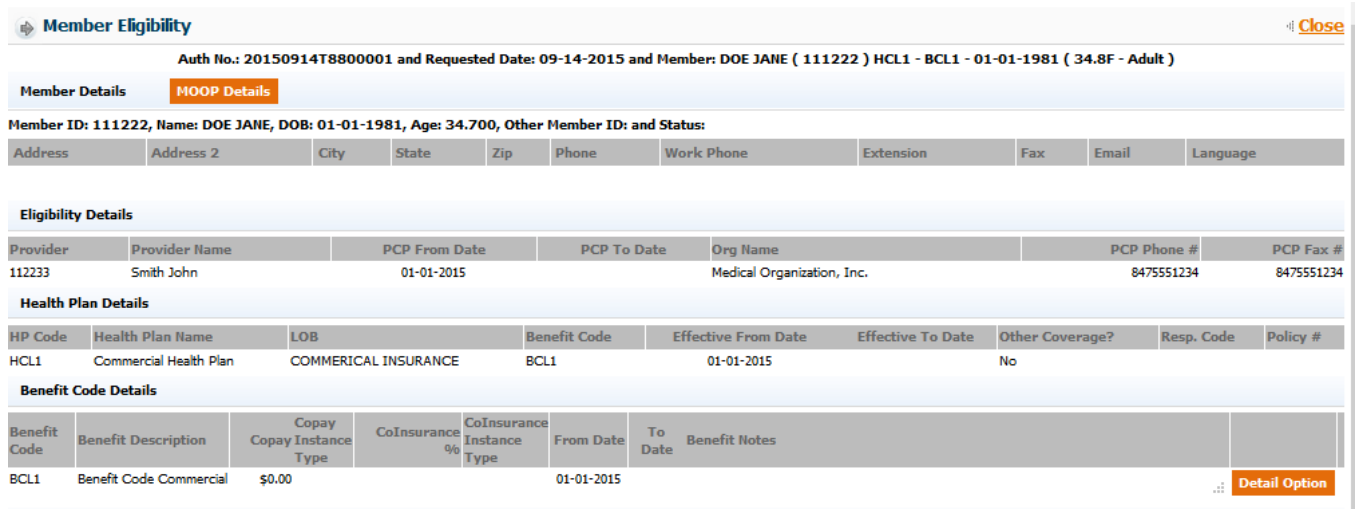


Step 7: To add additional details to the current authorization request, click the **Additional Details** button. The **Additional Details** screen will populate as shown below.

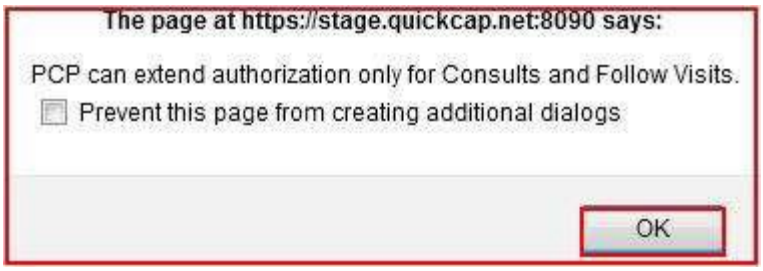


- ☐ In the **General Details** section, select the review date, priority of detail and criteria. Enter the information needed in the **Notes** field**.** Click the **Add** button to save the details.
- ☐ If you want to edit already added details, click the **Edit** icon.

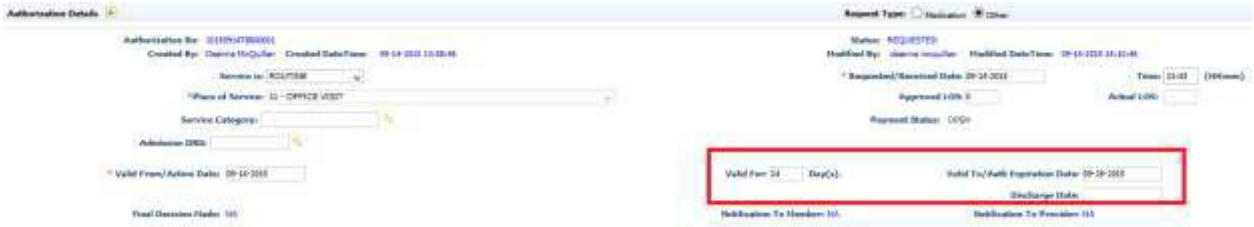
Step 8: To view the member's eligibility details, click the **Member Eligibility** button. The **Member Eligibility** screen will populate as shown below.



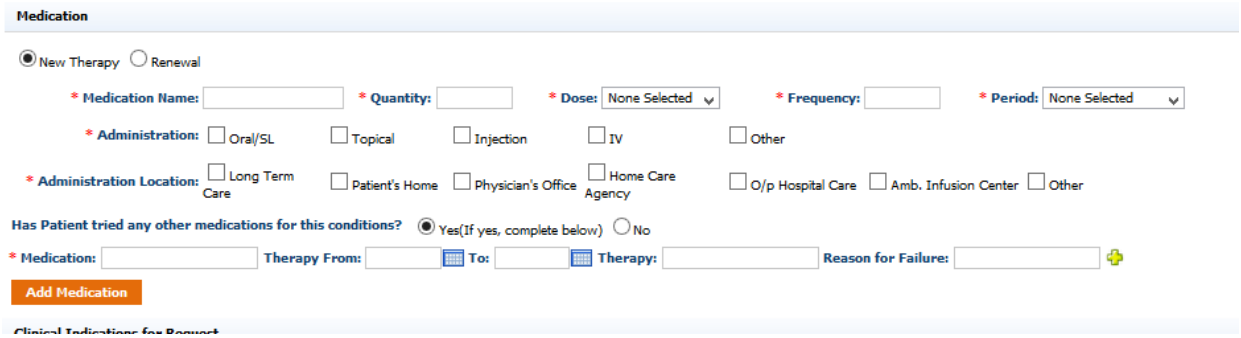
Step 9: If you want to extend the date of authorization, then click the **Extend Authorization** button. A message will pop up as follows.



☐ Click the **OK** button. This will redirect the user to the **Auth Expiration Date** field. Users can extend by either entering the new authorization expiration date or by entering the number of days in **Valid For** field.



Step 10: Users can add medication details and edit existing medication details from the **Medication** section.



Step 11: Users can send additional documentation related to the referral by adding the attachments in the **Documents** section.

Step 12: Click the **Save** button to save the updated request.

PRIOR AUTHORIZATION SUBMISSION OPTIONS:

Primary Care Physicians, Specialist Physician Offices and Ancillary Providers

Providers are responsible for verifying the eligibility of the member before services are delivered and the validity of an authorization before performing the services.

Submit Authorization Request using one of these methods:

1. Procare Quickcap Provider portal or by fax.

2. By FAX using the standard Treatment Authorization Request (TAR)Form enclosed and Fax to (888) 972-1931

3. Or verbal request by calling our UM Department at 855-548-0911.

Important! There may be a delay in the Determination process if the Treatment Authorization Request form is not filed completely and supporting documentations relating to the reason of treatment request are missing and the request may be returned for clarification.

Authorization Request Turn around time

All authorization request reviews will be made according to standard time frames, provided appropriate information is submitted or available to make a determination. Turn around times are:

URGENT and Part B Injectables: within 24-72 hours turn around time. Urgent Auths request that does not meet Urgent Criteria may cause in delay in the determination and may be rejected.

ROUTINE/NON-URGENT: within 3-5 business days and up to 14 days if incomplete supporting clinical documentations

RETRO REVIEWS (accepted only if within 48 hours of rendered services): Turn around time within 7-14 days.

Note: Retro authorizations must be submitted within two business days for UM review. If submitted after 48 hours, the next allowed date is up to 14 days but the following circumstances must occur:

- Unable to Know Situation-The provider and/or facility is unable to identify from which IPA to request an authorization. The patient is not able to tell the provider about their insurance coverage and/or the Medical Group or IPA she or he belongs to, or the provider verified different insurance coverage prior to rendering services.
- Not Enough Time Situations-The patient requires immediate medical services and the provider is unable to anticipate the need for a preauthorization immediately before or while performing a service.
- An enrollee is discharged from a inpatient facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

After 14 days of the date of service must be sent as a claim through the Provider Portal or by mail to: PPCIPA/ProcareMSO

P.O Box 7820

La Verne, CA 91750

Criteria for Determination

The Utilization Management review process uses a wide range of criteria, guidelines, and reference tools to assist in determinations of benefit coverage, behavioral health needs and medical appropriateness. Supporting clinical and Medicare and Health Plan benefit information, relevant to each particular case will be reviewed when making medical necessity coverage determinations related to approvals, modifications, deferrals or denials. PROCARE and PPC IPA will maintain a list of National evidence based guidelines adopted by the organization from Health Plans and evidence based publications, literature searches and other evidence based sources, all sites will be sited.

PROCARE and Premier Patient Care IPA maintain written policies addressing the application of objective and evidence-based criteria in making UM determinations while taking into account the local delivery system, individual circumstances and the member's needs such as age, comorbidities, and complications, progress of treatment, psychosocial situation and home environment, when applicable. In addition, we consider the following when applying criteria based on individual needs and assessment of the local delivery system:

- Availability of SNF and sub-acute care facilities or home care in the service area to support the patient after hospital discharge
- Benefit coverage for skilled nursing facilities, sub-acute care facilities, or home health care where needed
- Availability of inpatient outpatient and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as Ambulatory surgical centers vs inpatient surgery
- Availability of highly specialized services, i.e transplant or cancer facilities
- Ability of local hospitals to provide recommended services within the estimated length of stay

The Hierarchy of criteria process is as follow: Member's Eligibility with the Health Plan, CMS National Coverage determination (NCD), Local Coverage Determination (LCD), Local Coverage Medical Policy Article, Medicare benefit Policy manual, Health plan criteria (coverage summary, and Medical policy); Evidence based criteria such as Milliman Care Guidelines (MCG) latest version, and other evidence-based resources available including Academic and Specialty community based standards and practice, Board Certified Specialist Consultants.

All denial determination for lack of medical necessity is made by the Medical Director or designated physician reviewer. If the requesting Provider disagrees with the Denial determination, he or she may request a Peer to Peer discussion with the Medical Director or Specialist Medical Director or Appeal in writing and attached further supporting medical supporting documentation.

*Physicians may request copies of criteria and/or guidelines by calling the UM Department at (855) 548-0911 or email support@procaremso.com.

Provider FAX Notification (to Provider)

PROCARE will notify the referring provider, requested provider and the Primary Care Physician (if PCP is not the requesting provider) of all authorization decisions via fax, Provider portal, or per Provider request by secured email. Determination status is APPROVED, CANCELLED or DENIED.

See sample FAX Provider Notification in Appendix.

Member Notification

PROCARE notifies the member in writing for all decision determinations. This confirmation letter is sent to the member by mail within 48 hours of the decision determination. See sample in Appendix.

Medical Director Availability

The IPA Medical Director and/or Specialty Medical Director is available to discuss any case with the physician/provider. Please call the UM department Monday through Friday between the hours of 9:00 AM and 5:00 PM at (855) 548-0911.

AUTHORIZATION REQUEST PROVIDER NOTIFICATION SAMPLE

The following illustrates the details in the approval letter that is faxed to your office on a daily basis with the activities related to authorization referrals.

Report sections include:

Your approved Authorization Requests (referrals from you) and Referrals to you

For your information as a PCP (PCPs only)

SAMPLE

NOTIFICATION TO PCP & REQUESTED PROVIDER OF AUTORIZATION ACTIVITY
Attn: PCP and SPECIALIST

This letter is to notify you, the PCP of MEMBER NAME, that there has recently been authorization activity and to Requested provider - SPECIALIST for the determination on the authorization requested.

AUTHORIZATION: **APPROVED** NOTIFICATION #: **XXXXXXXXXXXXXXX**

Attn: SPECIALIST
Fax: (XXX) XXX-XXXX

Regarding your request for authorization received XX/XX/XXXX on behalf of the following member

MEMEBER NAME
MEMBER ADDRESS

HEALTHPLAN
MEMBER ID
MEMBER DOB
MEMBER CONTACT

The Medical Director/Physician Reviewer has reviewed your request on, XX/XX/XXXX and Approved the following:

Specialist: SPECIALIST
SPECIALIST ADDRESS

Fax #: (xxx) xxx-xxxx
Phone #: (xxx) xxx-xxxx
Speciality: Specialty

Diagnosis: XX.XXX
DIAGNOSIS DESCRIPTION

CPT	Modifier Code	CPT Descr	Unit	Reason Code	Note
XXXXX		DESCR	1.00		
XXXXX		DESCR	1.00		

CORRESPONDENCE

Approval Notificiation Letter

The approval letter notifies the member regarding the specific request (for service for a specific provider/physician) has been approved. Non Discrimination language is also attached to the Approval letters.

Denial Notification Letter

The denial letter notifies the member regarding the specific request (for service for a specific provider/physician) has been denied for a specific reason in the member's preferred language with easy to read 8th grade level. The letter also explains they have the right to appeal the decision by filing a grievance with their health plan and information on the IPA. In addition, Health plan submission guidelines, including the number of days the member has to file an appeal is described. Non Discrimination language is also attached to the Denial letters.

The denial letter is sent to the member with copies to the requesting provider and PCP. The Provider Denial Notification is also sent to the Requesting and Requested Provider along with the reasons for the denial and the clinical criteria along with a Peer to Peer phone number of Medical Director and appeal information.

Cancel Notification Letter

An Authorization request maybe cancelled for the following reasons: Provider request to cancel, Duplicate request; a "carved out" benefit based on Health Plan Responsibility; or Member not Eligible. Given the complex nature of medical group contracts, there are many occasions when the requested services will be the financial responsibility of the health plans; in which case, the requests maybe cancelled and may need to be authorized directly by the health plan. One example is the member request for an out of network second opinion. "Carved out" benefits are services that are covered by the health plans but administered by other entities or vendors other than the medical group. The best examples are Acupuncture services, vision, mental health, dental, and other Health Plan carved out services such as out of network or transplant cases that are not the responsibility of the IPA.

When authorization requests are being cancelled, the providers and the members will be notified with the exception of duplicate requests.

DENIAL PROCESS

The Utilization Management (UM) staff coordinates with other departments such as Quality Management and Claims, to ensure that accurate information is given to the members and providers when a denial for a service is processed.

It is Premier Patient Care IPA policy that:

All denial determinations are made by the IPA's Medical Director or Physician designee. Utilization Management staff will send denial confirmation letters to PCPs, requesting providers and members.

All denials of service will be handled in a timely manner according to CMS and health plan guidelines and will be documented and tracked.

All Peer -to - peer requests, and/or appeals will be handled in an efficient manner according to IPA/Health plan approved procedures.

Process

A denial letter is sent and fax to member, PCP, and requesting Provider by the UM staff, and copied to the member's Health Plan.

Denial letters are sent within 2 business days after the decision determination. In addition to the explanation for the denial, all letters will provide instructions for initiating an appeal in compliance with health plan and regulatory requirements.

Requests for service authorization commonly are denied for the following reasons:

- The provider requested is not contracted with the IPA.
- The service is not a Medicare covered benefit.
- The service is not medically necessary/medically appropriate.
- The member is not eligible.
- The member's benefits for that service have been exhausted.
- The services requested is within the scope of the primary care physician.

IF you have any questions or concern, please contact us at support@procaremso.com or 855-548-0911.

APPENDIX

CHAP1-gencorrectcodingpolicies
Revision Date: 1/1/2021

Chapter I
GENERAL CORRECT CODING POLICIES
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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

Revision Date (Medicare): 1/1/2021

Table of Contents

Revision Date (Medicare): 1/1/2021

LIST OF ACRONYMS

AA	Anesthesia Assistant
A/B MAC	A/B Medicare Administrative Contractor
ABN	Advanced Beneficiary Notice
AMA	American Medical Association
AOC	Add-On Code
ASC	Ambulatory Surgical/Surgery Center
CBC	Complete Blood Count
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMT	Chiropractic Manipulative Treatment
CMV	Cytomegalovirus
CNS	Central Nervous System
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CT	Computed Tomography
CTA	Computed Tomographic Angiography
DME	Durable Medical Equipment
D.O.	Doctor of Osteopathy
DOJ	Department of Justice
ECG	Electrocardiogram
E/M or E&M	Evaluation & Management Services
EEG	Electroencephalogram
EMG	Electromyogram
FNA	Fine Needle Aspiration
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HLA	Human Leukocyte Antigen
IPPB	Intermittent Positive Pressure Breathing
IVP	Intravenous Pyelogram
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
LT	Left Side
MAI	MUE Adjudication Indicator
M.D.	Medical Doctor
MRA	Magnetic Resonance Angiography

LIST OF ACRONYMS (Continued)

MRI	Magnetic Resonance Imaging
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
PET	Positron Emission Tomography
PSC	Program Safeguard Contractor
PTP	Procedure-To-Procedure
RAC	Recovery Audit Contractor
RC	Right Coronary Artery
RT	Right Side
RS&I	Radiological Supervision and Interpretation
SPECT	Single Photon Emission Computed Tomography
SSA	Social Security Act
UPIC	Unified Program Integrity Contractor
UOS	Unit(s) of Service
VAD	Ventricular Assist Device
WBC	White Blood Cell

Chapter I
General Correct Coding Policies

A. Introduction

Healthcare providers use Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes to report medical services performed on patients to Medicare Administrative Contractors (MACs). Healthcare Common Procedure Coding System (HCPCS) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA's) "CPT Manual," which is updated and published annually. HCPCS Level II codes are defined by the Centers for Medicare & Medicaid Services (CMS) and are updated throughout the year as necessary. Changes in CPT codes are approved by the AMA CPT Editorial Panel, which meets 3 times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific in defining a single service (e.g., CPT code 93000 (electrocardiogram)), while other codes define procedures consisting of many services (e.g., CPT code 58263 (vaginal hysterectomy with removal of tube(s) and ovary(s) and repair of enterocele)). Because many procedures can be performed via different approaches, different methods, or in combination with other procedures, there are often multiple HCPCS/CPT codes defining similar or related procedures.

CPT and HCPCS Level II code descriptors usually do not define all services included in a procedure. There are often services inherent in a procedure or group of procedures. For example, anesthesia services include certain preparation and monitoring services.

The CMS developed the National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. Prior to April 1, 2012, NCCI Procedure-to-Procedure (PTP) edits were placed into either the "Column One/Column Two Correct Coding Edit Table" or the "Mutually Exclusive Edit Table." However, on April 1, 2012, the edits in the "Mutually Exclusive Edit Table" were moved to the "Column One/Column Two Correct Coding Edit Table" so that all NCCI PTP edits are currently contained in this single table.

Combining the 2 tables simplifies researching NCCI PTP edits and online use of NCCI tables.

Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the 2 codes of an edit pair, the Column Two code is denied, and the Column One code is eligible for payment. However, if it is clinically appropriate to use an NCCI PTP-associated modifier, both the Column One and Column Two codes are eligible for payment. (NCCI PTP-associated modifiers and their appropriate use are discussed elsewhere in this chapter.)

When the NCCI was first established and during its early years, the "Column One/Column Two Correct Coding Edit Table" was termed the "Comprehensive/Component Edit Table." This latter terminology was a misnomer.Although the Column Two code is often a component of a more comprehensive Column One code, this relationship is not true for many edits. In the latter type of edit, the code pair edit simply represents 2 codes that should not be reported together. For example, a provider shall not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

In this chapter, Sections B–Q address various issues relating to NCCI PTP edits.

Medically Unlikely Edits (MUEs) prevent payment for a potentially inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) reportable under most circumstances by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is one that allows the vast majority of appropriately coded claims to pass the MUE. For more information concerning MUEs, see Section V of this chapter.

In this Manual, many policies are described using the term "physician." Unless otherwise indicated, the use of this term does not restrict the application of policies to physicians only. Rather, the policies apply 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 (IOM)," 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 (IOM)," Publication 100-04 ("Medicare Claims Processing Manual"), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

Providers reporting services under Medicare’s hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare IOM" instructions.

Physicians must report services correctly. This manual discusses general coding principles in Chapter I, and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. There are certain types of improper coding that physicians must avoid.

Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code. Some examples follow:

- A physician shall not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example, if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician shall report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician shall not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less;) plus CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)).

- A physician shall not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician shall report CPT code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code

46600 (Anoscopy; diagnostic,...) plus CPT code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be used with an endoscopic procedure code.

- A physician shall not unbundle a bilateral procedure code into 2 unilateral procedure codes. For example, if a physician performs bilateral mammography, the physician shall report CPT code 77066 (Diagnostic mammography... bilateral). The physician shall not report CPT code 77065 (Diagnostic mammography... unilateral) with 2 UOS or 77065LT plus 77065RT.

- A physician shall not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician shall not report CPT code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).

Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. For example, if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider shall report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician shall not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must avoid upcoding. A HCPCS/CPT code may be reported only if all services described by that code have been performed. For example, if a physician performs a superficial axillary lymphadenectomy (CPT code 38740), the physician shall not report CPT code 38745 (Axillary lymphadenectomy; complete).

Physicians must report UOS correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician shall not report UOS for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. For example, some therapy codes are reported in fifteen-minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A physician shall not report a per session code using fifteen-minute increments. CPT code

92507 or 92508 should be reported with one unit of service on a single date of service.

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

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."

This chapter addresses general coding principles, issues, and policies. Many of these principles, issues, and policies are addressed further in subsequent chapters dealing with specific groups of HCPCS/CPT codes. In this chapter, examples are often used to clarify principles, issues, or policies. The examples do not represent the only codes to which the principles, issues, or policies apply.

B. Coding Based on Standards of Medical/Surgical Practice

Most HCPCS/CPT code defined procedures include services that are integral to them. Some of these integral services have specific CPT codes for reporting the service when not performed as an integral part of another procedure. (For example, CPT code 36000 (Introduction of needle or intracatheter into a vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable with these types of nuclear medicine procedures. However, CPT code 36000 may be reported alone if the only service provided is the introduction of a needle into a vein. Other integral services do not have specific CPT codes. (For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT code.) Services integral to HCPCS/CPT code defined procedures are included in those procedures based upon the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.

Many NCCI PTP edits are based upon the standards of medical/surgical practice. Services that are integral to another service are component parts of the more comprehensive service. When integral component services have their own HCPCS/CPT codes, NCCI PTP edits place the comprehensive service in Column One and the component service in Column Two. Since a component service integral to a comprehensive service is not separately reportable, the Column Two code is not separately reportable with the Column One code.

Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

- Cleansing, shaving and prepping of skin;
- Draping and positioning of patient;
- Insertion of intravenous access for medication administration;
- Insertion of urinary catheter;
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia Services);
- Local, topical or regional anesthesia administered by the physician performing the procedure;
- Surgical approach including identification of anatomical landmarks, incision, evaluation of the surgical field, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring;
- Surgical cultures;
- Wound irrigation;
- Insertion and removal of drains, suction devices, and pumps into same site;
- Surgical closure and dressings;
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional);
- Application of TENS unit;
- Institution of Patient Controlled Anesthesia;
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided;
- Imaging and/or ultrasound guidance;

- Surgical supplies, except for specific situations where CMS policy permits separate payment.

Although other chapters in this Manual further address issues related to the standards of medical/surgical practice for the procedures covered by that chapter, it is not possible to discuss all NCCI PTP edits based upon the principle of the standards of medical/surgical practice due to space limitations. However, there are several general principles that can be applied to the edits, as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.

2. The component service is usually necessary to complete the comprehensive service.

3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Specific examples of services that are not separately reportable because they are components of more comprehensive services follow:

Medical:

1. Since interpretation of cardiac rhythm is an integral component of the interpretation of an electrocardiogram, a rhythm strip is not separately reportable.

2. Since determination of ankle/brachial indices requires both upper and lower extremity Doppler studies, an upper extremity Doppler study is not separately reportable.

3. Since a cardiac stress test includes multiple electrocardiograms, an electrocardiogram is not separately reportable.

Surgical:

1. Since a myringotomy requires access to the tympanic membrane through the external auditory canal, removal of impacted cerumen from the external auditory canal is not separately reportable.

2. A "scout" bronchoscopy to assess the surgical field, anatomic landmarks, extent of disease, etc., is not separately reportable with an open pulmonary procedure such as a pulmonary lobectomy.By contrast, an initial diagnostic bronchoscopy is separately reportable. If the diagnostic bronchoscopy is performed at the same patient encounter as the open pulmonary procedure and does not duplicate an earlier diagnostic bronchoscopy by the same or another physician, the diagnostic bronchoscopy may be reported with modifier 58 appended to the open pulmonary procedure code to indicate a staged procedure. A cursory examination of the upper airway during a bronchoscopy with the bronchoscope shall not be reported separately as a laryngoscopy. However, separate endoscopies of anatomically distinct areas with different endoscopes may be reported separately (e.g., thoracoscopy and mediastinoscopy).

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Since a colectomy requires exposure of the colon, the laparotomy and adhesiolysis to expose the colon are not separately reportable.

C. Medical/Surgical Package

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work.

The component elements of the pre-procedure and post-procedure work for each procedure are included component services of that procedure as a standard of medical/surgical practice. Some general guidelines follow:

1. Many invasive procedures require vascular and/or airway access. The work associated with obtaining the required access is included in the pre-procedure or intra-procedure work. The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work.

Airway access is necessary for general anesthesia and is not separately reportable. There is no CPT code for elective endotracheal intubation.CPT code 31500 describes an emergency endotracheal intubation and shall not be reported for elective endotracheal intubation.Visualization of the airway is a component part of an endotracheal intubation, and CPT codes describing procedures that visualize the airway (e.g., nasal endoscopy, laryngoscopy, bronchoscopy) shall not be reported with an endotracheal intubation. These CPT codes describe diagnostic and therapeutic endoscopies, and it is a misuse of these codes to report visualization of the airway for endotracheal intubation.

Intravenous access (e.g., CPT codes 36000, 36400, 36410) is not separately reportable when performed with many types of procedures (e.g., surgical procedures, anesthesia procedures, radiological procedures requiring intravenous contrast, nuclear medicine procedures requiring intravenous radiopharmaceutical). After vascular access is achieved, the access must be maintained by a slow infusion (e.g., saline) or injection of heparin or saline into a "lock." Since these services are necessary for maintenance of the vascular access, they are not separately reportable with the vascular access CPT codes or procedures requiring vascular access as a standard of medical/surgical practice. CPT codes 37211-37214 (Transcatheter therapy with infusion for thrombolysis) shall not be reported for use of an anticoagulant to maintain vascular access.

The global surgical package includes the administration of fluids and drugs during the operative procedure. CPT codes 96360-96377 shall not be reported separately for that operative procedure. Under OPPS, the administration of fluids and drugs during or for an operative procedure are included services and are not separately reportable (e.g., CPT codes 96360-96377).

When a procedure requires more invasive vascular access services (e.g., central venous access, pulmonary artery access), the more invasive vascular service is separately reportable if it is not typical of the procedure and the work of the more invasive vascular service has not been included in the valuation of the procedure.

Insertion of a central venous access device (e.g., central venous catheter, pulmonary artery catheter) requires passage of a catheter through central venous vessels and, in the case of a

pulmonary artery catheter, through the right atrium and ventricle. These services often require the use of fluoroscopic guidance. Separate reporting of CPT codes for right heart catheterization, selective venous catheterization, or pulmonary artery catheterization is not appropriate when reporting a CPT code for insertion of a central venous access device. Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 77002) shall not be reported separately. (CPT code 76001 was deleted January 1, 2019.)

2. Medicare Anesthesia Rules prevent separate payment for anesthesia services by the same physician performing a surgical or medical procedure. The physician performing a surgical or medical procedure shall not report CPT codes 96360-96377 for the administration of anesthetic agents during the procedure. If it is medically reasonable and necessary that a separate provider (anesthesia practitioner) perform anesthesia services (e.g., monitored anesthesia care) for a surgical or medical procedure, a separate anesthesia service may be reported by the second provider.

Under the OPPS, anesthesia for a surgical procedure is an included service and is not separately reportable. For example, a provider shall not report CPT codes 96360-96377 for anesthesia services.

When anesthesia services are not separately reportable, physicians and facilities shall not unbundle components of anesthesia and report them in lieu of an anesthesia code.

3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure that no intraoperative injury occurred or to verify that the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.

4. Many procedures require cardiopulmonary monitoring, either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable. Examples of these services include cardiac monitoring, pulse oximetry, and ventilation management (e.g., 93000-93010, 93040-93042, 94760, 94761).

5. 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 or XS.

The biopsy is not separately reportable if used for the purpose of assessing margins of resection or verifying resectability. 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.

6. Exposure and exploration of the surgical field is integral to an operative procedure and is not separately reportable. For example, an exploratory laparotomy (CPT code 49000) is not separately reportable with an intra-abdominal procedure.If exploration of the surgical field results in additional procedures other than the primary procedure, the additional procedures may generally be reported separately. However, a procedure designated by the CPT code descriptor as a "separate procedure" is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.

7. If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement, incision and drainage) is not separately reportable. Types of procedures to which this principle applies include, but are not limited to, -ectomy, -otomy, excision, resection, -plasty, insertion, revision, replacement, relocation, removal or closure. For example, debridement of skin and subcutaneous tissue at the site of an abdominal incision made to perform an intra-abdominal procedure is not separately reportable. (See Chapter IV, Section H (General Policy Statements), Subsection 11 for guidance on reporting debridement with open fractures and dislocations.)

8. If removal, destruction, or other form of elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure may be reported. For example, if an area of pilonidal disease contains an abscess,

incision and drainage of the abscess during the procedure to excise the area of pilonidal disease is not separately reportable.

9. An excision and removal (-ectomy) includes the incision and opening (-otomy) of the organ. A HCPCS/CPT code for an –otomy procedure shall not be reported with an –ectomy code for the same organ.

10. Multiple approaches to the same procedure are mutually exclusive of one another and shall not be reported separately. For example, both a vaginal hysterectomy and abdominal hysterectomy shall not be reported separately.

11. If a procedure using one approach fails and is converted to a procedure using a different approach, only the completed procedure may be reported. For example, if a laparoscopic hysterectomy is converted to an open hysterectomy, only the open hysterectomy procedure code may be reported.

12. If a laparoscopic procedure fails and is converted to an open procedure, the physician shall not report a diagnostic laparoscopy in lieu of the failed laparoscopic procedure. For example, if a laparoscopic cholecystectomy is converted to an open cholecystectomy, the physician shall not report the failed laparoscopic cholecystectomy nor a diagnostic laparoscopy.

13. If a diagnostic endoscopy is the basis for and precedes an open procedure, the diagnostic endoscopy may be reported with modifier 58 appended to the open procedure code. However, the medical record must document the medical reasonableness and necessity for the diagnostic endoscopy. A scout endoscopy to assess anatomic landmarks and extent of disease is not separately reportable with an open procedure. When an endoscopic procedure fails and is converted to another surgical procedure, only the completed surgical procedure may be reported. The endoscopic procedure is not separately reportable with the completed surgical procedure.

14. Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of

the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable:

(1) if it represents usual and necessary care in the operating room during the procedure; or

(2) if it occurs postoperatively and does not require return to the operating room. For example, control of hemorrhage is a usual and necessary component of a surgical procedure in the operating room and is not separately reportable. Control of postoperative hemorrhage is also not separately reportable unless the patient must be returned to the operating room for treatment. In the latter case, the control of hemorrhage may be separately reportable with modifier 78.

D. Evaluation & Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting Evaluation & 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 MAC. 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 service 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 MACs 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 performed on the same date of service as a 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 shall 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. The NCCI program contains many, but not all, possible edits based on these principles.

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 shall **not** 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 shall **not** 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.

E. Modifiers and Modifier Indicators

1. The AMA "CPT Manual" and CMS define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of 2 alphanumeric characters.

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier shall not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicare restrictions are fulfilled. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU

Modifiers 76 ("Repeat Procedure or Service by Same Physician") and 77 ("Repeat Procedure by Another Physician") are not NCCI PTP-associated modifiers. Use of either of these modifiers does not bypass an NCCI PTP edit.

Each NCCI PTP edit has an assigned modifier indicator. A modifier indicator of "0" indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit. A modifier indicator of "1" indicates that NCCI PTP-associated modifiers may be used to bypass an edit under appropriate circumstances. A modifier indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant.

It is very important that NCCI PTP-associated modifiers only be used when appropriate. In general, these circumstances relate to separate patient encounters, separate anatomic sites, or separate specimens. (See subsequent discussion of modifiers in this section.) Most edits involving paired organs or structures (e.g., eyes, ears, extremities, lungs, kidneys) have NCCI PTP modifier indicators of "1" because the 2 codes of the code pair edit may be reported if performed on the contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when 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 2 codes generally cannot be reported together unless the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic locations. However, if the 2 corresponding procedures are performed at the same patient encounter and in contiguous structures in the same organ or anatomic region, NCCI PTP-associated modifiers generally should not be used.

The appropriate use of most of these modifiers is straightforward. However, further explanation is provided regarding modifiers 25, 58, and 59. Although modifier 22 is not a modifier that bypasses an NCCI PTP edit, its use is occasionally relevant to an NCCI PTP edit and is discussed below.

a) **Modifier 22:** Modifier 22 is defined by the "CPT Manual" as "Increased Procedural Services." This modifier shall not be reported unless the service(s) performed is (are) substantially more extensive than the usual service(s) included in the procedure described by the HCPCS/CPT code reported. Occasionally, a provider may perform 2 procedures that should not be reported together based on an NCCI PTP edit. If the edit allows use of NCCI PTP-associated modifiers to bypass it and the clinical circumstances justify use of one of these modifiers, both services may be reported with the NCCI PTP-associated modifier. However, if the NCCI PTP edit does not allow use of NCCI PTP-associated modifiers to bypass it and the procedure qualifies as an unusual procedural service, the physician may report the Column One HCPCS/CPT code of the NCCI PTP edit with modifier 22. The MAC may then evaluate the unusual procedural service to determine whether additional payment is justified.

For example, CMS limits payment for CPT code 69990 (Microsurgical techniques, requiring use of operating microscope...) to procedures listed in the "IOM" ("Claims Processing Manual," Publication 100-04, 12-§20.4.5). If a physician reports CPT code 69990 with 2 other CPT codes and 1 of the codes is not on this list, an NCCI PTP edit with the code not on the list will prevent payment for CPT code 69990. Claims processing systems do not determine which procedure is linked with CPT code 69990. In situations such as this, the physician may submit their claim to the local MAC for readjudication appending modifier 22 to the CPT code. Although MAC cannot override an NCCI PTP edit that does not allow use of NCCI PTP-associated modifiers, the MAC has discretion to adjust payment to include use of the operating microscope based on modifier 22.

b) **Modifier 25:** The "CPT Manual" defines modifier 25 as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

Modifier 25 may be appended to E&M services reported with minor surgical procedures (with global periods of 000 or 010 days) or procedures not covered by Global Surgery Rules (with a global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider shall not report an E&M service for this work. Furthermore, Medicare Global Surgery Rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient.

c) **Modifier 58:** Modifier 58 is defined by the "CPT Manual" as a "Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period." It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy

after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI PTP-associated modifiers.

If a diagnostic endoscopic procedure results in the decision to perform an open procedure, both procedures may be reported with modifier 58 appended to the HCPCS/CPT code for the open procedure. However, if the endoscopic procedure preceding an open procedure is a "scout" procedure to assess anatomic landmarks and/or extent of disease, it is not separately reportable.

Diagnostic endoscopy is never separately reportable with another endoscopic procedure of the same organ(s) or anatomic region when performed at the same patient encounter. Similarly, diagnostic laparoscopy is never separately reportable with a surgical laparoscopic procedure of the same body cavity when performed at the same patient encounter.

If a planned laparoscopic procedure fails and is converted to an open procedure, only the open procedure may be reported. The failed laparoscopic procedure is not separately reportable. The NCCI program contains many, but not all, edits bundling laparoscopic procedures into open procedures. Since the number of possible code combinations bundling a laparoscopic procedure into an open procedure is much greater than the number of such edits in NCCI, the principle stated in this paragraph is applicable regardless of whether the selected code pair combination is included in the NCCI tables. A provider shall not select laparoscopic and open HCPCS/CPT codes to report because the combination is not included in the NCCI tables.

d) **Modifier 59:** Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. For the NCCI, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services, except in those instances where the services are "separate and distinct." Modifier 59 shall only be used if no other modifier more appropriately describes the relationships of the 2 or more procedure codes (see Section e for modifiers -X{EPSU}). The "CPT Manual" defines modifier 59 as follows:

Modifier 59: "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Modifier 59 and other NCCI-associated modifiers should **NOT** be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

NCCI PTP edits define when 2 procedure HCPCS/CPT codes may not be reported together, except under special circumstances. If an edit allows use of NCCI PTP-associated modifiers, the 2 procedure codes may be reported together when the 2 procedures are performed at different anatomic sites or different patient encounters. MAC processing systems use NCCI PTP-associated modifiers to allow payment of both codes of an edit. Modifiers 59 or -X{EPSU} and other NCCI PTP-associated modifiers shall NOT be used to bypass an NCCI PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI PTP-associated modifier used. Some examples of the appropriate use of modifiers 59 or -X{EPSU} are contained in the individual chapter policies.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe "different procedure or surgery." The code descriptors

of the 2 codes of a code pair edit usually represent different procedures or surgeries. The edit indicates that the 2 procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the 2 codes being different procedures/surgeries. However, if the 2 procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifiers 59 or -X{ES} may be appended to indicate that they are different procedures/surgeries on that date of service.

Modifier 59 or XS is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

There are several exceptions to this general principle about misuse of modifiers 59 or X{EPSU} that apply to some code pair edits for procedures performed at the same patient encounter.

(1) When a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure, it shall not be reported separately.

(2) When a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have

otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it shall not be reported separately.

(3) There is an appropriate use for modifiers 59 or X{ES} that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If 2 separate and distinct timed services are provided in separate and distinct time blocks, modifier 59 may be used to identify the services. The separate and distinct time blocks for the 2 services may be sequential to one another or split.When the 2 services are split, the time block for 1 service may be followed by a time block for the second service followed by another time block for the first service. All Medicare rules for reporting timed services are applicable. For example, the total time is calculated for all related timed services performed. The number of reportable UOS is based on the total time, and these UOS are allocated between the HCPCS/CPT codes for the individual services performed. The practitioner is not permitted to perform multiple services, each for the minimal reportable time, and report each of these as separate UOS.

Use of modifiers 59 or X{ES} to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifiers 59 or X{EPSU}. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. It does not include treatment of contiguous structures in the same organ or anatomic region.For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site.

If the same procedure is performed at different anatomic sites, it does not necessarily imply that a HCPCS/CPT code may be reported with more than one unit of service for the procedure. Determining whether additional UOS may be reported depends in part upon the HCPCS/CPT code descriptor including the definition of the code's unit of service, when present.

Example 1: The Column One/Column Two code edit with Column One CPT code 38221 (Diagnostic bone marrow biopsy) and Column Two CPT code 38220 (Diagnostic bone marrow, aspiration) includes two distinct procedures when performed at separate anatomic sites (e.g., contralateral iliac bones) or separate patient encounters. In these circumstances, it would be acceptable to use modifier 59. However, if both 38221 and 38220 are performed on the same iliac bone at the same patient encounter which is the usual practice, modifier 59 shall NOT be used. Although CMS does not allow separate payment for CPT code 38220 with CPT code 38221 when bone marrow aspiration and biopsy are performed on the same iliac bone at a single patient encounter, a physician may report CPT code 38222 (Diagnostic bone marrow; biopsy(ies) and aspiration(s)).

Example 2: The Column One/Column Two code edit with Column One CPT code 11055 (Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion) and Column Two CPT code 11720 (Debridement of nail(s) by any method(s); one to five) should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifiers 59 or –X{EPSU} should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifiers 59 or –XS may be reported with code 11720 if 1 to 5 nails are debrided and a hyperkeratotic lesion is pared on a toe other than 1 with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

e) **Modifiers XE, XS, XP, XU:** These modifiers were effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be used in lieu of modifier 59 whenever possible.The modifiers are defined as follows:

XE – "Separate Encounter, A service that is distinct because it occurred during a separate encounter." This modifier

shall only be used to describe separate encounters on the same date of service.

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"

F. Standard Preparation/Monitoring Services for Anesthesia

With few exceptions, anesthesia HCPCS/CPT codes do not specify the mode of anesthesia for a particular procedure. Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service HCPCS/CPT codes when performed in association with the anesthesia service. However, if the provider of the anesthesia service performs 1 or more of these services prior to and unrelated to the anticipated anesthesia service or after the patient is released from the anesthesia practitioner's postoperative care, the service may be separately reportable with modifiers 59 or -X{EU}.

G. Anesthesia Service Included in the Surgical Procedure

Under the CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical procedure. For example, separate payment is not allowed for the physician's performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia shall not be reported

in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician. Examples of improperly reported services that are bundled into the anesthesia service when anesthesia is provided by the physician performing the medical or surgical procedure include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), intravenous infusion/injection (CPT codes 96360-96368, 96374-96377) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042). However, if these services are not related to the delivery of an anesthetic agent, or are not an inherent component of the procedure or global service, they may be reported separately.

The physician performing a surgical or medical procedure shall not report an epidural/subarachnoid injection (CPT codes 62320-62327) or nerve block (CPT codes 64400-64530) for anesthesia for that procedure.

H. HCPCS/CPT Procedure Code Definition

The HCPCS/CPT code descriptors of 2 codes are often the basis of an NCCI PTP edit. If 2 HCPCS/CPT codes describe redundant services, they shall not be reported separately. Several general principles follow:

1. A family of CPT codes may include a CPT code followed by one or more indented CPT codes. The first CPT code descriptor includes a semicolon. The portion of the descriptor of the first code in the family preceding the semicolon is a common part of the descriptor for each subsequent code of the family. For example:

CPT code 70120 Radiologic examination, mastoids; less than 3 views per side

CPT code 70130 complete, minimum of 3 views per side

The portion of the descriptor preceding the semicolon ("Radiologic examination, mastoids") is common to both CPT codes 70120 and 70130. The difference between the 2 codes is the portion of the descriptors following the semicolon. Often, as in this case, 2 codes from a family may not be reported separately. A physician cannot report CPT codes 70120 and 70130 for a procedure performed on ipsilateral mastoids at the same

patient encounter. It is important to recognize, however, that there are numerous circumstances when it may be appropriate to report more than one code from a family of codes. For example, CPT codes 70120 and 70130 may be reported separately if the 2 procedures are performed on contralateral mastoids or at 2 separate patient encounters on the same date of service.

2. If a HCPCS/CPT code is reported, it includes all components of the procedure defined by the descriptor. For example, CPT code 58291 includes a vaginal hysterectomy with "removal of tube(s) and/or ovary(s)." A physician cannot report a salpingo-oophorectomy (CPT code 58720) separately with CPT code 58291.

3. CPT code descriptors often define correct coding relationships where 2 codes may not be reported separately with one another at the same anatomic site and/or same patient encounter.A few examples follow:

a) A "partial" procedure is not separately reportable with a "complete" procedure.

b) A "partial" procedure is not separately reportable with a "total" procedure.

c) A "unilateral" procedure is not separately reportable with a "bilateral" procedure.

d) A "single" procedure is not separately reportable with a "multiple" procedure.

e) A "with" procedure is not separately reportable with a "without" procedure.

f) An "initial" procedure is not separately reportable with a "subsequent" procedure.

I. CPT Manual and CMS Coding Manual Instructions

The CMS often publishes coding instructions in its rules, manuals, and notices. Physicians must use these instructions when reporting services rendered to Medicare patients.

The "CPT Manual" also includes coding instructions which may be found in the "Introduction," individual chapters, and

appendices. In individual chapters, the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow "CPT Manual" instructions unless CMS has provided different coding or reporting instructions.

The American Medical Association publishes "CPT Assistant" which contains coding guidelines. The CMS does not review nor approve the information in this publication. In the development of NCCI PTP edits, CMS occasionally disagrees with the information in this publication. If a physician uses information from "CPT Assistant" to report services rendered to Medicare patients, it is possible that MACs may use different criteria to process claims.

J. CPT "Separate Procedure" Definition

If a CPT code descriptor includes the term "separate procedure," the CPT code may not be reported separately with a related procedure. The CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.

A CPT code with the "separate procedure" designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach. Modifiers 59 or -X{ES} (or a more specific modifier, e.g., anatomic modifier) may be appended to the "separate procedure" CPT code to indicate that it qualifies as a separately reportable service.

K. Family of Codes

The "CPT Manual" often contains a group of codes that describe related procedures that may be performed in various combinations. Some codes describe limited component services, and other codes describe various combinations of component services. Physicians must use several principles in selecting the correct code to report:

1. A HCPCS/CPT code may be reported if and only if all services described by the code are performed.

2. The HCPCS/CPT code describing the services performed shall be reported. A physician shall not report multiple codes corresponding to component services if a single comprehensive code describes the services performed. There are limited exceptions to this rule which are specifically identified in this Manual.

3. HCPCS/CPT code(s) corresponding to component service(s) of other more comprehensive HCPCS/CPT code(s) shall not be reported separately with the more comprehensive HCPCS/CPT code(s) that include the component service(s).

4. If the HCPCS/CPT codes do not correctly describe the procedure(s) performed, the physician shall report a "not otherwise specified" CPT code rather than a HCPCS/CPT code that most closely describes the procedure(s) performed.

L. More Extensive Procedure

The "CPT Manual" often describes groups of similar codes differing in the complexity of the service. Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable. Several examples of this principle follow:

1. If 2 procedures only differ in that 1 is described as a "simple" procedure and the other as a "complex" procedure, the "simple" procedure is included in the "complex" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

2. If 2 procedures only differ in that 1 is described as a "simple" procedure and the other as a "complicated" procedure, the "simple" procedure is included in the "complicated" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

3. If 2 procedures only differ in that 1 is described as a "limited" procedure and the other as a "complete" procedure, the "limited" procedure is included in the "complete" procedure and is not separately reportable unless the 2 procedures are

performed at separate patient encounters or at separate anatomic sites.

4. If 2 procedures only differ in that 1 is described as an "intermediate" procedure and the other as a "comprehensive" procedure, the "intermediate" procedure is included in the "comprehensive" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

5. If 2 procedures only differ in that 1 is described as a "superficial" procedure and the other as a "deep" procedure, the "superficial" procedure is included in the "deep" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

6. If 2 procedures only differ in that 1 is described as an "incomplete" procedure and the other as a "complete" procedure, the "incomplete" procedure is included in the "complete" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

7. If 2 procedures only differ in that 1 is described as an "external" procedure and the other as an "internal" procedure, the "external" procedure is included in the "internal" procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites.

M. Sequential Procedure

Some surgical procedures may be performed by different surgical approaches.If an initial surgical approach to a procedure fails and a second surgical approach is used at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. If there are different HCPCS/CPT codes for the 2 different surgical approaches, the 2 procedures are considered "sequential," and only the HCPCS/CPT code corresponding to the second surgical approach may be reported. For example, a physician may begin a cholecystectomy procedure using a laparoscopic approach and have to convert the procedure to an open abdominal approach. Only the CPT code for the open cholecystectomy may be reported. The CPT code for the

failed laparoscopic cholecystectomy is not separately reportable.

N. Laboratory Panel

The "CPT Manual" defines organ and disease specific panels of laboratory tests. If a laboratory performs all tests included in one of these panels, the laboratory shall report the CPT code for the panel. If the laboratory repeats 1 of these component tests as a medically reasonable and necessary service on the same date of service, the CPT code corresponding to the repeat laboratory test may be reported with modifier 91 appended (See Chapter X, Section C (Organ or Disease Oriented Panels).)

O. Misuse of Column Two Code with Column One Code (Misuse of Code Edit Rationale)

The CMS manuals and instructions often describe groups of HCPCS/CPT codes that should not be reported together for the Medicare program. Edits based on these instructions are often included as misuse of a Column Two code with a Column One code.

A HCPCS/CPT code descriptor does not include exhaustive information about the code. Physicians who are not familiar with a HCPCS/CPT code may incorrectly report the code in a context different than intended. The NCCI has identified HCPCS/CPT codes that are incorrectly reported with other HCPCS/CPT codes as a result of the misuse of the Column Two code with the Column One code. If these edits allow use of NCCI PTP-associated modifiers (modifier indicator of "1"), there are limited circumstances when the Column Two code may be reported on the same date of service as the Column One code. Two examples follow:

1. Three or more HCPCS/CPT codes may be reported on the same date of service. Although the Column Two code is misused if reported as a service associated with the Column One code, the Column Two code may be appropriately reported with a third HCPCS/CPT code reported on the same date of service. For example, CMS limits separate payment for use of the operating microscope for microsurgical techniques (CPT code 69990) to a group of procedures listed in the online "Claims Processing Manual" (Chapter 12, Section 20.4.5 (Allowable Adjustments)). The NCCI has edits with Column One codes of surgical procedures not listed in this section of the manual and Column Two CPT code

of 69990. Some of these edits allow use of NCCI PTP-associated modifiers because the 2 services listed in the edit may be performed at the same patient encounter as a third procedure for which CPT code 69990 is separately reportable.

2. There may be limited circumstances when the Column Two code is separately reportable with the Column One code. For example, the NCCI has an edit with Column One CPT code of 47600 (Cholecystectomy) and Column Two CPT code of 12035 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm). If the patient has an abdominal wound in addition to and separate from the cholecystectomy surgical incision, then it may be separately reportable with CPT code 12035 using an NCCI PTP-associated modifier to bypass the edit. 47600 includes repair of the cholecystectomy surgical incision.

Misuse of code as an edit rationale may be applied to PTP edits where the Column Two code is not separately reportable with the Column One code based on the nature of the Column One coded procedure. This edit rationale may also be applied to code pairs where use of the Column Two code with the Column One code is deemed to be a coding error.

P. Mutually Exclusive Procedures

Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. An example of a mutually exclusive situation is the repair of an organ that can be performed by 2 different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an "initial" service or a "subsequent" service.

Q. Gender-Specific Procedures

The descriptor of some HCPCS/CPT codes includes a gender-specific restriction on the use of the code. HCPCS/CPT codes specific for one gender should not be reported with HCPCS/CPT codes for the opposite gender. For example, CPT code 53210 describes a total urethrectomy including cystostomy in a female, and CPT code 53215 describes the same procedure in a male. Since the patient cannot have both the male and female

procedures performed, the 2 CPT codes cannot be reported together.

R. Add-on Codes

Some codes in the "CPT Manual" are identified as "Add-on" Codes (AOCs), which describe a service that can only be reported in addition to a primary procedure. "CPT Manual" instructions specify the primary procedure code(s) for most AOCs. For other AOCs, the primary procedure code(s) is (are) not specified. When the "CPT Manual" identifies specific primary codes, the AOCs shall not be reported as a supplemental service for other HCPCS/CPT codes not listed as a primary code.

AOCs permit the reporting of significant supplemental services commonly performed in addition to the primary procedure. By contrast, incidental services that are necessary to accomplish the primary procedure (e.g., lysis of adhesions in the course of an open cholecystectomy) are not separately reportable with an AOC. Similarly, complications inherent in an invasive procedure occurring during the procedure are not separately reportable. For example, control of bleeding during an invasive procedure is considered part of the procedure and is not separately reportable.

In general, NCCI PTP edits do not include edits with most AOCs because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure (i.e., if an edit prevents payment of the primary procedure code, the AOC shall not be paid). However, NCCI does include edits for some AOCs when coding edits related to the primary procedures must be supplemented. Examples include edits with add-on HCPCS/CPT codes 69990 (Microsurgical techniques requiring use of operating microscope) and 95940/95941/G0453 (Intraoperative neurophysiology testing).

HCPCS/CPT codes that are not designated as AOCs shall not be misused as an AOC to report a supplemental service. A HCPCS/CPT code may be reported if and only if all services described by the CPT code are performed. A HCPCS/CPT code shall not be reported with another service because a portion of the service described by the HCPCS/CPT code was performed with the other procedure. For example, if an ejection fraction is estimated from an echocardiogram study, it would be inappropriate to additionally report CPT code 78472 (Cardiac blood pool imaging

with ejection fraction) with the echocardiography (CPT code 93307). Although the procedure described by CPT code 78472 includes an ejection fraction, it is measured by gated equilibrium with a radionuclide which is not used in echocardiography.

S. Excluded Service

The NCCI does not address issues related to HCPCS/CPT codes describing services that are excluded from Medicare coverage or are not otherwise recognized for payment under the Medicare program.

T. Unlisted Procedure Codes

The "CPT Manual" includes codes to identify services or procedures not described by other HCPCS/CPT codes. These unlisted procedure codes are generally identified as XXX99 or XXXX9 codes, and are located at the end of each section or subsection of the Manual. If a physician provides a service that is not accurately described by other HCPCS/CPT codes, the service shall be reported using an unlisted procedure code. A physician shall not report a CPT code for a specific procedure if it does not accurately describe the service performed. It is inappropriate to report the best fit HCPCS/CPT code unless it accurately describes the service performed, and all components of the HCPCS/CPT code were performed. Since unlisted procedure codes may be reported for a very diverse group of services, the NCCI generally does not include edits with these codes.

U. Modified, Deleted, and Added Code Pairs/Edits

Information moved to Introduction chapter, Section (Purpose), Page Intro-5 of this Manual

V. Medically Unlikely Edits (MUEs)

To lower the Medicare Fee-For-Service Paid Claims Error Rate, CMS has established units of service edits referred to as Medically Unlikely Edit(s)(MUEs).

An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable by the same provider for the same beneficiary on the same date of service. The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to

pass the MUE.

All claims submitted to MACs and Durable Medical Equipment (DME) MACs, and outpatient facility services claims (Type of Bill 13X, 14X, 85X) are tested against MUEs.

Prior to April 1, 2013, each line of a claim was adjudicated separately against the MUE value for the HCPCS/CPT code reported on that claim line. If the UOS on that claim line exceeded the MUE value, the entire claim line was denied.

In the April 1, 2013 version of MUEs, CMS began introducing date of service (DOS) MUEs. Over time CMS will convert many, but not all, MUEs to DOS MUEs. Since April 1, 2013, MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the UOS on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS MUE, all UOS on each claim line for the same date of service for the same HCPCS/CPT code are summed, and the sum is compared to the MUE value. If the summed UOS exceed the MUE value, all UOS for the HCPCS/CPT code for that date of service are denied. Denials due to claim line MUEs or DOS MUEs may be appealed to the local claims processing contractor. DOS MUEs are used for HCPCS/CPT codes where it would be extremely unlikely that more UOS than the MUE value would ever be performed on the same date of service for the same patient.

The MUE files on the CMS NCCI website display an "MUE Adjudication Indicator" (MAI) for each HCPCS/CPT code. An MAI of "1" indicates that the edit is a claim line MUE. An MAI of "2" or "3" indicates that the edit is a DOS MUE.

If a HCPCS/CPT code has an MUE that is adjudicated as a claim line edit, (i.e. MAI equal to "1") appropriate use of CPT modifiers (i.e. 59 or -X{EPSU}, 76, 77, 91, anatomic) may be used to report the same HCPCS/CPT code on separate lines of a claim. Each line of the claim with that HCPCS/CPT code will be separately adjudicated against the MUE value for that HCPCS/CPT code. Claims processing contractors have rules limiting use of these modifiers with some HCPCS/CPT codes.

MUEs for HCPCS codes with an MAI of "2" are absolute date of service edits. These are "per day edits based on policy." HCPCS

codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the HIPAA mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for CPT 94002 (Ventilation assist and management . . . initial day) because such use could not accurately describe 2 initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of "2" denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy.

MUEs for HCPCS codes with an MAI of "3" are "per day edits based on clinical benchmarks." MUEs assigned an MAI of "3" are based on criteria (e.g., nature of service, prescribing information) combined with data such that it would be possible but medically highly unlikely that higher values would represent correctly reported medically necessary services. If contractors have evidence (e.g., medical review) that UOS in excess of the MUE value were actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

Both the MAI and MUE value for each HCPCS/CPT code are based on one or more of the following criteria:

(1) Anatomic considerations may limit UOS based on anatomic structures. For example:

a) The MUE value for an appendectomy is "1" since there is only 1 appendix.

b) The MUE for a knee brace is "2" because there are 2 knees and Medicare policy does not cover back-up equipment.

c) The MUE value for a lumbar spine procedure reported per lumbar vertebra or per lumbar interspace cannot exceed "5" since there are only 5 lumbar vertebrae or interspaces.
d) The MUE value for a procedure reported per lung lobe cannot exceed "5" since there are only 5 lung lobes (3 in right lung and 2 in left lung).

(2) CPT code descriptors/CPT coding instructions in the "CPT Manual" may limit UOS. For example:
a) A procedure described as the "initial 30 minutes" would have an MUE value of "1" because of the use of the term "initial." A different code may be reported for additional time.
b) If a code descriptor uses the plural form of the procedure, it must not be reported with multiple UOS. For example, if the code descriptor states "biopsies," the code is reported with "1" unit of service regardless of the number of biopsies performed.
c) The MUE value for a procedure with "per day," "per week," or "per month" in its code descriptor is "1" because MUEs are based on number of services per day of service.
d) The MUE value of a code for a procedure described as "unilateral" is "1" if there is a different code for the procedure described as "bilateral."
e) The code descriptors of a family of codes may define different levels of service, each having an MUE of "1." For example, CPT codes 78102-78104 describe bone marrow imaging. CPT code 78102 is reported for imaging a "limited area." CPT code 78103 is reported for imaging "multiple areas." CPT code 78104 is reported for imaging the "whole body."
f) The MUE value for CPT code 86021 (Antibody identification; leukocyte antibodies) is "1" because the code descriptor is plural including testing for any and all leukocyte antibodies. On a single date of service only one specimen from a patient would be tested for leukocyte antibodies.
g) When reporting codes, it is important to assure the accuracy of coding and the correct UOS by selecting a code that accurately identifies the service performed based on factors including but not limited to, the route of administration. For example, for intravitreal injection of bevacizumab, select an intravitreal code

(e.g., C9257) rather than an intravenous code (e.g., J9035).

(3) Edits based on established CMS policies may limit UOS. For example:

a) The MUE value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB).

i. If the bilateral surgery indicator is "0," a bilateral procedure must be reported with "1" unit of service. There is no additional payment for the code if reported as a unilateral or bilateral procedure because of anatomy or physiology. Alternatively, the code descriptor may specifically state that the procedure is a unilateral procedure, and there is a separate code for a bilateral procedure.

ii. If the bilateral surgery indicator is "1," a bilateral surgical procedure must be reported with "1" unit of service and modifier 50 (bilateral modifier). A bilateral diagnostic procedure may be reported with "2" UOS on 1 claim line, "1" unit of service and modifier 50 on 1 claim line, or "1" unit of service with modifier RT on 1 claim line plus "1" unit of service and modifier LT on a second claim line.

iii. If the bilateral surgery indicator is "2," a bilateral procedure must be reported with "1" unit of service. The procedure is priced as a bilateral procedure because (1) the code descriptor defines the procedure as bilateral; (2) the code descriptor states that the procedure is performed unilaterally or bilaterally; or (3) the procedure is usually performed as a bilateral procedure.

iv. If the bilateral surgery indicator is "3," a bilateral surgical procedure must be reported with "1" unit of service and modifier 50 (bilateral modifier). A bilateral diagnostic procedure may be reported with "2" UOS on 1 claim line, "1" unit of service and modifier 50 on 1 claim line, or 1 unit of service with modifier RT on 1 claim line plus "1" unit of service and modifier LT on a second claim line.

b) The MUE value for a code may be "1" where the code descriptor does not specify a unit of service and CMS considers the default UOS to be "per day."
c) The MUE value for a code may be "0" because the code is listed as invalid, not covered, bundled, not separately payable, statutorily excluded, not reasonable and necessary, etc. based on:

i. The Medicare Physician Fee Schedule Database
ii. OPPS Addendum B
iii. Alpha-Numeric HCPCS Code File
iv. DMEPOS Jurisdiction List
v. Medicare "Internet-Only Manual (IOM)"

(4) The nature of an analyte may limit UOS and is in general determined by:

a) The nature of the specimen may limit the UOS. For example, CPT code 82575 describes a creatinine clearance test and has an MUE of "1" because the test requires a twenty-four-hour urine collection; or
b) The physiology, pathophysiology, or clinical application of the analyte is such that a maximum unit of service for a single date of service can be determined. For example, the MUE for CPT code 82747 (RBC folic acid) is "1" because the test result would not be expected to change during a single day, and thus it is not necessary to perform the test more than once on a single date of service.

(5) The nature of a procedure/service may limit UOS and is in general determined by the amount of time required to perform a procedure/service (e.g., overnight sleep studies) or clinical application of a procedure/service (e.g., motion analysis tests).

a) The MUE for many surgical or medical procedures is "1" because the procedure is rarely, if ever, performed more than 1 time per day (e.g., colonoscopy, motion analysis tests).
b) The MUE value for a procedure is "1" because of the amount of time required to perform the procedure (e.g., overnight sleep study).

(6) The nature of equipment may limit UOS and is in general determined by the number of items of equipment that would be used. For example, the MUE value for a wheelchair code is "1" because only 1 wheelchair is used at 1 time and

Medicare policy does not cover back-up equipment.

(7) Although clinical judgment considerations and determinations based on input from numerous physicians and certified coders are sometimes initially used to establish some MUE values, these values are subsequently validated or changed based on submitted and/or paid claims data.

(8) Prescribing information is based on FDA labeling as well as off-label information published in CMS-approved drug compendia. See below for additional information about how prescribing information is used in determining the MUE values.

(9) Submitted and paid claims data (100%) from a six-month period is used to ascertain the distribution pattern of UOS typically reported for a given HCPCS/CPT code.

(10) Published policies of the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) may limit UOS for some durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). For example:

a) The MUE values for many ostomy and urological supply codes, nebulizer codes, and CPAP accessory codes are typically based on a three-month supply of items.

b) The MUE values for surgical dressings, parenteral and enteral nutrition, immunosuppressive drugs, and oral anti-cancer drugs are typically based on a one-month supply.

c) The MUE values take into account the requirement for reporting certain codes with date spans.

d) The MUE value of a code may be "0" if the item is noncovered, not medically necessary, or not separately payable.

e) The MUE value of a code may be "0" if the code is invalid for claim submission to the DME MAC.

UOS denied based on an MUE may be appealed. Because a denial of services due to an MUE is a coding denial, not a medical necessity denial, the presence of an Advanced Beneficiary Notice of Noncoverage (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of "3," contractors will review the records to determine if the provider actually

furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of "1." CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under Section 1879 of the Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider/supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for UOS denied based on an MUE.

HCPCS J-code and drug related C and Q-code MUEs are based on prescribing information and 100% claims data for a six-month period of time. Using the prescribing information, the highest total daily dose for each drug was determined. This dose and its corresponding UOS were evaluated against paid and submitted claims data. Some of the guiding principles used in developing these edits are as follows:

(1) If the prescribing information defined a maximum daily dose, this value was used to determine the MUE value. For some drugs there is an absolute maximum daily dose. For others there is a maximum "recommended" or "usual" dose. In the latter 2 cases, the daily dose calculation was evaluated against claims data.

(2) If the maximum daily dose calculation is based on actual body weight, a dose based on a weight range of 110-150 kg was evaluated against the claims data. If the maximum daily dose calculation is based on ideal body weight, a dose based on a weight range of 90-110 kg was evaluated against claims data. If the maximum daily dose calculation is based on body surface area (BSA), a dose based on a BSA range of 2.4-3.0 square meters was evaluated against claims data.

(3) For drugs where the maximum daily dose is based on patient response or need, prescribing information and claims

data were used to establish the MUE values.

(4) Published off-label use of a drug was considered for the maximum daily dose calculation.

(5) The MUE values for some drug codes are set to "0." The rationale for such values include but are not limited to: discontinued manufacture of drug, non-FDA-approved compounded drug, practitioner MUE values for oral anti-neoplastic, oral anti-emetic, and oral immune suppressive drugs which should be billed to the DME MACs, outpatient hospital MUE values for inhalation drugs which should be billed to the DME MACs, and Practitioner/ASC MUE values for HCPCS C codes describing medications that would not be related to a procedure performed in an ASC.

Non-drug-related HCPCS/CPT codes may be assigned an MUE of "0" for a variety of reasons including, but not limited to, outpatient hospital MUE value for a surgical procedure only performed as an inpatient procedure, noncovered service, bundled service, DME MUE value for implanted devices and items related to implanted devices which should not be billed to the DME MACs, or packaged service.

The MUE files on the CMS NCCI website display an "Edit Rationale" for each HCPCS/CPT code. Although an MUE may be based on several rationales, only one is displayed on the website.One of the listed rationales is "Data." This rationale indicates that 100% claims data from a six-month period of time was the major factor in determining the MUE value. If a physician appeals an MUE denial for a HCPCS/CPT code where the MUE is based on "Data," the reviewer will usually confirm that (1) the correct code is reported; (2) the correct UOS are used; (3) the number of reported UOS were performed; and (4) all UOS were medically reasonable and necessary.

The first MUEs were implemented January 1, 2007. Additional MUEs are added on a quarterly basis on the same schedule as NCCI PTP updates. Prior to implementation proposed MUEs are sent to numerous national healthcare organizations for a sixty-day review and comment period.

Many surgical procedures may be performed bilaterally. Instructions in the CMS "IOM" (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 require that bilateral surgical procedures be reported using modifier 50 with one unit of service unless the code descriptor defines the procedure as "bilateral." If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with one unit of service without modifier 50. If a bilateral surgical procedure is performed at different sites bilaterally, one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

Some A/B MACs allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple UOS.If a provider reports services in this fashion, the provider should report the "from date" and "to date" on the claim line. Contractors are instructed to divide the UOS reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line.

Suppliers billing services to the DME MACs typically report some HCPCS codes for supply items for a period exceeding a single day. The DME MACs have billing rules for these codes. For some codes the DME MACs require that the "from date" and "to date" be reported. The MUEs for these codes are based on the maximum number of UOS that may be reported for a single date of service. For other codes the DME MACs permit multiple days' supply items to be reported on a single claim line where the "from date" and "to date" are the same.The DME MACs have rules allowing supply items for a maximum number of days to be reported at one time for each of these types of codes. The MUE values for these codes are based on the maximum number of days that may be reported at one time. As with all MUEs, the MUE value does not represent a utilization guideline. Suppliers shall not assume that they may report UOS up to the MUE value on each date of service. Suppliers may only report supply items that are medically reasonable and necessary.

Most MUE values are set so that a provider or supplier would only very occasionally have a claim line denied. If a provider encounters a code with frequent denials due to the MUE or frequent use of a CPT modifier to bypass the MUE, the provider or supplier should consider the following: (1) Is the HCPCS/CPT

code being used correctly? (2) Is the unit of service being counted correctly? (3) Are all reported services medically reasonable and necessary? and (4) Why does the provider's or supplier's practice differ from national patterns? A provider or supplier may choose to discuss these questions with the local Medicare contractor or a national healthcare organization whose members frequently perform the procedure.

Most MUE values are published on the CMS MUE webpage. However, some MUE values are not published and are confidential. These values shall not be published in oral or written form by any party that acquires one or more of them.

MUEs are not utilization edits. Although the MUE value for some codes may represent the commonly reported UOS (e.g., MUE of "1" for appendectomy), the usual UOS for many HCPCS/CPT codes is less than the MUE value. Claims reporting UOS less than the MUE value may be subject to review by claims processing contractors, Unified Program Integrity Contractor (UPICS), Recovery Audit Contractors (RACs), and Department of Justice (DOJ).

Since MUEs are coding edits, rather than medical necessity edits, claims processing contractors may have UOS edits that are more restrictive than MUEs. In such cases, the more restrictive claims processing contractor edit would be applied to the claim. Similarly, if the MUE is more restrictive than a claims processing contractor edit, the more restrictive MUE would apply.

A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of an MUE value for a HCPCS/CPT code by submitting a written request to: NCCIPTPMUE@cms.hhs.gov. The written request should include a rationale for reconsideration, as well as a suggestion. Please note that any submissions made to the NCCI program that contain Personally Identifiable Information (PII) or Protected Health Information (PHI) are automatically shredded, regardless of the content, in accordance with federal privacy rules with which the NCCI program must comply.

W. Add-on Code Edit Tables

Add-on Codes (AOCs) are discussed in Chapter I, Section R (Add-on Codes). CMS publishes a list of AOCs and their primary codes annually prior to January 1. The list is updated quarterly

based on the AMA's "CPT Errata" documents or implementation of new HCPCS/CPT add-on codes. CMS identifies AOCs and their primary codes based on "CPT Manual" instructions, CMS interpretation of HCPCS/CPT codes, and CMS coding instructions.

The NCCI program includes 3 AOC Edit Tables, 1 table for each of 3 "Types" of AOC. Each table lists the AOC with its primary codes. An AOC is a HCPCS/CPT code that describes a service that, with rare exception, is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner.

The "Type I AOC Edit Table" lists AOCs for which the "CPT Manual" or HCPCS tables define all acceptable primary codes. Claims processing contractors should not allow other primary codes with Type I AOCs. CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) is included as a Type I AOC since its only primary code is CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes). For Medicare purposes, CPT code 99292 may be eligible for payment to a physician without CPT code 99291 if another physician of the same specialty and physician group reports and is paid for CPT code 99291.

The "Type II AOC Edit Table" lists AOC for which the "CPT Manual" and HCPCS tables do not define any primary codes. Claims processing contractors should develop their own lists of acceptable primary codes.

The "Type III AOC Edit Table" lists AOCs for which the "CPT Manual" or HCPCS tables define some, but not all, acceptable primary codes. Claims processing contractors should allow the listed primary codes for these AOCs but may develop their own lists of additional acceptable primary codes.

Although the AOC and primary code are normally reported for the same date of service, there are unusual circumstances where the 2 services may be reported for different dates of service (e.g., CPT codes 99291 and 99292).

The first AOC edit tables were implemented April 1, 2013. For subsequent years, new AOC edit tables will be published to be effective for January 1 of the new year based on changes in the new year's "CPT Manual." The CMS also issues quarterly updates to the AOC edit tables if required due to publication of new HCPCS/CPT codes or changes in add-on codes or their primary codes. The changes in the quarterly update files (April 1, July 1, or October 1) are retroactive to the implementation date of that year's annual AOC edit files unless the files specify a different effective date for a change. Since the first AOC edit files were implemented on April 1, 2013, changes in the July 1 and October 1 quarterly updates for 2013 were retroactive to April 1, 2013 unless the files specified a different effective date for a change.

CHAP11-CPTcodes90000-99999
Revision Date: 1/1/2021

CHAPTER XI
MEDICINE
EVALUATION AND MANAGEMENT SERVICES
CPT CODES 90000 - 99999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

Table of Contents

Chapter XI
Medicine Evaluation and Management Services CPT Codes 90000 - 99999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the Current Procedural Terminology (CPT) codes in the range 90000-99999. Several general guidelines are repeated in this chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians shall report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A Healthcare Common Procedure Coding System/ Current Procedural Terminology (HCPCS/CPT) code shall be reported only if all services described by the code are performed. A physician shall 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 shall 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. Therapeutic or Diagnostic Infusions/Injections and Immunizations

1. CPT codes 96360-96379 and C8957 describe hydration and therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs. CPT codes 96401-96549 describe administration of chemotherapy or other highly complex drug or biologic agents. Issues related to chemotherapy administration are discussed in this section as well as Section N (Chemotherapy Administration).

2. CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter, only one "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance

administrations occur at separate intravenous access sites. To report 2 different "initial" service codes, use National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP)-associated modifiers.

3.If both lumina of a double lumen catheter are used for infusions of different substances or drugs, only one "initial" infusion CPT code may be reported. The double lumen catheter permits intravenous access through a single vascular site. Thus, it would not be correct to report 2 "initial" infusion CPT codes, 1 for each lumen of the catheter.

4. Because the placement of peripheral vascular access devices is integral to intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 96360-96368, 96374-96379, 96409-96417) shall not be reported separately. Because insertion of central venous access is not routinely necessary to perform infusions/injections, this service may be reported separately. Since intra-arterial infusion often involves selective catheterization of an arterial supply to a specific organ, there is no routine arterial catheterization common to all arterial infusions. Selective arterial catheterization codes may be reported separately.

5. The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D_5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately. Similarly, the fluid used to administer drug(s)/substance(s) is incidental hydration and shall not be reported separately.

Transfusion of blood or blood products includes the insertion of a peripheral intravenous line (e.g., CPT codes 36000, 36410), which is not separately reportable. Administration of fluid during a transfusion or between units of blood products to maintain intravenous line patency is incidental hydration and is not separately reportable.

If therapeutic fluid administration is medically necessary (e.g., correction of dehydration, prevention of nephrotoxicity)

before or after transfusion or chemotherapy, it may be reported separately.

6. Hydration concurrent with other drug administration services is not separately reportable.

7. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services shall not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare-approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.s, D.O.s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule."

8. The drug and chemotherapy administration CPT codes 96360-96375 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (Evaluation and management (E&M) service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility-based E&M CPT codes (e.g., 99202-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians shall not report drug administration services in a facility setting, a facility-based E&M CPT code (e.g., 99281-99285) shall not be reported by a physician with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the E&M code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.s, D.O.s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule."

Under the OPPS, hospitals may report drug administration services (CPT codes 96360-96377) and chemotherapy administration services (CPT codes 96401-96425) with facility-based E&M codes (e.g., 99281-99285, G0463) if the E&M service is significant and

separately identifiable. In these situations, modifier 25 should be appended to the E&M code.

9. Flushing or irrigation of an implanted vascular access port or device of a drug delivery system prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Do not report CPT code 96523.

10. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 shall **not** be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (Refilling and maintenance of implantable pump or reservoir for systemic drug delivery) and CPT code 96521 (Refilling and maintenance of portable pump) shall not be reported with CPT code 96416 (Initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump. Similarly under the OPPS, CPT codes 96521 (Refilling and maintenance of portable pump) and 96522 (Refilling and maintenance of implantable pump or reservoir for systemic drug delivery (e.g., intravenous, intra-arterial)) shall not be reported with HCPCS/CPT code C8957 (Initiation of prolonged intravenous infusion (more than 8 hours)).

CPT codes 96521 and 96522 shall **not** be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

11. Medicare Anesthesia Rules prevent separate payment for anesthesia services for a medical or surgical service when provided by the physician performing the service. Drug administration services (CPT codes 96360-96377) shall not be

reported for anesthesia provided by the physician performing a medical or surgical service.

12. 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 shall 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 used 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 PTP-associated modifier if performed in a non-facility site of service.

13. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported with HCPCS codes G0008, G0009, or G0010 respectively. Administration of other immunization(s) not excluded by law is reported with CPT codes 90460-90461 or 90471-90474, depending upon the patient's age and physician counseling of the patient/family. Based on CPT instructions, a physician shall report administration of all immunizations other than influenza, pneumococcal, or hepatitis B vaccines on a single date of service from either of these 2 code ranges and shall not report a combination of CPT codes from the 2 code ranges.

14. If one or more immunizations and a significant, separately identifiable E&M service are rendered by a physician

on the same date of service, both the immunization administration code (e.g., CPT codes 90460-90474) and the E&M code with modifier 25 appended may be reported. If the patient returns on another day solely to receive another immunization, only the immunization administration code shall be reported.

15. Similar to drug and chemotherapy administration CPT codes, CPT code 99211 (Evaluation and management service, office or other outpatient visit, established patient, level I) is not separately reportable with vaccine administration HCPCS/CPT codes 90460-90474, G0008-G0010. Other E&M CPT codes are separately reportable with a vaccine administration code if the E&M service is significant and separately identifiable, in which case the E&M CPT code may be reported with modifier 25.

16. CPT codes 96361 and 96366 are used to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes may be reported only if the infusion is medically reasonable and necessary for the patient's treatment or diagnosis.They shall not be reported for "keep open" infusions as often occur in the emergency department or observation unit.

C. Psychiatric Services

CPT codes for psychiatric services include diagnostic (CPT codes 90791, 90792) and therapeutic (individual, group, other) procedures. Since psychotherapy includes continuing psychiatric evaluation, CPT codes 90791 and 90792 are not separately reportable with individual, group, family, crisis, or other psychotherapy codes for the same date of service.

CPT codes 90832-90838 include all psychotherapy provided to a patient with family members as informants, if present, for a single date of service. Family psychotherapy (e.g., CPT codes 90846, 90847) focused on the patient addressing interactions between the patient and family members may be reported separately with psychotherapy CPT codes 90832-90838 on the same date of service if performed as a separate and distinct service during a separate time interval.

Psychotherapy (CPT codes 90832-90838) performed in a Medicare partial hospitalization setting may be reported with more than one unit of service to reflect the amount of psychotherapy provided during a single date of service.

Interactive services (diagnostic or therapeutic) are distinct services for patients who have "lost, or have not yet developed either the expressive language communication skills to explain their symptoms and response to treatment..." Interactive complexity to psychiatric services is reported with add-on CPT code 90785.

Diagnostic psychiatric evaluation is reported with one of 2 CPT codes.CPT code 90791 is psychiatric evaluation without medical E&M, and CPT code 90792 is psychiatric evaluation with medical E&M. E&M codes (e.g., 99202-99215) shall not be reported with either of these diagnostic psychiatric codes.

Individual psychotherapy codes are time-based codes. There are separate codes for psychotherapy without E&M service (CPT codes 90832, 90834, 90837) and Add-on Codes (AOCs) (CPT codes 90833, 90836, 90838) for psychotherapy to be reported in conjunction with the appropriate E&M code.

For practitioner services, E&M codes are not separately reportable on the same date of service as psychoanalysis (CPT code 90845), narcosynthesis (CPT code 90865), or hypnotherapy (CPT code 90880). These psychiatric services include E&M services provided on the same date of service. Facilities may separately report E&M codes and psychoanalysis, narcosynthesis, or hypnotherapy if the services are performed at separate patient encounters on the same date of service.

1. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes shall not be reported separately with an E&M, psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 shall not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code using an NCCI PTP-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening" services which are not covered under the Medicare program.

The same principles apply to separate reporting of E&M services with other screening, intervention, or counseling service HCPCS codes (e.g., G0442 (Annual alcohol misuse screening, 15 minutes), G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), and G0444 (Annual depression screening, 15 minutes). If an E&M, psychiatric diagnostic, or psychotherapy service is related to a problem which would normally require evaluation and management duplicative of the HCPCS code, the HCPCS code is not separately reportable. For example, if a patient presents with symptoms suggestive of depression, the provider shall not report G0444 in addition to the E&M, psychiatric diagnostic, or psychotherapy service code. The time and work effort devoted to the HCPCS code screening, intervention, or counseling service must be distinct and separate from the time and work of the E&M, psychiatric diagnostic, or psychotherapy service. Both services may occur at the same patient encounter.

D. Biofeedback

Biofeedback services use electromyographic techniques to detect and record muscle activity. CPT codes 95860-95872 (EMG) shall not be reported separately with biofeedback services based on the use of electromyography during a biofeedback session. If an EMG is performed as a separate medically necessary service for diagnosis or follow-up of organic muscle dysfunction, the appropriate EMG code(s) (e.g., CPT codes 95860-95872) may be reported separately. Modifiers 59 or -X{ES} should be appended to the EMG code to indicate that the service was a separately identifiable diagnostic service. Recording an objective electromyographic response to biofeedback is not sufficient to separately report a diagnostic EMG CPT code.

E. Dialysis

Renal dialysis procedures coded as CPT codes 90935, 90937, 90945, 90947, G0491, and G0492 include E&M services related to the dialysis procedure and the renal failure. If the physician additionally performs on the same date of service medically reasonable and necessary E&M services unrelated to the dialysis procedure or renal failure that are significant and separately identifiable, these services may be separately reportable. The

Centers for Medicare & Medicaid Services (CMS) allows physicians to additionally report if appropriate CPT codes 99202-99215, 99221-99223, 99238-99239, and 99291-99292. These codes must be reported with modifier 25 if performed on the same date of service as the dialysis procedure.

Per CMS payment policy, any E&M service related to the renal failure (e.g., hypertension, fluid overload, uremia, electrolyte imbalance) or dialysis procedure performed on the same date of service as the dialysis procedure shall not be reported separately even if performed at a separate patient encounter. E&M services for conditions unrelated to the dialysis procedure or renal failure may be reported separately with modifier 25 only if they cannot be performed during the dialysis session.

F. Gastroenterology

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

2. The gastroesophageal reflux test described by CPT code 91035 requires attachment of a telemetry pH electrode to the esophageal mucosa. If a physician uses endoscopic guidance to attach the electrode, the physician shall not report CPT code 43235 (Esophagogastroduodenoscopy,...; diagnostic...) for the guidance procedure. The guidance is not separately reportable. Additionally, it would be a misuse of CPT code 43235 since this code does not describe guidance, but a more extensive diagnostic endoscopy.

Similarly, the procedures described by CPT codes 91110 (Gastrointestinal tract intraluminal imaging, esophagus through ileum) and 91112 (Gastrointestinal transit and pressure measurement, stomach through colon) require a patient to swallow a capsule. If the patient cannot swallow a capsule, and a

physician places it in the stomach using endoscopic guidance, CPT code 43235 shall not be reported unless the physician performs a medically reasonable and necessary complete diagnostic upper gastrointestinal endoscopy procedure. CPT code 43235 should not be reported with modifier 52 for endoscopic guidance to place the capsule in the stomach.

G. Ophthalmology

1. General ophthalmological services (CPT codes 92002-92014) describe components of the ophthalmologic examination. When E&M codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-92014) shall not be reported separately. The E&M service includes the general ophthalmological services.

2. Special ophthalmologic services represent specific services not included in a general or routine ophthalmological examination. Special ophthalmological services are recognized as significant, separately identifiable services and may be reported separately.

3. For procedures requiring intravenous injection of dye or other diagnostic agent, insertion of an intravenous catheter and dye injection are integral to the procedure and are not separately reportable. Therefore, CPT codes 36000 (Introduction of a needle or catheter), 36410 (Venipuncture), 96360-96368 (IV infusion), 96374-96376 (IV push injection), and selective vascular catheterization codes are not separately reportable with services requiring intravenous injection (e.g., CPT codes 92230, 92235, 92240, 92242, 92287).

4. CPT codes 92230 and 92235 (Fluorescein angioscopy and angiography) include selective catheterization and injection procedures for angiography.

5. Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (e.g., CPT codes 92133, 92134) are generally mutually exclusive of one another, in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59 or XU to CPT code 92250.

6. Posterior segment ophthalmic surgical procedures (CPT

codes 67005-67229) include extended ophthalmoscopy (CPT codes 92201, 92202) 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. (CPT codes 92225 and 92226 were deleted on January 1, 2020).

7. CPT code 92071 (Fitting of contact lens for treatment of ocular surface disease) shall not be reported with a corneal procedure CPT code for a bandage contact lens applied after completion of a procedure on the cornea.

H. Otorhinolaryngologic Services

1. CPT coding for otorhinolaryngologic services includes codes for diagnostic tests that may be performed qualitatively during physical examination or quantitatively with electrical recording equipment. The procedures described by CPT codes 92552-92557, 92561-92588, and 92597 may be reported only if calibrated electronic equipment is used. Qualitative—assessment of these tests by the physician is included in the E&M service. (CPT codes 92585 and 92586 were deleted on January 1, 2021.)

2. Speech language pathologists may perform services coded as CPT codes 92507, 92508, or 92526. They do not perform services coded as CPT codes 97110, 97112, 97150, or 97530 which are generally performed by physical or occupational therapists. Speech language pathologists shall not report HCPCS/CPT codes 97110, 97112, 97150, 97530, 97129 as unbundled services included in the services coded as 92507, 92508, or 92526. (CPT code 97532 was deleted on January 1, 2018. (CPT code 97127 was deleted on January 1, 2020.)

3. A single practitioner shall not report CPT codes 92507 (Treatment of speech, language, voice...; individual) and/or 92508 (Treatment of speech, language, voice...; group) on the same date of service as HCPCS/CPT codes 97129, 97533 (Sensory integrative techniques to enhance...), or 97130 (Development of cognitive skills to improve...). However, if the 2 types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech language pathologist performs the procedures described by CPT codes 92507 and/or 92508 on the same date of service that an occupational therapist performs the procedures described by HCPCS/CPT codes 97129, 97533, and/or 97130, a provider entity that employs both types of practitioners may report both services using an NCCI

PTP-associated modifier. (CPT code 97532 was deleted on January 1, 2018. (CPT code 97127 and HCPCS code G0515 were deleted on January 1, 2020 and replaced with CTP codes 97129 and 97130 on January 1, 2020.)

4. Treatment of swallowing dysfunction and/or oral function for feeding (CPT code 92526) may use electrical stimulation. HCPCS code G0283 (Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care...) shall not be reported with CPT code 92526 for electrical stimulation during the procedure. The NCCI PTP edit (92526/G0283) for MACs does not allow use of NCCI PTP-associated modifiers with this edit because the same provider would never perform both of these services on the same date of service. However, the same edit in OCE for MACs does allow use of NCCI PTP-associated modifiers because 2 separate practitioners in the same outpatient hospital facility or institutional therapy provider might perform the 2 procedures for different purposes at different patient encounters on the same date of service.

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

6. Removal of cerumen by an audiologist prior to audiologic function testing is not separately reportable. If the cerumen is impacted, cannot be removed by the audiologist, and requires removal by a physician, the physician may report HCPCS code G0268 (Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing). The physician shall not report CPT code 69209 (Removal of impacted cerumen using irrigation/lavage, unilateral) or 69210 (Removal of impacted cerumen requiring instrumentation, unilateral) for this service.

7. CPT code 92540 (Basic vestibular evaluation...) includes all the services separately included in CPT codes 92541 (Spontaneous nystagmus test...), 92542 (Positional nystagmus test...), 92544 (Optokinetic nystagmus test...), and 92545 (Oscillating tracking test...).Therefore, none of the component test CPT codes (92541, 92542, 92544, and 92545) may be reported with CPT code 92540. Additionally, if all 4 component tests are performed, CPT code 92540 shall be reported rather than the 4 separate individual CPT codes. If 1, 2, or 3 of the component tests are performed without the others, the individual test codes may be reported separately. However, if 2 or 3

component test codes are reported, NCCI PTP-associated modifiers should be used.

8. CPT code 95992 describing canalith repositioning procedure(s) is reported with no more than one unit of service per day and includes all services necessary to achieve the canalith repositioning. Other CPT codes (e.g., 97110, 97112, 97140, 97530) shall not be reported separately for services related to the canalith repositioning.

9. Comprehensive central auditory function evaluation (CPT codes 92620, 92621) includes, when performed, filtered speech test (CPT code 92571), staggered spondaic word test (CPT code 92572), and synthetic sentence identification test (CPT code 92576).

I. Cardiovascular Services

Cardiovascular medicine services include non-invasive and invasive diagnostic testing including intracardiac testing as well as therapeutic services (e.g., electrophysiological procedures).

1. If cardiopulmonary resuscitation (CPR) is performed without other E&M services, only CPT code 92950 (Cardiopulmonary resuscitation (e.g., in cardiac arrest)) shall be reported. For example, if a physician directs cardiopulmonary resuscitation and the patient's attending physician resumes the care of the patient after the patient has been revived, the first physician may report CPT code 92950 but not an E&M code.

2. Critical care E&M services (CPT codes 99291 and 99292) and prolonged E&M services (CPT codes 99354-99357) are reported based on time. Providers shall not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged provider E&M service time. For example, the time devoted to performing cardiopulmonary resuscitation (CPT code 92950) shall not be included in critical care E&M service time.

3. There is no CPT code to report emergency cardiac defibrillation. It is included in cardiopulmonary resuscitation (CPT code 92950).If emergency cardiac defibrillation without cardiopulmonary resuscitation is performed in the emergency department or critical/intensive care unit, the cardiac defibrillation service is not separately reportable. Physicians shall not report CPT code 92960 (Cardioversion, elective...;

external) for emergency cardiac defibrillation. CPT code 92960 describes a planned elective procedure. If a planned elective external cardioversion is performed by a physician reporting critical care time (CPT codes 99291, 99292), the time to perform the elective external cardioversion shall not be included in the critical care time.

4. A number of diagnostic and therapeutic cardiovascular procedures (e.g., CPT codes 92950-92998, 93451-93533, 93600-93624, 93640-93657) routinely use intravenous or intra-arterial vascular access, routinely require electrocardiographic monitoring, and frequently require agents administered by injection or infusion techniques. Since these services are integral components of the more comprehensive procedures, codes for routine vascular access, ECG monitoring, and injection/infusion services are not separately reportable. Fluoroscopic guidance is integral to diagnostic and therapeutic intravascular procedures and is not separately reportable. HCPCS/CPT codes describing radiologic supervision and interpretation for specific interventional vascular procedures may be separately reportable. (CPT code 92993 was deleted on January 1, 2021.)

5. Cardiac output measurements (CPT codes 93561-93562) are routinely performed during cardiac catheterization procedures. Per CPT instruction, CPT codes 93561-93562 shall not be reported separately with cardiac catheterization codes.

6. CPT codes 93797 and 93798 describe comprehensive services provided by a physician for cardiac rehabilitation. Since these codes include all services necessary for cardiac rehabilitation, E&M codes shall not be reported separately unless a significant, separately identifiable E&M service is performed and documented in the medical record. The physician should report the E&M service with modifier 25 to indicate that it was significant and separately identifiable.

7. Cardiac rehabilitation services include medical nutrition services to reduce cardiac disease risk factors. Medical nutrition therapy (CPT codes 97802-97804) shall not be reported separately for the same patient encounter. However, medical nutrition therapy services provided under the Medicare benefit for patients with diabetes or chronic renal failure performed at a separate patient encounter on the same date of service may be reported separately.

8. Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation services

are included in the cardiac rehabilitation benefit and are not separately reportable. (CMS Final Rule ("Federal Register," Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier.

9. If a physician in attendance for a cardiac stress test obtains a history and performs a limited physical examination related to the cardiac stress test, a separate E&M code shall not be reported separately unless a significant, separately identifiable E&M service is performed unrelated to the performance of the cardiac stress test. The E&M code should be reported with modifier 25 to indicate that it is a significant, separately identifiable E&M service.

10. Cardiovascular stress tests include insertion of needle and/or catheter, infusion/injection (pharmacologic stress tests) and ECG strips (e.g., CPT codes 36000, 36410, 96360-96376, 93000-93010, 93040-93042). These services shall not be reported separately.

11. Microvolt T-wave alternans (MTWA) (CPT code 93025) testing requires a submaximal stress test that differs from the traditional exercise stress test (CPT codes 93015-93018) which uses a standard exercise protocol. CPT codes 93015-93018 shall not be reported separately for the submaximal stress test integral to MTWA testing. CPT codes 93015-93018 shall not be reported on the same date of service as CPT code 93025.

12. CPT codes 93040-93042 describe diagnostic rhythm ECG testing. They shall not be reported for cardiac rhythm monitoring in any site of service.

13. Routine monitoring of ECG rhythm and review of daily hemodynamics including cardiac output are part of critical care E&M services. Separate reporting of ECG rhythm strips and cardiac output measurements (CPT codes 93040-93042, 93561, 93562) with critical care E&M services is inappropriate. An exception to this principle may include a sudden change in patient status associated with a change in cardiac rhythm requiring a diagnostic ECG rhythm strip and return to the critical care unit. If reported separately, the time for this service is not included in the critical care time calculated for reporting the critical care E&M service.

14. Percutaneous coronary artery interventions (PCI) include stent placement, atherectomy, and balloon angioplasty. There are CPT codes describing various combinations of these PCI procedures. There are 5 major coronary arteries (left main, left anterior descending, left circumflex, right, and ramus intermedius).Only one PCI code may be reported for all PCIs of a major coronary artery through the native circulation. However, PCI treatment of a different second segment of a major coronary artery through a bypass graft may also be reported with a different PCI code for revascularization treatment through a coronary artery bypass. Two PCI codes shall not be reported for treatment of the same segment of a major coronary artery or one of its branches. For reporting purposes, there are 2 coronary branches of the left anterior descending (diagonals), left circumflex (marginals), and right (posterior descending, posterolaterals) coronary arteries. For reporting purposes, there are no recognized branches of the left main and ramus intermedius coronary arteries. Only one PCI code may be reported for each of up to 2 branches of a major coronary artery with recognized branches.PCI of a third branch of a major coronary artery with recognized branches shall not be reported. (Medicare does not pay separately for PCI in a branch of a major coronary artery as this payment is included in the payment for the PCI code for the corresponding major coronary artery.) One PCI code may be reported for each coronary artery bypass graft plus each branch off the main graft. PCI performed on a major coronary artery or coronary artery branch accessed through a bypass graft may be reported using a bypass graft PCI code. If a single lesion extends from one target vessel (major coronary artery, coronary bypass graft, or coronary artery branch) into another target vessel and can be revascularized with a single intervention, only one PCI code shall be reported even though 2 target vessels are treated.

15. Cardiac catheterization, percutaneous coronary artery interventional procedures (angioplasty, atherectomy, or stenting), and internal cardioversion include insertion of a needle and/or catheter, infusion, fluoroscopy and ECG rhythm strips (e.g., CPT codes 36000, 36140, 36160, 36200-36248, 36410, 96360-96376, 76000, 93040-93042). All these services are components of a cardiac catheterization, percutaneous coronary artery interventional procedure, or internal cardioversion and are not separately reportable. Additionally, ultrasound guidance is not separately reportable with these procedures. Physicians shall not report CPT codes 76937, 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound

procedure is performed for guidance during one of these procedures. (CPT code 76001 was deleted January 1, 2019.)

16. A cardiac catheterization procedure or a percutaneous coronary artery interventional procedure may require ECG tracings to assess chest pain during the procedure. These ECG tracings are not separately reportable. Diagnostic ECGs performed prior to or after the procedure may be separately reportable with modifier 59 or XU.

17. Percutaneous coronary artery interventions (e.g., stent, atherectomy, angioplasty) include coronary artery catheterization, radiopaque dye injections, and fluoroscopic guidance. CPT codes for these procedures (e.g., 93454-93461, 76000) shall not be reported separately. If medically reasonable and necessary diagnostic coronary angiography precedes the percutaneous coronary artery intervention, a coronary artery or cardiac catheterization and associated radiopaque dye injections may be reported separately. However, fluoroscopy is not separately reportable with diagnostic coronary angiography or cardiac catheterization.

18. While withdrawing the catheter during a cardiac catheterization procedure, physicians often inject a small amount of dye to examine the renal arteries and/or iliac arteries. These services when medically reasonable and necessary may be reported with HCPCS code G0278. A physician shall not report CPT codes 75625 (Abdominal aortography) or 75630 (Abdominal aortography with bilateral iliofemoral lower extremity angiography) unless a complete study including venous phase is performed and interpreted. In order to report angiography CPT codes 75625, 75630, or others with a cardiac catheterization procedure, the angiography procedure must be as complete a procedure as it would be without concomitant cardiac catheterization.

19. Placement of an occlusive device such as an angio seal or vascular plug into an arterial or venous access site after cardiac catheterization or other diagnostic or interventional procedure may be reported with HCPCS code G0269. A physician shall not separately report an associated imaging code such as CPT code 75710 or HCPCS code G0278.

20. Many Pacemaker/Implantable Defibrillator procedures (CPT codes 33202-33249) and Intracardiac Electrophysiology procedures (CPT codes 93600-93662) require intravascular placement of catheters into coronary vessels or cardiac chambers

under fluoroscopic guidance. Physicians shall not separately report cardiac catheterization or selective vascular catheterization CPT codes for placement of these catheters. A cardiac catheterization CPT code is separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. Fluoroscopy codes (e.g., CPT code 76000) are not separately reportable with the procedures described by CPT codes 33202-33249 and 93600-93662. Fluoroscopy codes intended for specific procedures may be reported separately. Additionally, ultrasound guidance is not separately reportable with these HCPCS/CPT codes. Physicians shall not report CPT codes 76937, 76942, 76998, 93318, or other ultrasound procedural codes if the ultrasound procedure is performed for guidance during one of the procedures described by CPT codes 33202-33249 or 93600-93662. (CPT code 76001 was deleted January 1, 2019.)

21. Endomyocardial biopsy requires intravascular placement of catheters into the right ventricle under fluoroscopic guidance. Physicians shall not separately report a right heart catheterization or selective vascular catheterization CPT code for placement of these catheters. A right heart catheterization CPT code may be separately reportable if it is a medically reasonable, necessary, and distinct service performed at the same or different patient encounter. The right heart catheterization CPT code may be reported only if a complete right heart catheterization procedure is performed. If an abbreviated right heart catheterization is medically reasonable and necessary, it may be reported with CPT code 93799 (Unlisted cardiovascular service or procedure). Fluoroscopy codes (e.g., CPT code 76000) are not separately reportable for an endomyocardial biopsy. (CPT code 76001 was deleted January 1, 2019.)

22. CPT codes 93600 (Bundle of His recording), 93602 (Intra-atrial recording), 93603 (Right ventricular recording), 93610 (Intra-atrial pacing), and 93612 (Intraventricular pacing) shall not be reported with a code describing insertion or replacement of an electrode or device (pacemaker, defibrillator) because they are integral to the procedure. If a physician performs a medically reasonable and necessary limited diagnostic electrophysiology test preceding the insertion or replacement of the electrode or device to determine the necessity to proceed with insertion or replacement of an electrode or device, the appropriate CPT codes describing the limited diagnostic electrophysiology testing may be reported with an NCCI-associated modifier. The limited diagnostic electrophysiology

testing to determine the necessity to proceed with insertion or replacement of the electrode or device may be performed at the same or different patient encounter.

23. Occasionally, it is medically reasonable and necessary to perform echocardiography (CPT codes 93303-93318 using intravenous push injections of contrast. The injection of contrast (e.g., CPT codes 96365, 96374, 96375, 96376) is not separately reportable.

HCPCS codes C8921-C8930 describe echocardiography procedures with contrast and include echocardiography without contrast if performed at the same patient encounter. Under the OPPS, facilities should report the appropriate code from the HCPCS code range C8921-C8930 when echocardiography is performed with contrast rather than the corresponding CPT code in the code range 93303-93350. Since the HCPCS codes C8921-C8930 include echocardiography without contrast if performed at the same patient encounter as echocardiography with contrast, a code from the HCPCS code range C8921-C8930 and the corresponding code from the CPT code range 93303-93352 shall not be reported separately for the same patient encounter for echocardiography.

CPT code 93352 is an AOC that describes use of echocardiographic contrast during stress echocardiography. It may be reported by physicians with CPT codes 93350 or 93351 in the appropriate site of service. CPT code 93352 is not separately payable under the OPPS.

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

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

26. A procedure to insert a central flow directed catheter (e.g., Swan-Ganz) (CPT code 93503) is often followed by a chest radiologic examination to confirm proper positioning of the flow directed catheter. A chest radiologic examination CPT code (e.g., 71045, 71046) shall not be reported separately for this radiologic examination.

27. Since cardioversion includes interrogation and programming of an implantable defibrillator if performed, interrogation and programming of an implantable defibrillator system (e.g., CPT codes 93282-93284, 93289, 93292, and 93295) shall not be reported separately with a cardioversion procedure (e.g., CPT codes 92960, 92961).

28. Since electronic analysis of an antitachycardia pacemaker system includes interrogation and programming of the pacemaker system, interrogation and programming of a pacemaker system (e.g., CPT codes 93279-93281, 93286, and 93288) shall not be reported separately with electronic analysis of an antitachycardia pacemaker system (CPT code 93724).

29. CPT code 92961 (Cardioversion, elective...; internal (separate procedure)) is not separately reportable with a cardiac catheterization or percutaneous cardiac interventional procedure. CPT code 92961 is defined as a "separate procedure," and CMS payment policy does not allow separate payment for a "separate procedure" performed with another procedure in an anatomically related region through similar access. The internal cardioversion, like a cardiac catheterization or a percutaneous cardiac interventional procedure, is performed using similar percutaneous vascular access and placement of one or more catheters into the heart under fluoroscopy. CPT codes for percutaneous vascular access, radiopaque dye injections, and fluoroscopic guidance shall not be reported separately.

30. CPT code 93623 (Programmed stimulation and pacing after intravenous drug infusion) is an AOC that may be reported per "CPT Manual" instructions only with CPT codes 93610, 93612, 93619, 93620, or 93653-93656. Although CPT code 93623 may be reported for intravenous drug infusion for diagnostic programmed stimulation and pacing, it shall not be reported for injections of a drug with stimulation and pacing following an intracardiac catheter ablation procedure (e.g., CPT codes 93650-93657) to confirm adequacy of the ablation. Confirmation of the adequacy of ablation is included in the intracardiac catheter ablation procedure.

31. Transesophageal echocardiography (TEE) monitoring (CPT code 93318) without probe placement is not separately reportable by a physician performing critical care E&M services. However, if a physician places a transesophageal probe to be used for TEE monitoring on the same date of service that the physician performs critical care E&M services, CPT code 93318 may be reported with modifier 59 or XU. The time necessary for probe placement shall not be included in the critical care time reported with CPT codes 99291 and 99292 as is true for all separately reportable procedures performed on a patient receiving critical care E&M services. Diagnostic TEE services may be separately reportable by a physician performing critical care E&M services.

32. CPT code 93590 describes percutaneous transcatheter closure of a mitral valve paravalvular leak. If a left heart catheterization by transapical puncture is additionally performed, add-on CPT code 93462 may additionally be reported. However, if the left heart catheterization is performed by transseptal puncture, CPT code 93462 shall not be additionally reported. Therefore, CPT code 93590 is listed as a primary code for add-on CPT code 93462. These 2 codes are also bundled in a PTP edit that allows use of an NCCI PTP-associated modifier to bypass it if left heart catheterization by transapical puncture is performed.

J. Pulmonary Services

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories.

1. Alternate methods of reporting data obtained during a spirometry or other pulmonary function session shall not be reported separately. For example, the flow volume loop is an alternative method of calculating a standard spirometric parameter.CPT code 94375 is included in standard spirometry (rest and exercise) studies.

2. If a physician in attendance for pulmonary diagnostic testing or therapy obtains a limited history and performs a limited physical examination related to the pulmonary testing or therapy, separate reporting of an E&M service is not appropriate. If a significant, separately identifiable E&M service is performed unrelated to the performance of the pulmonary diagnostic testing or therapy, an E&M service may be reported with modifier 25.

3. If multiple spirometric determinations are necessary to complete the service described by a CPT code, only one unit of service shall be reported. For example, CPT code 94070 describes bronchospasm provocation with an administered agent and uses multiple spirometric determinations as in CPT code 94010. A single unit of service includes all the necessary spirometric determinations.

4. Cardiopulmonary exercise testing (CPT code 94621) is a comprehensive exercise test with a number of component tests separately defined in the "CPT Manual." It is inappropriate to separately report component services such as, but not limited to, venous access, ECG monitoring, spirometric parameters performed before, during and after exercise, oximetry, O_2 consumption, CO_2 production, and rebreathing cardiac output calculations when performed during the same patient encounter as a cardiopulmonary exercise test. It is also inappropriate to report a cardiac stress test, a pulmonary stress test (CPT code 94618), or a component of either of these stress tests when performed during the same patient encounter as a cardiopulmonary exercise test.

5. Pursuant to the "Federal Register" (Volume 58, Number 230, 12/2/1993, Pages 63640-63641), ventilation management CPT codes (94002-94004 and 94660-94662) are not separately reportable with E&M CPT codes. If an E&M code and a ventilation management code are reported, only the E&M code is payable.

6.The procedure described by CPT code 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour) does not include any physician work RVUs. When performed in a facility, the procedure uses facility staff and supplies, and the physician does not have any practice expenses related to the procedure. Thus, a physician shall not report this code when the physician orders it in a facility. This code shall not be reported with CPT codes 99217-99239, 99281-99285, 99466-99467, 99291-99292, 99468-99469, 99471-99472, 99478-99480, 99304-99318, and 99324-99337 unless the physician supervises the performance of the procedure at a separate patient encounter on the same date of service outside the facility where the physician does have practice expenses related to the procedure.

7. CPT code 94060 (Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) describes a diagnostic test that is used to

assess patient symptoms that might be related to reversible airway obstruction. It does not describe treatment of acute airway obstruction. CPT code 94060 includes the administration of a bronchodilator. It is a misuse of CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction...) to report 94640 for the administration of the bronchodilator included in CPT code 94060. The bronchodilator medication may be reported separately.

8. CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) shall not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately.

An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.

If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.

If inhalation drugs are administered in a continuous treatment or a series of "back-to-back" continuous treatments exceeding one hour, CPT codes 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) may be reported instead of CPT code 94640.

9. CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator...) generally should not be reported for the same patient encounter. The demonstration

and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it uses the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the 2 services may be reported separately.

10. Practitioner ventilation management (e.g., CPT codes 94002-94005, 94660, 94662) and critical care (e.g., CPT codes 99291, 99292, 99466-99486) include respiratory flow volume loop (CPT code 94375), breathing response to carbon dioxide (CPT code 94400), and breathing response to hypoxia (CPT code 94450) testing if performed. (CPT code 94400 was deleted on January 1, 2021.)

K. Allergy Testing and Immunotherapy

The "CPT Manual" divides allergy and clinical immunology into testing and immunotherapy. Immunotherapy includes codes for the preparation of antigen (allergen) and separate codes for allergen administration.

1. If percutaneous or intracutaneous (intradermal) single test (CPT codes 95004 or 95024) and "sequential and incremental" tests (CPT codes 95017, 95018, or 95027) are performed on the same date of service, both the "sequential and incremental" test and single test codes may be reported if the tests are for different allergens or different dilutions of the same allergen. The unit of service to report is the number of separate tests. A single test and a "sequential and incremental" test for the same dilution of an allergen shall not be reported separately on the same date of service. For example, if the single test for an antigen is positive and the physician proceeds to "sequential and incremental" tests with 3 additional **different** dilutions of the same antigen, the physician may report one unit of service for the single test code and 3 UOS for the "sequential and incremental" test code.

2. Photo patch tests (CPT code 95052) consist of applying a patch(s) containing allergenic substance(s) to the skin and exposing the skin to light. Physicians shall not unbundle this service by reporting both CPT code 95044 (Patch or application tests) plus CPT code 95056 (Photo tests) rather than CPT code 95052.

3. Evaluation and management codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed.

Obtaining informed consent is included in the immunotherapy service and shall not be reported with an E&M code. If E&M services are reported, modifier 25 should be used.

4. In general, allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. Allergy testing is performed prior to immunotherapy to determine the offending allergens. CPT codes for allergy testing and immunotherapy are generally not reported on the same date of service unless the physician provides allergy immunotherapy and testing for additional allergens on the same day. Physicians shall not report allergy testing CPT codes for allergen potency (safety) testing prior to administration of immunotherapy. Confirmation of the appropriate potency of an allergen vial for immunotherapy is an inherent component of immunotherapy. Additionally, allergy testing is an integral component of rapid desensitization kits (CPT code 95180) and is not separately reportable.

L. Neurology and Neuromuscular Procedures

The "CPT Manual" defines codes for neuromuscular diagnostic and therapeutic services. Sleep testing, nerve and muscle testing, and electroencephalographic procedures are included. The "CPT Manual" guidelines for sleep testing are very precise and should be followed carefully when reporting these services.

1. Sleep testing differs from polysomnography in that the latter requires sleep staging. Sleep staging includes a qualitative and quantitative assessment of sleep as determined by standard sleep scoring techniques. A “sleep study” and “polysomnography” shall not be reported separately for the same patient encounter.

2. Polysomnography requires at least one central and usually several other EEG electrodes. EEG procurement for polysomnography (sleep staging) differs greatly from that required for diagnostic EEG testing (e.g., speed of paper, number of channels). EEG testing shall not be reported separately with polysomnography unless a complete diagnostic EEG is performed separately in the usual manner at a separate patient encounter on the same date of service. If a complete diagnostic EEG is performed at a separate patient encounter on the same date of service as a polysomnography, modifier 59 or XE should be appended to the EEG code.

3. Continuous electroencephalographic monitoring services (e.g., CPT codes 95700-95726) describe different services than those provided during sleep testing or polysomnography. These procedures may be reported separately with sleep testing only if they are performed as significant, separately identifiable services distinct from EEG testing included in sleep testing or polysomnography. In the latter situation, the EEG codes must be reported with modifier 59 or XU to indicate that a different service was performed. (CPT codes 95950, 95951, 95953, and 95956 are deleted as of January 1, 2020)

4. If nerve testing (e.g., EMG, nerve conduction velocity) is performed to assess the level of paralysis during anesthesia or during mechanical ventilation, the range of CPT codes 95851-95943 are not separately reportable. These codes describe significant, separately identifiable diagnostic services requiring a formal report in the medical record. Electrical stimulation used to identify or locate nerves during a procedure involving treatment of a cranial or peripheral nerve (e.g., nerve block, nerve destruction, neuroplasty, transection, excision, repair) is integral to the procedure and is not separately reportable.

5. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) shall not be reported by the physician performing an operative or anesthesia procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure shall not report other 90000 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. (CPT code 92585 was deleted January 1, 2021.)

6. CPT code 95940 describes continuous intraoperative neurophysiology monitoring in the operating room requiring one on one monitoring and personal attendance. HCPCS code G0453 describes continuous intraoperative neurophysiology monitoring for a single patient from outside the operating room (remote or nearby). The unit of service for each of these procedures is "each 15 minutes." A physician shall not report both of these procedures for the same time period. If the 2 procedures are reported for the same date of service for the same patient, the time period for each procedure must be distinct and not overlapping with the time period for the other procedure.

CPT code 95941 describes continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or monitoring of more than one case while in the operating room. This code is not valid for Medicare practitioner services. It is a packaged service under Medicare Hospital OPPS (Outpatient Prospective Payment System).

M. Central Nervous System Assessments/Tests

1. Neurobehavioral status exam (CPT codes 96116 and 96121) shall not be reported when a mini-mental status examination is performed. CPT codes 96116 and 96121 shall not be reported with psychiatric diagnostic examinations (CPT codes 90791 or 90792). CPT codes 96116 and 96121 may be reported with other psychiatric services or E&M services only if a complete neurobehavioral status exam is performed. If a mini-mental status examination is performed by a physician, it is included in the E&M service.

2. The psychiatric diagnostic interview examination (CPT codes 90791, 90792), psychological/neuropsychological testing (CPT codes 96136-96146), and psychological/ neuropsychological evaluation services (CPT codes 96130-96133) must be distinct services if reported on the same date of service. "CPT Manual" instructions permit physicians to integrate other sources of clinical data into the report that is generated for CPT codes 96130-96133. Since the procedures described by CPT codes 96130-96139 are timed procedures, physicians shall not report time for duplicating information (collection or interpretation) included in the psychiatric diagnostic interview examination and/or psychological/neuropsychological evaluation services or test administration and scoring. (CPT codes 96101 and 96118 were deleted January 1, 2019.)

3. Central nervous system (CNS) assessment/test CPT codes (e.g., 96130-96133, 96136-96146, 96105, 96125, 96127) shall not be reported for tests that are reportable as part of an E&M service when performed. In order to report a CNS assessment/ test CPT code, the test cannot be self-administered. It must be administered as required by the code descriptor of the reported CPT code. The test must assess CNS function (e.g., psychological health, aphasia, neuropsychological health) per requirements of the CNS assessment/test CPT code descriptors. The assessment must use tests described by the code descriptor or other tests not available in the public domain. (CPT codes 96101-96103 and 96118-96120 were deleted January 1, 2019.)

N. Chemotherapy Administration

1. The CPT codes 96360, 96365, 96374, 96409, and 96413 describe "initial" service codes. For a patient encounter, only 1 "initial" service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report 2 different "initial" service codes, use NCCI PTP-associated modifiers.

2. CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services shall not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare-approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate. For purposes of this paragraph, the term "physician" refers to M.D.s, D.O.s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule."

3. The drug and chemotherapy administration HCPCS/CPT codes 96360-96375,96377 and 96401-96425 have been valued to include the work and practice expenses of CPT code 99211 (E&M service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility-based E&M CPT codes (e.g., 99202-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service. Since physicians shall not report drug administration services in a facility setting, a facility-based E&M CPT code (e.g., 99281-99285) shall not be reported with a drug administration CPT code unless the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service. In such situations, the E&M code should be reported with modifier 25. For purposes of this paragraph, the term "physician" refers to M.D.s, D.O.s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule."

Under the OPPS, hospitals may report drug administration services and facility-based E&M codes (e.g., 99281-99285, G0463) if the E&M service is significant and separately identifiable. In these situations, modifier 25 should be appended to the E&M code.

4. Flushing or irrigation of an implanted vascular access port or device prior to or subsequent to the administration of chemotherapeutic or non-chemotherapeutic drugs is integral to the drug administration service and is not separately reportable. Under these circumstances, do not report CPT code 96523.

5. CPT code 96522 describes the refilling and maintenance of an implantable pump or reservoir for systemic drug delivery. The pump or reservoir must be capable of programmed release of a drug at a prescribed rate. CPT code 96522 shall not be reported for accessing a non-programmable implantable intravenous device for the provision of infusion(s) or chemotherapy administration.

CPT code 96522 (Refilling and maintenance of implantable pump or reservoir) and CPT code 96521(Refilling and maintenance of portable pump) shall not be reported with CPT code 96416 (Initiation of prolonged intravenous chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump) or CPT code 96425 (Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than eight hours) requiring the use of a portable or implantable pump). CPT codes 96416 and 96425 include the initial filling and maintenance of a portable or implantable pump. CPT codes 96521 and 96522 are used to report subsequent refilling of the pump.

CPT codes 96521 and 96522 shall not be reported for accessing or flushing an indwelling peripherally-placed intravenous catheter port (external to skin), subcutaneous port, or non-programmable subcutaneous pump. Accessing and flushing these devices is an inherent service facilitating these infusion(s) and is not reported separately.

6. A concurrent intravenous infusion of an antiemetic or other non-chemotherapeutic drug with intravenous infusion of chemotherapeutic agents may be reported separately as CPT code 96368 (Concurrent intravenous infusion). CPT code 96368 may be reported with a maximum of one unit of service per patient encounter regardless of the number of concurrently infused drugs

or the length of time for the concurrent infusion(s). Hydration concurrent with chemotherapy is not separately reportable.

O. Special Dermatological Procedures

1. Medicare does not allow separate payment of E&M CPT code 99211 with photochemotherapy procedures (CPT codes 96910-96913) for services performed by a nurse or technician such as examining a patient prior to a subsequent procedure for burns or reactions to the prior treatment. If a physician performs a significant separately identifiable medically reasonable and necessary E&M service on the same date of service, it may be reported with modifier 25.

2. Reflectance confocal microscopy (CPT codes 96931-96936) is performed to determine whether a skin lesion is malignant.PTP edits allow physicians to report on the same date of service excision of the lesion if malignant, but not biopsy or excision of the lesion if benign.

P. Physical Medicine and Rehabilitation

1. An occupational therapist may report only one evaluation/re-evaluation (CPT codes 97165-97168) on a single date of service. A physical therapist may report only one evaluation/re-evaluation (CPT codes 97161-97164) on a single date of service. A physician or facility shall not report both an occupational therapy evaluation/re-evaluation service and physical therapy evaluation/re-evaluation service if performed by the same practitioner. If the 2 services are performed by 2 different practitioners on the same date of service, both procedures may be reported.

2. With one exception, providers shall not report more than one physical medicine and rehabilitation therapy service for the same fifteen-minute time period. (The only exception involves a "supervised modality" defined by CPT codes 97010-97028, which may be reported for the same fifteen-minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI PTP edits pair a "timed" CPT code with another "timed" CPT code or a non-timed CPT code. These edits may be bypassed with modifier 59 or XU if the 2 procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter. The NCCI program does not include all edits pairing 2 physical medicine and rehabilitation services (excepting "supervised

modality" services) even though they shall **not** be reported for the same fifteen-minute time period.

3. The NCCI program contains PTP edits with Column One codes of the physical medicine and rehabilitation therapy services and Column Two codes of the physical therapy and occupational therapy re-evaluation CPT codes of 97164 and 97168 respectively. The re-evaluation services shall not be routinely reported during a planned course of physical or occupational therapy. However, if the patient's status should change and a re-evaluation is medically reasonable and necessary , it may be reported with modifier 59 or XU appended to CPT code 97164 or 97168 as appropriate.

4. The procedure coded as CPT code 97755 (Assistive technology assessment...direct one-on-one contact with written report, each 15 minutes) is intended for use on severely impaired patients requiring adaptive technology. For example, a patient with the use of only one or no limbs might require the use of high-level adaptive technology.

5. This subsection was removed January 1, 2021. See prior versions of the Manual.

6. Based on "CPT Manual" instructions, debridement CPT codes 97597-97602 shall not be reported in conjunction with surgical debridement (CPT codes 11042-11047) for the same wound. Similarly, CPT code 97602 shall not be reported in conjunction with CPT codes 97597 and 97598 for the same wound.

7. Physical or occupational therapy services performed at the same patient encounter as cardiac rehabilitation or pulmonary rehabilitation services are included in the cardiac rehabilitation or pulmonary rehabilitation benefit and are not separately reportable. (CMS Final Rule ("Federal Register," Vol. 74, No. 226, November 25, 2009, Pages 61884-61885)). If physical therapy or occupational therapy services are performed at a separate, medically reasonable and necessary patient encounter on the same date of service as cardiac rehabilitation or pulmonary rehabilitation services, both types of services may be reported using an NCCI PTP-associated modifier. Similarly, physical and occupational therapy services are not separately reportable with therapeutic pulmonary procedures (e.g., HCPCS codes G0237-G0239) for the same patient encounter.

8. CPT codes 97750 (Physical performance test or measurement), 97755 (Assistive technology assessment), and 97763

(Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes) are not separately reportable for the same date of service with a physical therapy evaluation/re-evaluation CPT code (e.g., 97161-97164) or occupational therapy evaluation/re-evaluation CPT code (e.g., 97165-97168) when the 2 services are performed by a single practitioner or 2 practitioners of the same specialty. If the 2 services are performed by 2 different practitioners of different specialties, the 2 services may be reported using an NCCI PTP-associated modifier. For example, if a physical therapist performs 1 service and an occupational therapist performs the other service, the 2 services may be reported separately. However, if a physical therapist performs 1 service and a different physical therapist performs the other service, the 2 services are not separately reportable.

CPT codes 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes) and 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes) are not separately reportable for the same date of service with physical therapy re-evaluation CPT code 97164 or occupational therapy re-evaluation CPT code 97168 when the 2 services are performed by a single practitioner or 2 practitioners of the same specialty. If the 2 services are performed by 2 different practitioners of different specialties, the 2 services may be reported using an NCCI PTP-associated modifier.

9. CPT Code 97610 (Low frequency, non-contact, non-thermal ultrasound..., per day) is not separately reportable for treatment of the same wound with other active wound care management CPT codes (97597-97606) or wound debridement CPT codes (e.g., CPT codes 11042-11047, 97597, 97598).

Q. Medical Nutrition Therapy

1. CPT codes 97802-97804 (Medical nutrition therapy;...) are used to report Medicare-covered medical nutrition therapy services after an initial referral each year.
If during the same year there is a change in the patient's diagnosis, medical condition, or treatment regimen, the treating physician may make a second referral for medical nutrition therapy. These services should be reported with HCPCS codes G0270-G0271 (Medical nutrition therapy... following second

referral in same year for change in diagnosis, medical condition or treatment regimen...) rather than CPT codes 97802-97804.

2. Medical nutrition therapy services (CPT codes 97802-97804) performed at the same patient encounter as a cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service are included in the cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service and are not separately reportable. The Medicare program provides a medical nutrition therapy benefit to beneficiaries for medical nutrition therapy related to diabetes mellitus or renal disease. If a physician provides a Medicare-covered medical nutrition service to a beneficiary with diabetes mellitus or renal disease on the same date of service as a cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service but at a separate patient encounter, the medical nutrition therapy service may be separately reportable with an NCCI PTP-associated modifier. The Medicare-covered medical nutrition service cannot be provided at the same patient encounter as the cardiac rehabilitation, pulmonary rehabilitation, or pulmonary therapeutic service.

R. Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment (OMT) is subject to Global Surgery Rules. Per Medicare Anesthesia Rules, a provider performing OMT cannot separately report anesthesia services such as nerve blocks or epidural injections for OMT. In addition, per Medicare Global Surgery Rules, postoperative pain management after OMT (e.g., nerve block, epidural injection) is not separately reportable. Further, since a single therapeutic intervention is recognized per region, a physician shall not report OMT and an injection for the same region. Epidural or nerve block injections performed on the same date of service as OMT, unrelated to the OMT, and in a different region than the OMT, may be reported with OMT using modifier 59 or XS.

S. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of 5 spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes

under the Medicare program, the provider may report CMT and the above codes using modifier 59 or XS.

T. Miscellaneous Services

1. When CPT code 99175 (Ipecac or similar administration for individual emesis and continued observation until stomach adequately emptied of poison) is reported, observation time provided predominantly to monitor the patient for a response to an emetogenic agent shall not be included in other timed codes (e.g., critical care, prolonged services).

2. If hypothermia is accomplished by regional infusion techniques, chemotherapy administration CPT codes shall not be reported unless chemotherapeutic agents are also administered at the same patient encounter.

3. Therapeutic phlebotomy (CPT code 99195) is not separately reportable with autologous blood collection (CPT codes 86890, 86891), plasmapheresis, or exchange transfusion. Services integral to performing the phlebotomy (e.g., CPT codes 36000, 36410, 96360-96376) are not separately reportable.

4. Physician attendance and supervision of hyperbaric oxygen therapy (CPT code 99183) includes E&M services related to the hyperbaric oxygen therapy. E&M services integral to this procedure include, but are not limited to, updating history and physical, examining the patient, reviewing laboratory results and vital signs with special attention to pulmonary function, blood pressure, and blood sugar levels, clearing patient for procedure, monitoring and/or assisting with patient positioning, evaluating and treating the patient for barotrauma and other complications, prescribing appropriate medications, etc. A physician shall not report an E&M CPT code for these services. If a physician performs unrelated, significant, and separately identifiable E&M services on the same date of service, the physician may report those E&M services with modifier 25.

U. Evaluation & Management (E&M) Services

CPT codes for E&M services are principally included in the CPT code range 99202-99499. The codes describe the site of service (e.g., office, hospital, home, nursing facility, emergency department, critical care), the type of service (e.g., new or initial encounter, follow-up or subsequent encounter), and various miscellaneous services (e.g., prolonged physician

service, care plan oversight service). Some E&M codes are based on the duration of the encounter (e.g., per diem services.)

Medicare does not recognize consultation E&M CPT codes 99241-99255 for billing and payment purposes. If a physician performs a consultation E&M, the physician may report the appropriate level of E&M service for the site of service where the consultation E&M occurs.

Rules governing the reporting of more than one E&M code for a patient on the same date of service are very complex and are not described herein. However, the NCCI program contains numerous edits based on several principles including, but not limited to:

1. A physician may report only one "new patient" code on a single date of service.

2. A physician may report only one code from a range of codes describing an initial E&M service on a single date of service.

3. A physician may report only one "per diem" E&M service from a range of per diem codes on a single date of service.

4. A physician shall not report an "initial" per diem E&M service with the same type of "subsequent" per diem service on the same date of service.

5. A physician shall not double count time if reporting more than one E&M service for the same date of service or same monthly period.

6. E&M codes describing observation/inpatient care services with admission and discharge on same date (CPT codes 99234-99236) shall not be reported on the same date of service as initial hospital care per diem codes (99221-99223), subsequent hospital care per diem codes (99231-99233), or hospital discharge day management codes (99238-99239).

The prolonged service with direct face-to-face patient contact E&M codes (CPT codes 99354-99357) may be reported in conjunction with some E&M codes.

Since critical care (CPT codes 99291-99292) and prolonged E&M services (CPT codes 99354-99357) are reported based on time, providers shall not include the time devoted to performing

separately reportable services when determining the amount of critical care or prolonged provider E&M service time.

E&M services, in general, are cognitive services, and significant procedural services are not included in E&M services. Certain procedural services that arise directly from the E&M service are included as part of the E&M service. For example, cleansing of traumatic lesions, closure of lacerations with adhesive strips, application of dressings, counseling and educational services are included in E&M services.

Digital rectal examination for prostate screening (HCPCS code G0102) is not separately reportable with an E&M code. The CMS published this policy in the "Federal Register," November 2, 1999, Page 59414 as follows:

> "As stated in the July 1999 proposed rule, a digital rectal exam (DRE) is a very quick and simple examination taking only a few seconds. We believe it is rarely the sole reason for a physician encounter and is usually part of an E/M encounter. In those instances when it is the only service furnished or it is furnished as part of an otherwise non-covered service, we will pay separately for code G0102. In those instances when it is furnished on the same day as a covered E/M service, we believe it is appropriate to bundle it into the payment for the covered E/M encounter."

Because of the intensive nature of caring for critically ill patients, certain practitioner services in addition to patient history, examination, and medical decision making are included in the evaluation and management associated with critical and intensive care. Per "CPT Manual" instructions, services not separately reportable by practitioners reporting critical care CPT codes 99291 and 99292 include, but are not limited to, the interpretation of cardiac output measurements (CPT codes 93561 and 93562), chest X-rays (CPT codes 71045 and 71046), blood gases, and data stored in computers (ECGs, blood pressures, hematologic data), gastric intubation (CPT codes 43752,43753), temporary transcutaneous monitoring (CPT code 92953), ventilator management (CPT codes 94002-94004, 94660, 94662), and vascular access procedures (CPT codes 36000, 36410, 36600). However, facilities may separately report these services with critical care CPT codes 99291 and 99292.

Per "CPT Manual" instructions, practitioner inpatient neonatal and pediatric critical and intensive care services (i.e., CPT codes 99468-99480) include the same services included in critical care CPT codes 99291 and 99292 as well as additional services listed in the "CPT Manual" specific to neonatal and pediatric critical and intensive care services. These services shall not be reported separately by practitioners reporting CPT codes 99468-99480. However, facilities may separately report these services with CPT codes 99468-99480.

Per Medicare rules, critical and intensive care CPT codes include thoracic electrical bioimpedance (CPT code 93701) which shall not be reported separately.

Certain sections of CPT codes include codes describing specialty-specific services which primarily involve E&M services. When codes for these services are reported, a separate E&M service from the range of CPT codes 99202-99499 shall not be reported on the same date of service. Examples of these codes include general and special ophthalmologic services and general and special diagnostic and therapeutic psychiatric services.

Medicare Global Surgery Rules define the rules for reporting 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 MAC. 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 days 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 service 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 MACs have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) 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 shall 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.

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 shall **not** 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 shall **not** 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 that is above and beyond the usual pre- and post-operative work of the procedure 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. Examples of "XXX" procedures include allergy testing and immunotherapy, physical therapy services, and neurologic and vascular diagnostic testing procedures.

Pediatric and neonatal critical and intensive care CPT codes (99468-99480) are per diem codes that are generally reported by only one physician on each day of service. These codes are reported by the physician directing the inpatient critical or intensive care of the patient. These codes shall not be reported by other physicians performing critical care services on the same date of service. Critical care services provided by a second physician of a different specialty may be reported with CPT codes 99291 and 99292. However, if a neonate or infant becomes critically ill on a day when initial or subsequent intensive care service (CPT codes 99477-99480) has been performed by one physician and is transferred to a critical care level of care provided by a different physician in a different group, the second physician may report a per diem critical care service (CPT codes 99468-99476).

7. CPT codes 99238 and 99239 describe hospital discharge day management. These codes shall not be reported with initial hospital care (CPT codes 99221-99223) or initial observation care (CPT codes 99218-99220) for the same date of service. If a physician provides initial hospital care or observation care on the same day as discharge, the services shall be reported with CPT codes 99234-99236 (Observation or inpatient hospital care with admission and discharge on the same date of service). Additionally, CPT codes 99238 and 99239 include all physician services provided to the patient on the date of discharge. The physician shall not report another E&M CPT code (e.g., 99202-99215, 99281-99285) on the same date of service that the physician reports CPT code 99238 or 99239.

8. HCPCS codes G0396 and G0397 describe alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services. These codes shall not be reported separately with an E&M, psychiatric diagnostic, or psychotherapy service code for the same work/time. If the E&M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 shall not be additionally reported. If a physician reports either of these G codes with an E&M, psychiatric diagnostic, or psychotherapy code using an NCCI PTP-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M, psychiatric diagnostic, or psychotherapy service and is a service that is not included in the E&M, psychiatric diagnostic, or psychotherapy service based on the clinical reason for the E&M, psychiatric diagnostic, or psychotherapy service.

CPT codes 99408 and 99409 describe services which are similar to those described by HCPCS codes G0396 and G0397, but are "screening" services which are not covered under the Medicare program. Where CPT codes 99408 and 99409 are covered by State Medicaid programs, the policies explained in the previous paragraph for G0396/G0397 also apply to 99408/99409.

9. Transesophageal echocardiography (TEE) monitoring (CPT code 93318) without probe placement is not separately reportable by a physician performing critical care E&M services. However, if a physician places a transesophageal probe to be used for TEE monitoring on the same date of service that the physician performs critical care E&M services, CPT code 93318 may be reported with modifier 59 or XU. The time necessary for probe placement shall not be included in the critical care time reported with CPT codes 99291 and 99292 as is true for all separately reportable procedures performed on a patient receiving critical care E&M services. Diagnostic TEE services are separately reportable by a physician performing critical care E&M services.

10. Practitioner ventilation management (e.g., CPT codes 94002-94005, 94660, 94662) and critical care (e.g., CPT codes 99291, 99292, 99466-99486) include respiratory flow volume loop (CPT code 94375) and breathing response to hypoxia (CPT code 94450) testing if performed. (CPT code 94400 was deleted on January 1, 2021).

V. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2.Providers/suppliers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are 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 (UOS) incorrectly. The provider/supplier should consider contacting their national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS. 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 submitting a written request to: NCCIPTPMUE@cms.hhs.gov. The written request should include a rationale for reconsideration, as well as a suggestion. Please note that any submissions made to the NCCI program that contain Personally Identifiable Information (PII) or Protected Health Information (PHI) are automatically shredded, regardless of the content, in accordance with federal privacy rules with which the NCCI program must comply.

3. For purposes of reporting UOS for antigen preparation (i.e., CPT codes 95145-95170), the physician reports "number of doses." Medicare defines a dose for reporting purposes as 1 milliliter (ml).Thus, if a physician prepares a 10 ml vial of antigen, the physician may only report a maximum of 10 UOS for that vial even if the number of actual administered doses is greater than 10.Medicare payment amounts for these codes were determined by dividing the practice expenses for a 10 ml vial into 10 doses. (See "Internet-Only Claims Processing Manual," Publication 100-04, Chapter 12, Section 200 (B)(7)).

4. CPT code 94681 (Oxygen uptake, expired gas analysis; including CO_2 output, percentage oxygen extracted) may be reported one time per day. It includes rest and exercise determinations.

5. The unit of service for CPT codes 90849 (Multiple family group psychotherapy) and 90853 (Group psychotherapy (other than of a multiple family group)) is each separate and distinct therapy session even if it lasts longer than one hour. These are not timed codes and shall not be reported with a unit of service corresponding to any particular time interval. A

practitioner may report only one unit of service on a single date of service. An outpatient facility may report one unit of service for each separate and distinct group or multiple family group therapy session provided by a different practitioner.

Prior to January 1, 2017, the unit of service for CPT codes 90846 (Family psychotherapy (without the patient present)), 90847 (Family psychotherapy (conjoint psychotherapy) (with patient present))was each separate and distinct therapy session regardless of the length of time of the session. A practitioner could only report one unit of service for each day of family therapy, and an outpatient facility could report one unit of service for each separate and distinct therapy session provided by a different practitioner.

Effective January 1, 2017, the code descriptors for CPT codes 90846 (Family psychotherapy (without the patient present), 50 minutes) and 90847 (Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes) were modified.

Group therapy services provided in a PHP (partial hospitalization program) should be reported with HCPCS codes G0410 or G0411 which are timed codes.

6. CPT code 90845 (Psychoanalysis) includes all psychoanalysis services performed by a physician on a single date of service.

7. CPT codes 90867, 90868, and 90869 describe delivery of therapeutic repetitive transcranial magnetic stimulation (TMS) treatment.CPT code 90867 may be reported only once with a single unit of service during a course of TMS treatment since it describes the initial treatment. CPT codes 90868 and 90869 may be reported with only one unit of service per day since they are not timed codes and only one treatment session would be performed on a single date of service.

8. The MUE values for CPT codes 93797 and 93798 (Physician services for outpatient cardiac rehabilitation... (per session)) are "2." Medicare allows a maximum of 2 one-hour sessions per day.

9. The MUE value for CPT code 92546 (Sinusoidal vertical axis rotational testing) is "1." Since there is only one vertical axis and the word "testing" references all testing, not individual tests, only one unit of service may be reported for a

patient encounter. Because it is highly unlikely that a provider would perform this testing at 2 separate patient encounters on the same date of service, correct reporting of this code on more than 1 line of a claim should be very uncommon.

10. CPT codes 92081-92083 describe visual field examinations. The visual field examination (one unit of service) includes examination of both the right and left eyes. Additionally, if a physician performs visual field examination with the eyelids in the patient's usual position and with the eyelids taped up at the same patient encounter, the visual field examination code shall be reported with only one unit of service.

11. The MUE value for CPT code 93568 (Injection procedure during cardiac catheterization; for pulmonary angiography) is "1." The code descriptor indicates that the angiography includes all pulmonary vessels and their branches. The code shall not be reported with separate UOS for different parts of the pulmonary vasculature.

12. The code descriptor for CPT code 95887 states: "Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)." The MUE for this code is one since the code descriptor includes all non-extremity "muscle(s)." A physician shall not report this code with more than one unit of service on more than one line of a claim for the same date of service.

13. CPT code 91122 describes anorectal manometry which includes all measurements performed at the same patient encounter.The MUE value for this code is "1" since it is unlikely that this procedure would be performed more than once on a single date of service.

14. CPT code 95873 describes electrical stimulation for guidance in conjunction with chemodenervation, and CPT code 95874 describes needle electromyography for guidance in conjunction with chemodenervation. During a patient encounter, only one of these codes may be reported with a maximum of one unit of service for guidance in conjunction with chemodenervation regardless of the number of muscles chemodenervated.

15. CPT codes 90935 and 90937 describe a hemodialysis procedure (i.e., session) with single or repeated evaluations respectively by a physician or other qualified health care provider. Each of these codes may be reported with a single unit of service for a single hemodialysis procedure (i.e., session.) CPT codes 90945 and 90947 describe a dialysis procedure (i.e., session) other than hemodialysis with single or repeated evaluations respectively by a physician or other qualified health care provider. Each of these codes may be reported with a single unit of service for a single dialysis procedure (i.e., session) other than hemodialysis.

16. CPT codes 93922 and 93923 describe bilateral noninvasive physiologic studies of the upper or lower extremities. The MUE value for each of these codes is "2" since it is unlikely that this testing would be performed on both the upper and lower extremities on the same date of service.

17. 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 1 unit of service on a single claim line unless the code descriptor defines the procedure as "bilateral." If the code descriptor defines the procedure as a "bilateral" procedure, it shall be reported with 1 unit of service without modifier 50. The 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 2 claim lines, each with 1 unit of service using modifiers LT and RT on different claim lines. This reporting requirement does not apply to non-surgical diagnostic procedures.

18. Some allergy testing CPT codes (e.g., 95004, 95017-95052) are reported based on the number of individual tests performed.CMS payment policy does not allow including testing of positive or negative controls in the number of tests reported. For example, if percutaneous testing (CPT code 95018) with penicillin allergens administering 6 allergens plus a positive and negative control is performed, only 6 tests may be reported for CPT code 95018.

19. Audiologic function testing (CPT codes 92550-92588)

includes testing of both ears, and only one unit of service for any of these CPT codes may be reported for the described testing on both ears. If only one ear is tested, the appropriate CPT code should be reported with modifier 52.

20. The unit of service for CPT code 93505 (Endomyocardial biopsy) is the procedure to obtain the endomyocardial biopsy and includes biopsy specimens from one or more endomyocardial sites.

21. Physical therapy evaluation (CPT codes 97161-97163) and occupational therapy evaluation (CPT codes 97165-97167) shall not be reported with more than one unit of service per episode of care. Physical therapy re-evaluation (CPT code 97164) and occupational therapy re-evaluation (CPT code 97168) shall not be reported with more than one unit of service per date of service.

22. CPT code 92941 describes percutaneous transluminal revascularization of an acute total/subtotal occlusion of a coronary artery or coronary artery bypass graft during an acute myocardial infarction. This code may be reported with one unit of service. If additional revascularization procedures of coronary arteries or coronary artery bypass grafts are performed at the same patient encounter, these procedures shall not be reported with CPT code 92941, but with other CPT codes such as 92920, 92924, and/or 92943.

W. General Policy Statements

1. The MUE values and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians shall 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 using the term “physician.” Unless indicated differently the use 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) shall 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 using 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 using tissue adhesive may be reported separately. If a practitioner uses 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 uses 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 the OPPS, HCPCS code G0168 is not recognized and paid. Facilities may report wound closure using 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 shall not report CPT codes 00100-01999, 62320-62327, or 64400-64450 for anesthesia for a procedure.Additionally, the physician shall 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) shall not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

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 shall 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 used 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 PTP-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) shall 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 shall 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 using modifier 78.

10. 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. The 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.

11. 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, modifier 59 or modifier XS.

The biopsy is not separately reportable if used for the purpose of assessing margins of resection or verifying resectability.

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.

12. 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 PTP-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 PTP-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 PTP-associated modifiers should generally not be used.

13. 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.

14.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 shall 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 PTP-associated modifier if appropriate.

15. CPT code 36591 describes “collection of blood specimen from a completely implantable venous access device.” CPT code 36592 describes “collection of blood specimen using an established central or peripheral venous catheter, not otherwise specified.” These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

16. CPT code 96523 describes “irrigation of implanted venous access device for drug delivery system.” This code may be reported only if no other service is reported for the patient encounter.

Premier Patient Care IPA Treatment Authorization
Request Form Fax completed form to 888-972-1931

***Please note*:** *Incomplete request form without supporting clinical notes will delay the determination process. Determination Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the requested provider.*

Type of Request: *circle one* **ROUTINE** **URGENT** ***(medical condition that requires immediate intervention)*** **RETRO**

MEMBER INFORMATION **Date:**

Patient Name:_____ Gender: M / F Date of Birth:_____

Patient's Address:_____
Street City Zip

Phone:_____ Health Plan: _____

Subscriber Name:_____ Subscriber #_____

Member's Primary Care Provider: _____

REQUESTING PROVIDER	**REQUESTED PROVIDER & FACILITY**
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Non-Contracted Providers only):
Today's Date:	Place of Service:

REQUESTED SERVICES AND MEDICAL NECESSITY

Diagnosis Description(s):_____

ICD10(s):_____

Reason for Referral: _____

Information to support requested service: (please attached relevant clinical notes, physical exam, labs, test results)_____

_____

Requested Service(s): Description:_____ CPT:_____ # Units_____

Description:_____ CPT:_____ # Units_____

Description:_____ CPT:_____ Units

Description:_____ CPT:_____ Quantity_____

- Approved authorizations are effective from the date they are received and expire two (2) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed.
- Providers must verify member eligibility to ensure coverage. Approved Authorization is not a guarantee of payment.
- Claims for services rendered without required prior authorization may be denied reimbursement.
- Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to Premier Patient Care IPA- UM Dept at fax at 855-405-2288. For any questions, please call our **UM Department at (855)-548-0911.**
  This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety code §1370, and California Evidence Code §1157.

PREMIER PATIENT CARE
Your Partner in Health

C/O Procare MSO
Claims Department
855-548-0911 Main Line
888-972-1931 FAX

Direct Authorization Referral

The purpose of this direct referral form is to provide PCP with **Premier Patient Care IPA members** direct access to our specialists **without requesting a Prior authorization**. For this direct referral form to be valid, you must use Premier Patient Care IPA in Network Providers. If you do not see a specific provider or service, you must request a prior authorization or inquire Provider Relations regarding LOA option. All lab work must be referred to our Exclusive lab: MDLAB. All claims will be reviewed for medical necessity appropriateness. Please use only **ONE SPECIALTY PER DIRECT REFERRAL.**

PATIENT

Patient/Member Name:	DOB:	Member ID:
Health Plan:	ICD 9 CODE:	
Diagnosis:		

PROVIDER

REFER TO PROVIDER NAME:

Specialty of Provider:		SPC Phone:
Address:		Appt. Date & Time:
PCP Signature:	**PCP Name *(please print)*:**	Today's Date:

DIRECT SERVICES:

☐ 93303- 99306 Cardiac Echo

☐ 93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

☐ 93971- Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study
☐ 93000 EKG
☐ 77057 Mammogram screening
☐ 93294 Pacemaker check
☐ 99381-99397 Well Woman Exam (Including Pap) & Diagnosis Code V72.31
☐ X-Ray Location: _____
☐ Yearly Diabetes RetinalScreening: _____
☐ Yearly Glaucoma Eye ExamScreening: _____
☐ Yearly Foot Exam (If Diabetic)
☐ BMD Screening : 77080 (only for women 65-85 after fracture within 6 months and every two years thereafter)
☐ Colonoscopy (Every 10 Years)
☐ Initial consult CPT: 99201-99203

PCP: Your member must be referred to an In-Network Provider and utilize contracted facilities and lab, unless indicated above. Please give the Direct Referral form to your patient prior to scheduling an appointment. Direct Referrals must be signed and dated by PCP or on-call provider.

Member : Please schedule an appointment for member and have member bring this form to the specialist

Specialist: Member must be eligible with Premier Patient Care IPA on the Date of Service is rendered.

Attached Signed Direct Referral with the claim when billing. Send HCFA CMS 1500 Claims to Premier Patient Care IPA, C/o ProcareMSO

P.O BOX 7820 La Verne, CA 91750

For EDI Electronic claims: Clearing house is Office Ally and Payer id is PCMSO.

DATE

Transmission from: PREMIER PATIENT CARE IPA
c/o Procare Physician Services MSO, Inc
12828 Harbor Blvd, Suite 300, Garden Grove, CA 92840
Phone: (855) 548-0911 UM Fax: (888) 972-1931

This transmission contains Protected Health Information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

WARNING: This message is intended as notification to **PCP and SPECIALIST**. for authorization of requested services. The following information is confidential and considered privileged by law. If the reader of this transmission is not the intended recipient or a designated party on behalf of **PCP and SPECIALIST**, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you are not the intended recipient, please notify the UM Department at (855) 548-0911 and shred this information. Thank you for your cooperation.

NOTIFICATION TO PCP & REQUESTED PROVIDER OF AUTORIZATION ACTIVITY
Attn: PCP and SPECIALIST

This letter is to notify you, the PCP of MEMBER NAME, that there has recently been authorization activity and to Requested provider - SPECIALIST for the determination on the authorization requested.

AUTHORIZATION: **APPROVED** NOTIFICATION #: **XXXXXXXXXXXXXXXX**

Attn: SPECIALIST
Fax: (XXX) XXX-XXXX

Regarding your request for authorization received XX/XX/XXXX on behalf of the following member

MEMEBER NAME
MEMBER ADDRESS

HEALTHPLAN
MEMBER ID
MEMBER DOB
MEMBER CONTACT

The Medical Director/Physician Reviewer has reviewed your request on, XX/XX/XXXX and Approved the following:

Specialist: SPECIALIST
SPECIALIST ADDRESS

Fax #: (xxx) xxx-xxxx
Phone #: (xxx) xxx-xxxx
Speciality: Specialty

Diagnosis: XX.XXX DIAGNOSIS DESCRIPTION
XX.XXX
XX.XXX

CPT	Modifier Code	CPT Descr	Unit	Reason Code	Note

XXXXX XXXXX		DESCR DESCR	1.00 1.00		

DATE

Transmission from: PREMIER PATIENT CARE IPA
c/o Procare Physician Services MSO, Inc
12828 Harbor Blvd, Suite 300, Garden Grove, CA 92840
Phone: (855) 548-0911 UM Fax: (888) 972-1931

This transmission contains Protected Health Information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

WARNING: This message is intended as notification to **PCP and SPECIALIST**. for authorization of requested services. The following information is confidential and considered privileged by law. If the reader of this transmission is not the intended recipient or a designated party on behalf of **PCP and SPECIALIST**, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you are not the intended recipient, please notify the UM Department at (855) 548-0911 and shred this information. Thank you for your cooperation.

CPT	Modifier Code	CPT Descr	Unit	Reason Code	Note
XXXXX		Descr	1.00		

Reason Code

Place of Service:
Facility:

Notes:
1) Please remember to contact your member within 24 hours of this notice to assist them in setting up an appointment.
2) The member must remain eligible with the health plan/IPA at the time of service for this authorization remain valid. Authorization for the above services will **be effective for DATE.**
3) Questions about this referral may be directed to the Utilization Management Department at (855) 548-091
4) If you disagree with the findings of this Referral, you may **appeal** in writing. You may also request criteria used in this determination. The Medical Director or Physician Reviewer is available to discuss th determination at any time at (855) 548-0911.

QUICKCAP Portal Request Form

Identification

Provider Name: _____

Employee Name: _____

Email Address: _____

Office Address: _____

Phone Number: _____

Tax ID#: _____

IPA(s) Contracted: _____

Requesting Manager

Please allow 7 business days for accounts to be set up. Please use one form per user, maximum up to three users per provider office only. It is the responsibility of the Office Manager to immediately notify ProCare MSO of an individual's removal from the position or no longer employed.

_____ _____

Provider Signature Date

_____ _____

Office Manager Signature Date

Please fax form to ProCare MSO at (888) 972-1931

FOR ADMINISTRATION & IT USE ONLY

Received By: _____

Date: _____

12828 Harbor Blvd Ste 300
Garden Grove, CA 92843
P 714-620-8300 | F: 888-972-1931

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Medical Coverage

Date: <Date> **Member number: <Member Number>**

Name: <Member Name>
[<member address line 1>]
[<member address line 2>]
[<member city, state zip>]

[<Provider Name:>]
[<Date(s) of Service:>]

Your request was *denied*

We've <Insert appropriate term: denied, partially approved, stopped, reduced, suspended> the <Insert appropriate term: Part B drug or Medicaid drug> listed below requested by you or your doctor:

<*Insert services/items here*:>

Why did we deny your request?

We <Insert appropriate term: denied, partially approved, stopped, reduced, suspended> the <Insert appropriate term: Part B drug or Medicaid drug> listed above because:

<Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision>

[Insert the additional text if MA-PD has determined that the requested drug is covered under Part D:

This request was denied under your Medicare Part B benefit; however, coverage/payment for the requested drug(s) has been approved under Medicare Part D [include an explanation of the conditions of approval in a readable and understandable format]. If you think Medicare Part B should cover this *drug for you, you may appeal.*]

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask Health Net to review our decision by asking us for an appeal**.** [<Insert Medicaid information explaining plan level appeal must be exhausted prior to requesting State Fair Hearing or other state external review.>]

Plan Appeal: Ask Health Net for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with Health Net" for information on how to ask for a plan level appeal.

[Insert text shown below, if applicable]

> [***How to keep your services while we review your case:*** *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.]*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-800-275-4737 (CA MA HMO), 1-800-431-9007 (CA C-SNP & D-SNP) to learn how to name your representative. TTY users call 711. Hours of operation From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with Health Net

Standard Appeal – We'll give you a written decision on a standard appeal within **7 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a **Part B drug** you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to **7 days** for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a **Part B drug** you've already received.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within **7 days**.

How to ask for an appeal with Health Net

Step 1: You, your representative, or your doctor [provider] must ask us for an appeal. Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the **Part B drug or Medicaid drug**. Call your doctor if you need this information.

  If you're asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.

We recommend keeping a copy of everything you send us for your records. *You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision*.

Step 2: Mail, fax, or deliver your appeal.

For a Standard Appeal:

Mailing Address:	**In Person Delivery Address:**
Health Net of California, Inc.	Health Net of California, Inc.
Medicare Appeals and Grievances	Medicare Appeals and Grievances
P.O. Box 10450	21281 Burbank Blvd.
Van Nuys, CA 91410-0450	Woodland Hills, CA 91367
	TTY Users Call: 711 (National Relay Service)

Phone: 1-800-275-4737 (CA MA HMO),
1-800-431-9007 (CA C-SNP & D-SNP)
TTY Users Call: 711 (National Relay Service)
Fax: 1-844-273-2671

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: 1-800-275-4737 (HMO), 1-800-431-9007 (CA CSNP & DSNP)
TTY Users Call: 711 (National Relay Service)
Fax: 1-844-273-2671 (Standard & Fast Appeal)

What happens next?

If you ask for an appeal and we continue to deny your request for a **Part B drug or Medicaid drug**, we'll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

[Insert text shown below, if applicable]

How to ask for a Medicaid State Fair Hearing

[Insert the following text only if the service/item or Part B drug or Medicaid drug is subject to Medicaid appeal rights.]

If Health Net denies your appeal request, you can take the steps listed below to request a State Fair Hearing. You or your representative must ask for a State Fair Hearing (in writing or by phone) within (120) days of the date of the notice that denies your appeal request. You have up to (180) days if you have a good reason for your request being late. You can ask for a State Hearing by phone or in writing:

- By phone: Call **1-800-952-5253**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**

- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.]

[A copy of this notice has been sent to:]

Get help & more information

- Health Net Toll Free: 1-800-275-4737 (CA MA HMO), 1-800-431-9007 (CA C-SNP & D-SNP)
  TTY users call: 711
- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays or ca.healthnetadvantage.com
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.acl.gov to find help in your community.
- State or local aging/disability resources contact information: 1-916-419-7500/Local 1-800-510-2020

[May insert instructions for how enrollees can receive this notice in an alternate language or format from the plan.]

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov