Medicare
Carriers Manual
Part 3 - Claims Process

Transmittal 1703   **Date: MAY 4, 2001**

CHANGE REQUEST 1624

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4630 – 4630 (Cont.)	4-441- 4-464 (24 pp.)	4-441 – 4-463 (23 pp.)

NEW/REVISED MATERIAL--EFFECTIVE/IMPLEMENTATION DATE: 07/01/01

Section 4630, Correct Coding Initiative.--This section is being revised to reinstate modifier 25 into the HCPCS modifier listing; update the "Appeals" section with additional correspondence language; reinstate the "Savings Type Indicator Edit" in the Savings Record Format; reinstate the "Savings Type Indicator Edit" in the Systems Record Format; and add "HCPCS" to headings involving CPT procedure code definitions and CPT coding manual instructions and guidelines, to be consistent with actual policy statements.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

4630.   CORRECT CODING INITIATIVE

A.   Effective Date/Scope.--The effective date for the implementation of the Correct Coding Initiative (CCI) edits within your claims processing system is for dates of service on or after January 1, 1996. This applies only to the specific CCI edit combinations and not the associated policies. Where HCFA has previously instructed you to install specific edits, these edits should continue. Your claims processing system should not be altered to reflect the underlying policies of the CCI.

B.   EOMB/ MSN Messages.--The following message should be displayed on the beneficiary's EOMB/MSN for assigned claims for CCI editing on the same claim:

EOMB—"Medicare does not pay for this service because it is part of another service that was performed at the same time." (EOMB message 16.16) or

MSN—"Payment is included in another service received on the same day." (MSN message 16.8)

Display the following message on the beneficiary's EOMB/MSN for assigned claims for CCI editing on different claims:

EOMB—"Medicare has reduced payment for this service because part of this service was paid on another claim. You are not responsible for the amount above the approved amount." (EOMB message 16.27) or

MSN—"This allowance has been reduced by the amount previously paid for a related procedure." (MSN message 16.9)

The following message should be displayed on the beneficiary's EOMB/MSN for unassigned claims for CCI editing on the same claim:

EOMB—"Medicare does not pay for this service because it is part of another service that was performed at the same time." (EOMB message 16.16) "The doctor may not bill or collect more than the Medicare limiting charge." (EOMB message 16.35) (Add EOMB message 16.35 as appropriate for unassigned claims.) or

MSN—"Payment is included in another service received on the same day." (MSN message 16.8) "Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider." (NOTE: this message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by HCFA.)--CO45 with adjustment amount in excess of the limiting charge; PR42 with the amount that is the difference between the allowed amount and the limiting charge for which the beneficiary is liable; if excess payment made by the beneficiary. Also report MA77 or MA78 as applicable for the provider to refund the excess to the beneficiary. (MSN message 30.3)

Display the following message on the beneficiary's EOMB/MSN for unassigned claims for CCI editing on different claims:

Your doctor cannot charge you more than the Medicare charge limit. If you have already paid more than this amount you are entitled to a refund from the provider." (EOMB message 16.28) or

MSN—"This allowance has been reduced by the amount previously paid for a related procedure." (MSN message 16.9)

C.   Remittance Notice Messages.--When either EOMB message 16.16 or 16.35 applies, use claim adjustment reason code B15 ("Claim/service denied/reduced because this service/procedure is not paid separately.") at the service level on the provider remittance notice. Also, use remark code M80 ("We cannot pay for this when performed during the same session as another approved service for this beneficiary.") with the same service on the same provider remittance notice.

When either EOMB/MSN message 16.27 or 16.28 applies, use claim adjustment reason code B10 ("Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.") at the service level on the provider remittance notice. Also, use remark code M80 ("We cannot pay for this when performed during the same session as another approved service for this beneficiary.") with the same service on the same provider remittance notice.

D.   Correct Coding Modifier Indicators and HCPCS Modifiers.--

1.   The Correct Coding File Formats continue to include a Correct Coding Modifier (CCM) indicator for both the Comprehensive/Component Table and the Mutually Exclusive Table. This indicator determines whether a CCM causes the code pair to bypass the edit. This indicator will be either a "0", "1", or a "9". A "0" means that a CCM is not allowed and will not bypass the edits. A "1" means that a CCM is allowed and will bypass the edits. A "9" means that the use of modifiers is not specified. In addition, the "9" indicator is used for all those code pairs that have a deletion date that is the same as the effective date. This indicator was created so that no blank spaces would be in the indicator field.

Following are instructions for codes with modifiers.

2.   Subject all line items with identical modifiers to the CCI edit. Line items with the modifiers listed below are not subject to the CCI edit. Line items with the following modifiers are nevertheless subject to existing instructions such as those in §§4820ff:

E1 - E4, FA, F1 - F9, TA, T1 - T9, LT, RT, -25, -58, -59, -78, -79, LC, LD, RC, and -91.

3.   However, the -59 modifier may not be used with the following codes:

77427 Radiation treatment management, five treatments
99201-99499 Evaluation and management services

When a provider submits a claim for any of the codes specified above with the -59 modifier, process the claim as if the modifier were not present. In addition to those messages specified in subsection B, convey the following message on the providers remittance notice:

"The procedure code is inconsistent with the modifier used, or a required modifier is missing." (ANSI 4)

No additional message should be conveyed on the beneficiary's EOMB/MSN.

4.   The following is background and explanation regarding the -59 modifier.

a.   Definition.--The -59 modifier is used to indicate a distinct procedural service. The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

b.   Rationale.--Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because you cannot easily identify these circumstances, a modifier was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury (in extensive injuries).

c.   Instruction--The secondary, additional, or lesser procedure(s) or service(s) must be identified by adding the modifier -59.

Following are examples of the appropriate use of the -59 modifier:

EXAMPLE 1: CPT codes describing chemotherapy administration include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. For a given agent, only one intravenous route (push or infusion) is appropriate at a given session. It is recognized that frequently combination chemotherapy is provided by different routes at the same session. When this is the case, using the CPT codes 96408, 96410, and 96414, the -59 modifier (different substance) should be attached to the lesser valued technique indicating that separate agents were administered by different techniques.

EXAMPLE 2: When a recurrent incisional or ventral hernia requires repair, the appropriate recurrent incisional or ventral hernia repair code is billed. A code for initial incisional hernia repair is not to be billed in addition to the recurrent incisional or ventral hernia repair unless a medically necessary initial incisional hernia repair is performed at a different site. In this case, the -59 modifier should be attached to the initial incisional hernia repair code.

5.   The following is background and explanation regarding the -91 modifier.

a.   Definition--The -91 modifier is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a lab procedure or service was distinct or separate from other lab services performed on the same day. This may indicate that a repeat clinical diagnostic laboratory test was distinct or separate from a lab panel or other lab services performed on the same day and was performed to obtain subsequent reportable test values.

b.   Rationale.--Multiple laboratory services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because you cannot easily identify these circumstances, a modifier (-91) was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a laboratory procedure code indicates a repeat test or procedure on the same day.

c.   Instruction--The additional, or repeat laboratory procedure(s) or service(s) must be identified by adding the modifier -91.

EXAMPLE: When cytopathology codes are billed, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a family of progressive codes (subsequent codes include services described in the previous CPT code, e.g., 88104-88107, 88160-88162) is to be billed. If multiple services on different specimens are billed, the –91 modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports.

E.   Limiting Charge.--Medicare does not make separate payment for procedures that are part of a more comprehensive group of services nor does it make payment for services that cannot be performed at the same time. These are not medical necessity denials. Instead, payment for the comprehensive procedure includes any separately identified component parts of the procedure. The limitation on liability protections in §1879 of the Act are not a consideration nor are the physician refund protections in §1842(l) of the Act a consideration. The maximum a provider may bill a Medicare beneficiary is whatever the limiting charge is for the comprehensive (Column I) service. This policy has been in effect since January 1, 1991.

The limiting charge provisions of the law apply to those services which are submitted on unassigned claims and are paid under the physician fee schedule, with the exclusion of those which have a Medicare Fee Schedule Data Base status code indicator of "N" (non-covered service); X (statutory exclusion) except for mammography services (which are subject to the limiting charge provisions); and R (restricted coverage), if the service is deemed non-covered.

Procedure codes that are listed in the correct coding initiative and are component parts of other procedures or cannot be performed at the same time are not separately payable when billed with the principal service. Also, these are subject to the charge limits, if the unbundled service is identified with a status code subject to Medicare charge limits. These instances are limiting charge violations and must be included on the affected providers' Limiting Charge Exception Report.

F.   Appeals.--When a request for review is received as a result of an initial determination based on a correct coding initiative edit, and after determining that the reviews were coded correctly, the reviewer must come to the same conclusion as the initial determination (i.e., the review does not result in an increase in payment). If the review determines that a correct coding modifier not submitted with the initial claim could have been appended to either code of an edit code pair, the reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of "1". If the correct coding initiative edit modifier indicator is a "0", the reviewer must come to the same conclusion as the initial determination. If the conclusion is the same as the initial determination, your review determination must repeat the generic language that appears in the EOMB/MSN or remittance advice notice pertaining to the correct coding edit. In addition, you must include the more detailed explanation of the correct coding initiative edit which can be found in the standard correspondence language for Part B Medicare carriers. (See subsections L.1 and L.2.)

G.   Savings Report.--Provide a quarterly report of savings generated by the CCI edits. These quarterly reports are due on the 20th day of the month following the end of the quarter, i.e., April 20th, July 20th, October 20th, and January 20th. The savings files must be in an Extended Binary Code Decimal Interchange Code (EBCDIC) format. The files are to be submitted using the Network Data Mover.

- Multiple files will not be accepted.

- Record all data in EBCDIC and display mode.

- Do not submit compressed data.

Use the following sample Job Control Language (JCL) for sending the savings files to HCFA via Network Data Mover (NDM):

Sample NDM JCL

```
/************************************************************************/
/*  NDM process to transfer files from carrier or FI to HCFA           */
/*      - replace XXXXX with your carrier ID number                     */
/*      - replace FROM DSN name with the file name you are sending to HCFA   */
/*      - USERID,PASSWORD refers to your NDM userid assigned to their facility  */
/************************************************************************/

TESTPROC   PROCESS   SNODEID=(USERID,PASSWORD)
STEPUS01      COPY FROM (DSN=TWxx.@AAA0000.CORRCODE.FILE-
              DISP=SHR
              PNODE)
              TO   (DSN=MU00.@BF12372.CXXXXX,
                  DISP=(NEW,CATLG,DELETE))
                  CKPT=200K
                  COMPRESS
STEPUS02     IF (STEPUS01 = 0) THEN
      RUN JOB (DSN=MU00.@BF12372.CLIST(CXXXXX)) SNODE
      EIF
/*
//
```

Use the following revised record format to report savings:

Savings Record Format

Field	Type	Record Position	Length
Carrier Number	Numeric	1	5
Comprehensive Column 1 Code or Mutually Exclusive Column 1 Code	Character	6	5
Modifier I	Character	11	2
Modifier II	Character	13	2
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	15	5
Modifier I	Character	20	2
Modifier II	Character	22	2
Provider Specialty	Character	24	2
HCPCS Frequency	Numeric	26	10
HCPCS Savings	Numeric	36	12
Savings Type Indicator Edit "1" CCE "2" Mutually Exclusive (Recommended, but not required)	Numeric	48	1

Submit these reports to:

> Health Care Financing Administration
> Program Development and Information Group/Division of Health Plan and Provider Data
> 7500 Security Blvd.
> Mail Stop: C4-14-21
> Baltimore, Maryland 21244-1850

H.   National Technical Information Service (NTIS), Department of Commerce.-The official method for providers to receive the CCI edits is through NTIS at this time. HCFA has designated NTIS as the sole distributor of the CCI edits. The narrative introduction of the NTIS product is considered public domain and may be freely reproduced. However, the specific CPT code combinations may **not** be reproduced. However, it must be noted neither the narrative introduction nor the narrative portion of each chapter is intended to supersede any current Medicare policy. Anyone wishing to receive the CCI edits must purchase them through NTIS.

To purchase the CCI edits call the National Technical Information Service:

>   o   To receive the information by fax, call (703) 605-6880.

>   o   To order subscriptions, call (703) 605-6060 or (800) 363-2068.

Ordering and product information are also available via the World Wide Web at "www.ntis.gov/product/correct-coding.htm".

I.   Adjustments.--Adjust for underpayment if the wrong, lower paying code is paid on the first of multiple claims submitted. If the wrong, higher paying code is paid on the first of multiple claims submitted, pay the subsequent claim(s) and initiate recovery action on the previously paid claim(s).

J.   Professional Component Modifier.--Use modifier 26 when reporting the physician component of a service separately. If this modifier is used with a Column II code that is reported with a Column I code, deny the Column II code with the modifier.

K.   Ambulatory Surgical Center (ASC) Facility.--These instructions also apply to claims for ASC facility services. However, do not pay an ASC facility fee for an approved code under CCI unless that code is on the list of Medicare-covered ASC procedures.

L.   Correspondence Language.--Standard language has been developed for use in correspondence. You may receive questions related to specific code combinations or reductions in payment due to specific codes billed. You have received through standard system maintainers, a list of all CCI edits and an associated correspondence language policy/example number for each procedure code combination. The first position of the Correspondence Language Policy/Example Number refers to the appropriate section of the General Correspondence Language. (See §4630.L.1.) The entire Correspondence Language Policy/Example Number refers to examples of the general policy which can be found in the Correspondence Language Section-specific Examples. (See subsection L.2.)

1.   National Correct Coding Initiative Edit Policy: General Correspondence Language.--

a.   Standard Preparation/Monitoring Services.--Anesthesia services require certain other services to prepare a patient prior to the administration of anesthesia and to monitoring during the course of anesthesia. Additionally, when monitored anesthesia care is provided, the attention devoted to patient monitoring is of a similar level of intensity so that general anesthesia may be established if needed. The specific services necessary to prepare and monitor a patient vary among procedures, based on the extent of the surgical procedure, the type of anesthesia (e.g., general, monitored anesthesia care (MAC), regional, local, etc.), and the surgical risk. Although a determination as to medical necessity and appropriateness must be made by the physician performing the anesthesia, when these services are performed, they are included in the anesthesia service. Accordingly, when reporting the anesthesia service code _____ (comprehensive code), the services described by _____ (component code) are included in the anesthesia service.

b.   HCPCS/CPT Procedure Code Definition.--The CPT procedure code definition, or descriptor, is based upon the consistent interpretation of the procedure performed in contemporary medical practice and by many physicians in clinical practice. When a CPT code associated with a descriptor is submitted to Medicare, all services described by the narrative should have been performed. Because procedures can be performed in different ways and often, several related procedures are performed at a single session, several CPT codes may exist which describe similar procedures performed in different fashions, with different levels of complexity, or associated with other related procedures. Accordingly, several component services, which have different CPT codes, may be described in one, more comprehensive CPT code. Only the single CPT code most accurately describing the procedure performed or service rendered should be reported.

The separate component CPT codes, describing services included in a more comprehensive code, should not be billed. The code _____ (comprehensive) includes the service described by the code _____ (component) according to the CPT descriptors and therefore _____ (component code) is bundled with _____ (comprehensive code).

        c.   HCPCS/CPT Coding Manual Instruction and Guideline.--In addition to CPT procedure code definition or descriptor, instructions and guidelines in CPT are provided either as an introduction to CPT sections or parenthetically. These instructions are further clarified in companion CPT publications such as CPT Assistant copyright by the American Medical Association. In the case of _____ (comprehensive code) and _____ (component code), CPT instructions identify appropriate methodology for code submission and accordingly, _____ (component code) is included in _____ (comprehensive code).

        d.   Mutually Exclusive Procedures.--In order to provide a sufficiently broad listing of descriptive terms and identifying codes in CPT, certain services or procedures are listed which would not reasonably be performed at the same session by the same provider on the same beneficiary. CPT codes that represent services which are related but could not reasonably be performed together have been identified. In the case of _____ (comprehensive code) and _____ (component code), it would be unreasonable to expect these services to be performed at a single patient encounter and, therefore, these CPT codes have been bundled.

        e.   Sequential Procedures.--On occasions where it is necessary that the same provider attempts several procedures in direct succession at a patient encounter to accomplish the same end, only the procedure that successfully accomplishes the expected result is reported. Generally, this occurs when a less extensive procedure fails and requires the performance of a more extensive procedure. Failed procedures (and therefore medically unnecessary procedures) followed by a more extensive procedure should not be separately reported. Procedures that are often performed in sequence have been identified and the less extensive procedure has been bundled into the more extensive procedure. In the case of _____ (comprehensive code) and _____ (component code), when these services are performed in sequence at the same patient encounter, only _____ (comprehensive code) is reported; _____ (component code) is bundled into _____ (comprehensive code).

        f.   CPT Separate Procedure Definition--The CPT parenthetical expression "separate procedure" following a narrative description of a code designates that the procedure or service can be performed alone and independently of, or not immediately related to, other services (in which case it is acceptable) or as a part of a related, more comprehensive procedure. When the service is performed as an integral part of a related procedure, it does not warrant separate identification and should not be reported separately. _____ (component code) is designated as a "separate procedure"; therefore, if it is reported with _____ (comprehensive code), _____ (component code) is bundled with _____ (comprehensive code).

        g.   Most Extensive Procedures.--When a procedure can be performed with varying levels of complexity, CPT has developed code groups which describe a basic procedure but retain different definitions to qualify the codes in the group as to the level of complexity of the procedure. When submitting a CPT code included in a group of codes that describes a procedure, only the code describing the most extensive service that was actually performed is reported. Both_____ (component code) and _____ (comprehensive code) identify a similar procedure but with different levels of complexity; accordingly only the most extensive service, _____ (comprehensive code), actually performed is reported.

        h.   "With" Versus "Without" Procedures.--Certain CPT descriptors identify, as part of the narrative, that the procedure can be performed with or without certain services. CPT code combinations that are identical except that one code describes a procedure without a certain service and the other describes a procedure with that same service cannot be billed together. Since reporting both _____ (comprehensive code) and _____ (component code) represents such a combination and poses a contradiction to the services actually performed in the encounter, _____ (component code) is bundled with _____ (comprehensive code).

i.   Designation of Sex Procedures.--The performance of certain procedures may require significantly different approaches when performed in a male as opposed to a female. CPT code descriptors designate these procedures by specifying if the service or procedure is to be reported for a male or a female or by anatomical description. CPT code combinations that are identical except that one code describes a procedure for a female and the other describes a procedure for a male cannot be reported for the same session, the same provider, and the same beneficiary. CPT codes _____ (comprehensive code) and _____ (component code) represent such a combination and should not be billed together.

j.   Standards of Medical/Surgical Practice.--Under Medicare, all of the services necessary to accomplish a procedure according to standard medical/surgical practices are included in the description of the procedure as provided by CPT. Many ancillary procedures that are typically necessary to accomplish a more comprehensive procedure have been assigned independent CPT codes because they may be performed independently in other settings and may be billed separately. The service described by _____ (component code) is typically included when performing the procedure described by _____ (comprehensive code) and is therefore bundled with _____ (comprehensive code).

k.   Anesthesia Included in Surgical Procedures.--Under the Physicians' Fee Schedule, Medicare does not pay for anesthesia when provided by the same physician who performs the procedure requiring the anesthesia. CPT codes describing anesthesia services or services that are bundled into anesthesia services should not be reported in addition to the basic procedure requiring the anesthesia services. Accordingly, _____ (component code representing the anesthesia service or service bundled into anesthesia) is included in the basic service described by _____ (comprehensive code).

l.   Laboratory Panels.--Laboratory panels, described in CPT as "Organ or Disease Oriented Panels," represent groupings of tests which are commonly performed together in clinical practice. When a CPT code describing a panel is submitted, codes identifying the individual tests included in the panel should not be reported as well. _____ (comprehensive code representing the panel test) includes _____ (component code); accordingly, _____ (component code) is bundled with _____ (panel test or comprehensive code).

m.   Deleted Edits.--Proposed correct coding edits were developed based on review of existing local and national edits, review of standards of medical care, review of CPT instructions and descriptors, and review of provider billing patterns. The initial body of CPT code edits have undergone scrutiny by physicians and providers including Carrier Medical Directors, representatives of the AMA's CPT Advisory Committee, and other national medical societies. Based upon input from these sources, code edits were deleted because they were not compatible with the narrative Correct Coding Policy or the implementation of the code edit would generate logistical conflicts. The CPT code pair _____ (comprehensive code) and _____ (component code) was deleted from the policy recommendations for these reasons.

n.   Misuse of Column 2 code with Column 1 code.--CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating "with or without" a service.) A CPT code should not be reported out of the context for which it was intended. Either intentionally or unintentionally, a provider may report a service or procedure using a CPT code that may be construed to describe the service/procedure but, in no way, was the code intended to be used in this fashion. When CPT code _____ (Column 2 code or component code) is reported as services associated with services described by CPT _____ (Column 1 code or comprehensive code), reporting the former code represents a misuse of this code and should not be separately allowed.

2.   National Correct Coding Initiative Edit Policy: Section-Specific Examples of Correspondence Language.--

a.   Anesthesia (CPT Codes 00000 - 09999).--

Policy Number 1.00000 - Standard Preparation/Monitoring Services.--An example of the policy for standard preparation/monitoring services integral to the anesthesia service is bundling the placement of intravenous access (CPT code 36000) prior to providing general anesthesia. This procedure is necessary to prepare the patient for a general anesthesia and, therefore, the service is included as a part of the anesthesia service. Code 36000 is bundled into all anesthesia service codes.

b.   Integumentary (CPT Codes 10000 - 19999).--

(1)   Policy Number 2.10000 – HCPCS/CPT Procedure Code Definition.--In the example of comprehensive code 19162 and component code 19160 and based on the format of the Physicians' Current Procedural Terminology, the description for code 19162 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 19160 (that part before the semicolon) is also considered a part of code 19162. The full description of code 19162 is mastectomy, partial; with axillary lymphadenectomy. Code 19160 is a component of code 19162 and is appropriately bundled into this procedure.

(2)   Policy Number 3.10000 – HCPCS/CPT Coding Manual Instruction and Guideline.--For example, in the instruction under excision of benign lesions, it is noted that the excision includes simple closure. The comprehensive code of 11400, which represents excision of a benign lesion, except skin tag for the trunk, arms, or legs with a diameter of 0.5 centimeters or less, includes the component code 12001 which describes the simple repair of superficial wounds of the same site up to 2.5 centimeters in diameter. Therefore, code 12001 is bundled with code 11400.

(3)   Policy Number 4.10000 - Mutually Exclusive Procedures.--For example, a physician performing a destruction of a malignant lesion of the arm by any method (code 17260) would not also excise the same malignant lesion of the arm (code 11600). Only one method of treatment of the malignant skin lesion would be rendered on the same lesion in the same session. Therefore, codes 17260 and 11600 are mutually exclusive of each other.

(4)   Policy Number 5.10000 - Sequential Procedures.--For example, if a breast lesion is being excised after preoperative placement of a radiologic marker (code 19125), and intraoperatively the surgeon elects to obtain a confirmatory fine needle aspiration (described by code 88170) at the time of excision, the cytological biopsy (fine needle aspiration) represents a part of the excision procedure. Code 88170 is bundled into code 19125 and thus code 19125 is the appropriate code to report.

(5)   Policy Number 6.10000 - CPT Separate Procedure Definition.--In the example of the comprehensive code 19125 and component code 19100, the needle core biopsy of the breast represented by code 19100 is classified as a "separate procedure." When the service represented by code 19100 is performed with an excision of a breast lesion (CPT code 19125), it is not performed alone or independent of the related and more comprehensive service described by code 19125; therefore, code 19100 cannot be reported separately but rather is bundled into code 19125.

(6)   Policy Number 7.10000 - Most Extensive Procedures.--For example, when a radical mastectomy is performed, the extensive resection of tissue is intended to remove all lesions, in the surgical resection field. While the primary lesion(s) is (are) generally malignant, other lesions, such as cysts, nipple lesions, may also be resected. CPT Code 19240 describes a modified radical mastectomy which includes removal of all breast tissue. Separate reporting of codes, such as 19120 which describe excision of breast lesions such as cysts, etc. is not appropriate with code 19240 because the latter represents the most comprehensive service. In this case code 19120 is bundled into code 19240.

(7)   Policy Number 8.10000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 19272 and component code 19271, the only difference in the code descriptions is the fact that code 19271 does not include mediastinal lymphadenectomy and code 19272 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 19271 is bundled with code 19272.

(8)   Policy Number 10.10000 - Standards of Medical/Surgical Practice.--In the example of comprehensive code 11730 for the simple avulsion of a nail plate, partial or complete with the component code 11040 for skin debridement, if it was necessary to also debride skin at the same time and at the same site of the nail avulsion, then the debridement would be included in the nail avulsion and would be considered a part of the procedure.

(9)   Policy Number 11.10000 - Anesthesia Included in Surgical Procedures.--For example, when a digital procedure avulsion of a nail plate (CPT code 11730) is performed, local anesthesia may be accomplished by the surgeon using a digital nerve block. Because digital nerve block represents anesthesia for the procedure (which is not separately payable when performed by the surgeon), it is inappropriate to report code 64450 for the digital nerve block. Code 64450 is bundled into code 11730 when the same physician performs both procedures.

(10) Policy Number 14.10000 - Misuse of Column 2 Code With Column 1 Code.--For example, CPT code 11900 ("Intralesional injection") is intended to describe a therapeutic cutaneous intralesional injection. It would represent a misuse of the code to **report** this code with other procedures (e.g., CPT code 11400) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure, which is an excision of a benign skin lesion.

    c.   Musculoskeletal (CPT Codes 20000 - 29999).--

(1)   Policy Number 2.20000 – HCPCS/CPT Procedure Code Definition.--In the example of comprehensive code 21045 and component code 21044 and based on the format of the Physicians' Current Procedural Terminology, the description for code 21045 is indented, which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 21044 (that part before the semicolon) is also considered a part of code 21045. The full description of code 21045 is excision of malignant tumor of mandible; radical resection. Code 21044 is a component of code 21045 and is appropriately bundled into this procedure.

(2)   Policy Number 3.20000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 27427 and component code 29889, a parenthetical note under the code description for procedure 29889 states that procedure codes 29888 and 29889 should not be used with reconstruction procedures represented by codes 27427-27429. Thus, the arthroscopic repair or reconstruction of the cruciate ligament is bundled into the related and more comprehensive procedure designated by code 27427.

(3)   Policy Number 4.20000 - Mutually Exclusive Procedures.--In the example of Column 1 code 27441 and Column 2 code 27442, both services describe a knee arthroplasty of the tibial plateau. In any one session on the same knee only one of the two procedures would be performed. Therefore these two services are mutually exclusive of each other.

(4)   Policy Number 5.20000 - Sequential Procedures.--For example, if a deep bone biopsy is performed and an initial attempt by trocar or needle is made (designated by code 20225), followed by an open biopsy at the same site as described by code 20250 in the same session, both codes should not be reported. The procedures have been performed sequentially, and the more comprehensive biopsy procedure, in this case described by code 20250, should be reported.

(5)   Policy Number 6.20000 - Separate Procedure Definition--In the example of the comprehensive code 29876 and component code 29870, the diagnostic knee arthroscopy represented by code 29870 is classified as a "separate procedure". When the service represented by code 29870 is performed with an arthroscopic major synovectomy (code 29876), it is not performed alone or independent of the related and more comprehensive service described by code 29876. Therefore, code 29870 cannot be reported separately but rather is bundled into code 29876.

(6)   Policy Number 7.20000 - Most Extensive Procedures.--For example, if in the course of obtaining a bone biopsy (code 20240), a muscle biopsy is obtained through the same incision (code 20200), the most extensive procedure represented by code 20240 is reported. Therefore, code 20200 is bundled with code 20240.

(7)   Policy Number 8.20000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 21155 and component code 21154, the only difference in the code descriptions is the fact that code 21154 does not include LeFort I and code 21155 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 21154 is bundled with code 21155.

(8)   Policy Number 10.20000 - Standards of Medical/Surgical Practice.--For example, in the course of a radical excision of a bursa or synovia of the wrist, as described by CPT code 25115, it is standard medical practice to attempt to preserve neurologic function by isolating and freeing nerves as necessary. Accordingly, neuroplasty is carried out, if possible, in the course of the excision. Code 64719 for neuroplasty is not reported in this case but rather bundled into the code 25115.

(9)   Policy Number 11.20000 - Anesthesia Included in Surgical Procedures.--For example, in the course of performing a joint or ganglion aspiration (code 20600), a digital nerve block may be performed prior to the procedure. Because this block is being performed for the primary procedure which is the joint aspiration in this case, the digital nerve block (code 64450) is not reported separately but bundled with the primary procedure (code 20600).

(10) Policy Number 14.20000 - Misuse of Column 2 Code With Column 1 Code.--For example, CPT code 20550 ("Injection, tendon sheath, ligament, trigger point or ganglion cyst") is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g., CPT code 28292 for Keller, McBride, or Mayo type procedure) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure.

d.   Respiratory/Cardiovascular/Lymphatic/Diaphragm (CPT Codes 30000 - 39999).--

(1)   Policy Number 2.30000 – HCPCS/CPT Procedure Code Definition--In the example of the comprehensive code 33612 and the component code 33611 and based on the format of the Physicians' Current Procedural Terminology, the description for code 33612 is indented, which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 33611 (that part before the semicolon) is also considered a part of code 33612. The full description of code 33612 is "Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction." Code 33611 is therefore a component of code 33612 and is appropriately bundled into this procedure.

(2)   Policy Number 3.30000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 35142 and component code 35355, authors of the CPT manual, by way of a parenthetical note, instruct the coder that "Procedures 35001 - 35162 include preparation for anastomosis including endarterectomy." Therefore, procedure code 35355 is bundled into code 35142 because the thromboendarterectomy is considered a part of the direct repair of the aneurysm.

(3)   Policy Number 4.30000 - Mutually Exclusive Procedures.--For example, CPT codes 33820 and 33822 describe two types of repairs of the patent ductus arteriosus. Because only one type of repair would be performed at any given time in the same session, these procedures are considered mutually exclusive and would not be reported together.

(4)   Policy Number 5.30000 - Sequential Procedures.--For example, if, at the same session, a percutaneous needle biopsy of the pleura (code 32400) is attempted and/or completed and the patient subsequently (but at the same surgical session) undergoes a thoracotomy to perform an open biopsy of the pleura (code 32402), both the open and the needle biopsy are not reported. In this instance the open biopsy, the most comprehensive service, is reported.

(5)   Policy Number 6.30000 - Separate Procedure Definition—In the example of the comprehensive code 30903 and component code 30801, the cauterization and/or ablation by any method of the mucosa of the unilateral or bilateral turbinates, superficial (CPT code 30801) is classified in the CPT manual as a "separate procedure". When this service represented by code 30801 is performed with the complex control of anterior nasal hemorrhage by any method (CPT code 30903), it is not performed alone or independent of the related and more comprehensive services described by code 30903 and therefore does not meet the criteria for the "separate procedure" definition. For that reason, code 30801 cannot be reported separately but rather is bundled into code 30903.

(6)   Policy Number 7.30000 - Most Extensive Procedures.--For example, when a patient undergoes a thoracotomy for bilobectomy and tissue is removed for biopsy as part of the procedure, the most extensive service is described by CPT code 32482. It would not be appropriate to report separately for a thoracotomy for biopsy of lung as well (code 32095). This procedure is bundled into code 32482.

(7)   Policy Number 8.30000 - "With" Versus "Without" Procedures
In the example of the comprehensive code 31230 and component code 31225, the only difference in the code descriptions is the fact that code 31225 does not include orbital exenteration and code 31230 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 31225 is bundled with code 31230.

(8)   Policy Number 10.30000 - Standards of Medical/Surgical Practice.--For example, if in the course of performing a thoracotomy for bilobectomy (code 32482), it is felt necessary to perform destruction by a neurolytic agent (code 64620), the destruction is believed to be necessary in order to successfully complete the thoracotomy. It is inappropriate to report separately for services described by CPT code 64620 as these services are necessary to complete the procedure. Therefore code 64620 is bundled into code 32482.

(9)   Policy Number 11.30000 - Anesthesia Included in Surgical Procedures.-- For example, if in the course of performing a thoracotomy for bilobectomy (code 32482), it is felt necessary to perform an intercostal nerve block (code 64420), the intercostal nerve block is believed to be necessary in order to successfully complete the thoracotomy. It is inappropriate to report separately for services described by CPT code 64420 as these services are necessary to complete the comprehensive procedure and are bundled with this primary procedure.

(10) Policy Number 14.30000 - Misuse of Column 2 Code With Column 1 Code.--For example, code 35226 ("Repair blood vessel, direct; lower extremity") is intended to describe an open blood vessel repair of the lower extremity. It would represent a misuse of code 35226 to report this code as a repair of the site where a percutaneous removal of an intra-aortic balloon assist device occurred (CPT code 33968).

e.   Digestive (CPT Codes 40000 - 49999).--

(1)   Policy Number 2.40000 – HCPCS/CPT Procedure Code Definition.--In the example of the comprehensive code 45805 and the component code 45800 and based on the format of the Physicians' Current Procedural Terminology, the description for code 45805 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 45800 (that part before the semicolon) is also considered a part of code 45805. The full description of code 45805 is closure of rectovesical fistula ; with colostomy. Code 45800 is a component of code 45805 and is appropriately bundled into this procedure.

(2)   Policy Number 3.40000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 49505 and component code 49568, authors of the CPT manual, by way of an instruction/guideline above code 49495, instruct the coder that "With the exception of the incisional hernia repairs (see 49560-49566) the use of mesh or other prostheses is not separately reported." Therefore, code 49568 (mesh implantation) should not be reported with code 49505 (inguinal hernia repair).

(3)   Policy Number 4.40000 - Mutually Exclusive Procedures.--For example, an esophageal lesion may be excised either through a thoracic or cervical approach but not both. Accordingly, CPT code 43100 is not reported with code 43101, describing different approaches to accomplish the same procedure.

(4)   Policy Number 5.40000 - Sequential Procedures.--For example, if, at the same session, an anoscopy with control of bleeding (code 46614)is performed and is directly followed by an internal/external, complex hemorrhoidectomy described by code 46260 based on the findings of the endoscopic service, the more comprehensive procedure, in this case the hemorrhoidectomy, is reported as a sequential procedure to the anoscopy.

(5)   Policy Number 6.40000 - Separate Procedure Definition--In the example of the comprehensive code 44150 and the component code 44005, the enterolysis represented by code 44005 is classified as a separate procedure. When the service represented by code 44005 is performed with the colectomy (code 44150), it is not performed alone or independent of the related and more comprehensive service described by code 44150. Code 44005 cannot be reported separately but rather is bundled into code 44150.

(6)   Policy Number 7.40000 - Most Extensive Procedures.--For example, when excision of a parotid tumor is performed, it may or may not be accompanied by a unilateral radical neck dissection; completing the parotid tumor excision with a radical neck dissection represents a more extensive procedure than without the radical neck dissection. Accordingly, it is inappropriate to report CPT codes 42425 and 42426, the latter including the radical neck dissection. Only CPT code 42426 is reported if a radical neck dissection accompanied the parotid gland excision.

(7)   Policy Number 8.40000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 40812 and component code 40810, the only difference in the code descriptions is the fact that code 40810 does not include repair and code 40812 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 40810 is bundled with code 40812

(8)   Policy Number 10.40000 - Standards of Medical/Surgical Practice.--For example, in the course of a tonsillectomy (code 42821), bleeding may be expected and the control of the bleeding intraoperatively represents part of the procedure. It is inappropriate to report separately for control of oropharyngeal hemorrhage (code 42961) which occurs during the same operative session. Therefore, code 42961 is bundled with code 42821.

(9)   Policy Number 11.40000 - Anesthesia Included in Surgical Procedures.-- For example, when a local anesthetic injection is performed as a part of an inguinal hernia repair (code 49505), the local anesthetic procedure (code 64425) performed by the surgeon is included in the surgical procedure and is not reported separately. Therefore, code 64425 is bundled into code 49505.

(10)   Policy Number 14.40000 - Misuse of Column 2 Code With Column 1 Code.--For example, CPT code 91105 ("Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poison)") is intended to represent a non-endoscopic procedure. Accordingly, if the only service provided is endoscopic lavage in the course of an upper gastrointestinal endoscopy (e.g., CPT code 43227 for "rigid or flexible esophagoscopy with control of bleeding, any method"), CPT code 91105 should not be separately reported unless performed as a distinct, non-endoscopic procedure.

f.   Genitourinary (CPT Codes 50000 - 59999).--

(1)   Policy Number 2.50000 – HCPCS/CPT Procedure Code Definition.--In the example of comprehensive code 55605 and the component code 55600 and based on the format of the Physicians' Current Procedural Terminology, the description for code 55605 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 55600 (that part before the semicolon) is also considered a part of code 55605. The full description of code 55605 is vesiculotomy; complicated. Code 55600 is a component of code 55605 and is appropriately bundled into this procedure.

(2)   Policy Number 3.50000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 52320 for "cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus" and component code 52332 for "cystourethroscopy, with insertion of indwelling ureteral stent (e.g, Gibbons or double J-type)," there is an instruction above these codes in the CPT manual and under the Section: Ureter and Pelvis which states, "The insertion and removal of a temporary stent during diagnostic or therapeutic cystourethroscopic intervention(s) is included in 52320-52355 and should not be reported separately." Therefore, procedure code 52332 is included in code 52320 based on this CPT manual guideline. If however, a permanent self-retaining, indwelling stent is inserted during cystourethroscopic diagnostic or therapeutic intervention(s), then the –59 modifier may be appended to either code to indicate that the stent represented by code 52332 is a permanent and not a temporary stent.

(3)   Policy Number 4.50000 - Mutually Exclusive Procedures.--For example, when a ureteral diversion is accomplished, it may be diverted to the intestine (ureteroenterostomy, CPT code 50800) or diverted as a ureterostomy (cutaneous, CPT code 50860). For a single ureteral diversion procedure, it is inappropriate to report both codes as these are mutually exclusive procedures.

(4)   Policy Number 5.50000 - Sequential Procedures.--For example, if, at the same session, a needle or punch biopsy of the prostate (CPT code 55700) is undertaken, and is followed by an incisional biopsy (CPT code 55705) either to supplement or to obtain adequate tissue, the appropriate CPT code to report is 55705, not both of these codes.

(5) Policy Number 6.50000 – CPT Separate Procedure Definition.--In the example of the comprehensive code 58150 and the component code 58700, the salpingectomy represented by code 58700 is classified as a "separate procedure". When the service represented by code 58700 is performed with a total abdominal hysterectomy (code 58150), it is not performed alone or independent of the related and more comprehensive service described by code 58150. Code 58700 cannot be reported separately but rather is bundled into code 58150.

(6) Policy Number 7.50000 - Most Extensive Procedures.--For example, when a cystourethroscopy is performed and lesions are identified, biopsied, and removed by laser or cryosurgery, this service is accurately described by CPT code 52224. A less comprehensive service, described by code 52204, which includes the services described above without mention of fulguration of bladder lesions, is not reported in addition to code 52224.

(7) Policy Number 8.50000 - "With " Versus "Without" Procedures.--In the example of the comprehensive code 59151 and component code 59150, the only difference in the code description is the fact that code 59150 does not include salpingectomy and/or oophorectomy, whereas code 59151 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session; therefore, procedure code 59150 is bundled with code 59151.

(8) Policy Number 9.50000 - Designation of Sex Procedures.--For example, procedure code 52270 describes a cystourethroscopy with an internal urethrotomy for a female and code 52275 describes the identical procedure but only for a male. These two procedures cannot be reported for the same session, same provider, and the same beneficiary. Only the appropriate one should be submitted.

(9) Policy Number 10.50000 - Standards of Medical/Surgical Practice.--For example, when a bladder neck suspension is performed under endoscopic control (CPT code 51845), and endoscopy is performed prior to the procedure for assessment of the anticipated surgical field or during the procedure, the endoscopy is necessary to accomplish the procedure. It is inappropriate to submit other endoscopy CPT codes like 52005 for services performed as described above.

(10) Policy Number 11.50000 - Anesthesia Included in Surgical Procedures.-- For example, when a conization of the cervix is performed, as described by CPT code 57520, and anesthesia is provided by the surgeon in the form of an injection of the anesthetic agent into the paracervical (uterine) nerve (CPT code 64435), separate reporting for the anesthesia services is inappropriate. Services described by CPT code 64435 are bundled into code 57520 if performed by the same physician.

(11) Policy Number 14.50000 - Misuse of Column 2 Code with Column 1 Code.--For example, code 44950 ("Appendectomy") is intended to describe an incidental appendectomy during another intra-abdominal surgical procedure which would not warrant separate identification. Therefore, if this procedure was performed incidental to and reported with the more comprehensive code 58152 ["total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpourethrocystopexy (Marshall-Marchetti-Krantz type)"], then this instance would represent a misuse of this code for the appendectomy.

g. Endocrine/Nervous System (CPT Codes 60000 - 69999).--

(1) Policy Number 2.60000 – HCPCS/CPT Procedure Code Definition.--In the example of the comprehensive code 60281 and the component code 60280 and based on the format of the Physicians' Current Procedural Terminology, the description for code 60281 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 60280 (that part before the semicolon) is also considered a part of code 60281. The full description of code 60281 is "Excision of thyroglossal duct cyst or sinus; recurrent." Code 60280 is therefore a component of code 60281 and is appropriately bundled into this procedure.

(2)   Policy Number 3.60000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 66920 and component code 66600, a CPT manual instruction is given at the beginning of the section on lens removal procedures. Iridectomy is a procedure that is included as a part of the service rendered for the extraction of the lens. Therefore, 66600 is one code for iridectomy that is a part of the more comprehensive service, the lens extraction (code 66920), and warrants bundling into code 66920.

(3)   Policy Number 4.60000 - Mutually Exclusive Procedures.--For example, craniectomies may be performed by various methods and different approaches. Accordingly, code 61518 is not reported with code 61526 because these describe separate methods to accomplish the same procedure, in this case the craniectomy.

(4)   Policy Number 5.60000 - Sequential Procedures.--For example, when a fine needle aspiration of the thyroid is attempted, failed and then is followed by a percutaneous core needle biopsy at the same session, the procedure (in this case the core needle biopsy) which was successfully accomplished should be reported. CPT code 88170 is bundled into code 60100.

(5)   Policy Number 6.60000 – CPT Separate Procedure Definition.--In the example of the comprehensive code 65855 and the component code 65860, the severing of adhesions represented by code 65860 is classified as a "separate procedure". When the service represented by code 65860 is performed with a trabeculoplasty (code 65855), it is not performed alone or independent of the related and more comprehensive service described by code 65855. Code 65860 cannot be reported separately but rather is bundled into code 65855.

(6)   Policy Number 7.60000 - Most Extensive Procedures.--For example, when a patient requires destruction of an extensive diabetic retinopathy by photocoagulation (code 67228) as opposed to the destruction of a localized retinal lesion by cryotherapy (code 67208), the more comprehensive service is reported since the destruction of the retinopathy represents the most extensive service.

(7)   Policy Number 8.60000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 60605 and component code 60600, the only difference in the code descriptions is the fact that code 60600 does not include excision of carotid artery and code 60605 does include it. Reporting both codes together is a contradiction in the actual performance of the service at the same session. Therefore, procedure code 60600 is bundled with code 60605.

(8)   Policy Number 10.60000 - Standards of Medical/Surgical Practice.--For example, when an ectropion (accompanied by an everted punctum) is repaired by performing a blepharoplasty, the blepharoplasty procedure, as described by CPT code 67917 would include the procedures necessary to correct the lesion(s), including the associated everted punctum, even if this was accomplished by cautery. It is inappropriate to separately report code 68705 as an independent procedure when performed on the same lid.

(9)   Policy Number 11.60000 - Anesthesia Included in Surgical Procedures.--For example, when anesthesia is provided by the same surgeon removing a cataract (CPT code 66984), the anesthesia service is included in the procedure. Reporting code 64400 for the nerve block separately from the cataract removal is inappropriate.

(10) Policy Number 14.60000 - Misuse of Column 2 Code With Column 1 Code.--For example, CPT code 20550 ("Injection, tendon sheath, ligament, trigger point or ganglion cyst") is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g., CPT code 64721 for carpal tunnel release) when the only service provided is injection of local anesthesia in order to accomplish the comprehensive procedure (the carpal tunnel release) or as part of the comprehensive procedure.

h. Radiology (CPT Codes 70000 - 79999).--

(1) Policy Number 2.70000 – HCPCS/CPT Procedure Code Definition.--In the example of the comprehensive code 71270 and the component code 71260, the complete description of code 71270 is "Computerized axial tomography, thorax; without contrast material, followed by contrast material(s) and further sections." The CT scan with contrast material is included in the service described by code 71270; therefore code 71260 is a component of code 71270 and is appropriately bundled into this procedure.

(2) Policy Number 3.70000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 77600 and component code 77261, a CPT manual instruction is given at the beginning of the section on hyperthermia. It states that "The listed treatments include management during the course of therapy and follow-up care for three months after completion. Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included." Therefore, 77261 is one code for clinical treatment planning that is part of the more comprehensive service, the hyperthermia (code 77600), and warrants bundling into code 77600.

(3) Policy Number 4.70000 - Mutually Exclusive Procedures.-- Cineradiography may be described separately from other radiological procedures in two ways as reflected in the Column 1 code 76125 and Column 2 code 76120. For the same session, it would be inappropriate to report both codes in describing the services necessary to accomplish the same procedure.

(4) Policy Number 6.70000 - CPT Separate Procedure Definition.--In the example of the comprehensive code 70370 and the component code 76000, the fluoroscopy represented by code 76000 is classified as a "separate procedure". When the service represented by code 76000 is performed with a radiologic examination including fluoroscopy (code 70370), it is not performed alone or independent of the related and more comprehensive service described by code 70370. Therefore, code 76000 cannot be reported separately but rather is bundled into code 70370.

(5) Policy Number 7.70000 - Most Extensive Procedures.--For example, when radiologic supervision and interpretation services (S & I) are provided for myelography, there are CPT codes describing localized areas (code 72240 for cervical myelography). CPT code 72270 is to be used when reporting S&I services for myelography of the entire spinal canal. Accordingly, codes 72240 and 72270 are not reported together for services performed on the same session because the service described by 72270 is the most extensive service.

(6) Policy Number 8.70000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 70460 and component code 70450, the only difference in the code descriptions is the fact that code 70450 does not include contrast material and code 70460 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Procedure code 70450 is bundled with code 70460.

(7)   Policy Number 10.70000 - Standards of Medical/Surgical Practice.--For example, when intravenous contrast administration is required for a radiologic examination, such as an abdominal CT scan (reported with CPT code 74170), it is necessary to insert an intravenous catheter to administer the contrast. Since the intravenous catheter is integral to the performance of the test, submission of code 36000 in addition to 74170 is inappropriate.

(8)   Policy Number 14.70000 – Misuse of Column 2 Code with Column 1 Code.--In the example of comprehensive code 77600 and component code 97020, the CPT manual states that "Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy." The hyperthermia may be induced by a variety of sources including application of a microwave modality. Therefore, it is a misuse of the component code 97020, the possible induction source, with comprehensive code 77600 because procedure 97020 does not represent radiation therapy or chemotherapy.

i.   Pathology/Laboratory (CPT Codes 80000 - 89999).--

(1)   Policy Number 2.80000 - HCPCS/CPT Procedure Code Definition.--In the example of the comprehensive code 80192 and the component code 80190 and based on the format of the Physicians' Current Procedural Terminology, the description of code 80192 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 80190 (that part before the semicolon) is also considered a part of code 80192. The full description of code 80192 is procainamide; with metabolites (e.g., n-acetyl procainamide). Code 80190 is therefore a component of code 80192 and is appropriately bundled into this procedure.

(2) Policy Number 3.80000 - HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 87260 and component code 87206, there is a reference note at the beginning of the series of CPT codes 87260-87999 in the CPT manual that states, "Infectious agents by antigen detection, direct fluorescence microscopy, or nucleic acid probe techniques should be reported as precisely as possible. The most specific code possible should be reported." Therefore, code 87206 is included in code 87260 based on this CPT manual guideline.

(3)   Policy Number 4.80000 - Mutually Exclusive Procedures.--There are different ways of performing blood counts for the purpose of obtaining distinct information as reflected by the Column 1 code 85014 and Column 2 code 85024. Both codes should not be reported together; the code that more accurately describes the service rendered should be reported.

(4)   Policy Number 5.80000 - Sequential Procedures.--For example, when a screen cold agglutinin (code 86156) is positive for the presence of cold agglutinins and it is followed by a cold agglutinin titer (code 86157) in the same session, then the tests are considered sequential. Accordingly, the cold agglutinin titer (code 86157), which gives quantitative information, is the service that should be reported.

(5)   Policy Number 7.80000 - Most Extensive Procedures.--For example, the results of certain laboratory determinations may require medical interpretative judgment which the pathologist renders based only on the individual test. In this case, the appropriate CPT code to report is 80500. An attending physician may request the pathologist to interpret the results in the context of the patient's medical history and records, in which case the appropriate CPT code to report is 80502. Because interpreting a test with the perspective of a patient's history and other test results is more comprehensive than interpreting the result as an isolated test, CPT code 80502 is the procedure to report.

(6)   Policy Number 8.80000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 81000 and component code 81002, the only difference in the code descriptions is the fact that code 81002 does not include microscopy and code 81000 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 81002 is bundled with code 81000.

(7)   Policy Number 10.80000 - Standards of Medical/Surgical Practice.--For example, when a glucose tolerance test with three specimens is performed (code 82951), a blood, reagent strip glucose (code 82948) is considered a part of the procedure. Therefore, the more comprehensive service (code 82951) is reported.

(8)   Policy Number 12.80000 - Laboratory Panels.--In the example of code 80076 for the hepatic function panel, the CPT manual indicates that a serum albumin (code 82040) is a part of this laboratory panel of tests. If all seven individual tests which are included in this laboratory panel are performed at the same patient encounter, then the hepatic function panel code 80076 should be reported and not the individual test procedures such as the serum albumin (CPT code 82040). Therefore, it is considered duplicate reporting if these two procedures are billed together. The actual service performed should be reported.

(9)   Policy Number 14.80000 – Misuse of Column 2 Code with Column 1 Code.--In the example of comprehensive code 88141 for the diagnostic cervical or vaginal cytopathology by any reporting system requiring interpretation by a physician which represents the professional component and component code G0143 for screening cervical or vaginal cytopathology by any reporting system with manual screening and rescreening by a cytotechnologist representing the technical component, code 88141 should only be used with the other technical component codes for diagnostic screening by a cytotechnologist, which are CPT codes 88142-88154 and 88164-88167 according to the CPT manual. Reporting code 88141 with G0143 would therefore be a misuse of code 88141 and therefore G0143 is not allowed with 88141 at the same encounter.

j.   Medicine (CPT Codes 90000 - 99999).--

(1)   Policy Number 2.90000 – HCPCS/CPT Procedure Code Definition.--In the example of the comprehensive code 91012 and the component code 91010 and based on the format of the Physicians' Current Procedural Terminology, the description for code 91012 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 91010 (that part before the semicolon) is also considered a part of code 91012. The full description of code 91012 is "esophageal motility study; with acid perfusion studies." Code 91010 is a component of code 91012 and is appropriately bundled into this procedure.

(2)   Policy Number 3.90000 – HCPCS/CPT Coding Manual Instruction and Guideline.--In reference to the example of the comprehensive code 90935 and component code 36145, at the beginning of the dialysis section, authors of the CPT Manual have instructed the coder that all other patient care services which are rendered during a dialysis procedure are included in the dialysis procedure. Since an introduction of a needle or intracatheter to the arteriovenous shunt is performed during dialysis, code 36145 is bundled into the dialysis code 90935.

(3)   Policy Number 4.90000 - Mutually Exclusive Procedures.--For example, when 24 hour EEG monitoring for localization of seizure focus is performed by a portable 16 channel EEG recording, it is appropriate to report CPT code 95953. Because a 16 channel EEG is not also separately performed and transmitted telemetrically (CPT code 95956) over the same 24 hours, codes 95956 and 95953 are not reported together.

(4)   Policy Number 6.90000 - CPT Separate Procedure Definition.--In the example of the comprehensive code 91105 and the component code 91055, gastric intubation and washings represented by code 91055 is classified as a "separate procedure". When the service represented by code 91055 is performed with gastric intubation and aspiration or lavage (code 91105), it is not performed alone or independent of the related and more comprehensive service described by code 91105. Code 91055 cannot be reported separately but rather is bundled into code 91105.

(5)   Policy Number 7.90000 - Most Extensive Procedures.--For example, when a rhythm strip is interpreted, the interpretation is limited to establishing the nature of the cardiac rhythm. This interpretation service is described by code 93042. When an electrocardiogram (CPT code 93010) is performed, interpretation of the rhythm represents a part of the interpretation of the electrocardiogram. Accordingly, when an electrocardiogram is interpreted, only the more extensive service (in this example, code 93010) is reported.

6)   Policy Number 8.90000 - "With" Versus "Without" Procedures.--In the example of the comprehensive code 93732 and component code 93731, the only difference in the code descriptions is the fact that code 93731 does not include reprogramming and code 93732 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 93731 is bundled with code 93732.

(7)   Policy Number 10.90000 - Standards of Medical/Surgical Practice.--For example, when fluorescein angiography is performed (code 92235), it is necessary to obtain vascular access, described by CPT code 36000 for administration of the fluorescein; the test cannot be performed without vascular access. Since the services described by code 36000 are integral to performance of the services described by code 92235, only the latter code is reported.

(8)   Policy Number 11.90000 - Anesthesia Included in Surgical Procedures.--For example, when electroconvulsive therapy (code 90870) is performed, anesthesia is routinely administered for the therapy (code 00104). If the anesthesia is given by the same physician who is performing the therapy, the anesthesia would be included in the therapy service.

(9)   Policy Number 14.90000 - Misuse of Column 2 Code With Column 1 Code.--In the example of code 96912 ("Photochemotherapy; psoralens and ultraviolet A (PUVA)") and code 77401 ("Radiation treatment delivery, superficial and/or ortho voltage"), these two procedures are not intended to describe similar services and are generally provided by different specialists. It is imaginable that one service could be construed as a form of the other but both codes should not be reported to describe one service.

k.   HCPCS/CPT Level II (Codes A0000 - V9999).--

(1)   Policy Number 2. A-V – HCPCS/CPT Procedure Code Definition.--In the example of the comprehensive code G0004 and the component code G0005, the descriptions of both codes include a common portion. "Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period;" is a part of the definitions of both codes. Code G0004 is more comprehensive in that it also "includes transmission, physician review and interpretation" and not just the "recording (includes hook-up, recording and disconnection)" like code G0005. Code G0005 is therefore a component of code G0004 and is appropriately bundled into this procedure.

(2)   Policy Number 4. A-V - Mutually Exclusive Procedures.--For example, colorectal cancer screening with barium enema (code G0120) is an alternative screening method to a colorectal cancer screening by colonoscopy on an individual at high risk (code G0105). Therefore, these codes are not reported together.

(3)   Policy Number 6.A-V – CPT Separate Procedure Definition.--In the example of the comprehensive code G0104 and the component code 36410, the venipuncture represented by code 36410 is classified as a "separate procedure." When the service presented by code 36410 is performed with a flexible sigmoidoscopy for colorectal cancer screening (code G0104), it is not performed alone or independent of the related and more comprehensive service described by code G0104; therefore, code 36410 cannot be reported separately but rather is bundled into code G0104.

(4)   Policy Number 7. A-V - Most Extensive Procedures.--For example, when a complete patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period including transmission, physician review, and interpretation (code G0004) is performed at the same time as a tracing only of a post-symptom telephonic transmission of electrocardiogram rhythm strip(s) and 24 hour attended monitoring, per 30 day period (code G0015), then only one service, the more extensive, more comprehensive procedure should be reported. In this case, G0004 should be reported because it includes both the technical and professional portions of the service and G0015 includes only the technical portion.

(5)   Policy Number 10. A-V - Standards of Medical/Surgical Practice.--For example, the performance of the procedure described in code A4301 ("Implantable access total system; catheter, port/reservoir (venous, arterial or epidural), percutaneous access") includes the service described in code A4300 ["Implantable vascular access portal/catheter (venous, arterial, epidural, or peritoneal)"] as a part of the procedure required to complete the service. Therefore only the complete procedure (code A4301) actually performed should be reported for the same session.

(6)   Policy Number 14.A-V – Misuse of Column 2 code with Column 1 Code.--In the example of comprehensive code G0166 for external counterpulsation per treatment session and component code 93000 for the interpretation and report of a routine ECG with at least 12 leads, reporting code 93000 to represent the triggering by an ECG of the automatic mechanism which activates the balloon catheter in the aorta would be a misuse of code 93000. Therefore, code 93000 would not be allowed in the same encounter as G0166 for this purpose.

3.   National Correct Coding Initiative Edit Policy: Explanation of General Correspondence Language.--The following is an explanation of the General Correspondence Language using, as an example, the code pair 20610 (comprehensive or Column1 code) and 20550 (component or Column 2 code).

a.   Edits--The hard copy of the edits for 20610/20550 shows:

Correspondence Language

Comprehensive Code	Component Code	Policy /Example Number
20610	20550	14.20000

b.   Policy/Example Number 14.20000--The "14" in 14.20000 refers to the 14th policy (Section L.1.n.) in the General Correspondence Language, which states:

Misuse of Column 2 code with Column 1 code: CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating "with or without" a service.) A CPT code should not be reported out of the context for which it was intended. Either

intentionally or unintentionally, a provider may report a service or procedure using a CPT code that may be construed to describe the service/procedure but, in no way, was the code intended to be used in this fashion. When CPT code 20550   (Column 2 code or component code) is reported as services associated with services described by CPT 20610 (Column 1 code or comprehensive code), reporting the former code represents a misuse of this code and should not be separately allowed.

The number "2" in 14.20000 refers to CPT codes in the range of 20000-29999. To find examples of this policy (misuse of column 2 code with column 1 code), go to the section in Correspondence Language Section-specific Examples, which refers to the range of codes which encompasses the comprehensive code of the code pair in question. In this example, the comprehensive code is 20610. It is necessary to go to the section related to CPT codes 20000 – 29999 and look for policy number 14.20000. It states:

"Policy Number 14.20000 – Misuse of Column 2 Code with Column 1 Code.-- For example, CPT code 20550 ("Injection, tendon sheath, ligament, trigger point or ganglion cyst") is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g., CPT code 28292 for Keller, McBride, or Mayo type procedure) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure."

4.   National Correct Coding Initiative Edit Policy: Deleted Codes Examples.-

a.   Policy Number 13.DeletePR3 - Priority 3 Example.--In the course of evaluating a breast mass, a fine needle aspiration procedure (code 88170) is often performed and, in order to obtain sufficient tissue for receptor assay, etc., a needle core biopsy (code 19100) is performed as well. In accordance with the sequential procedure policy, the edit pair 88170 - 19100 was proposed. When commenters identified that the purpose of the core biopsy was not just a sequential procedure to the fine needle aspiration but is frequently performed for different reasons (receptor assays), it was decided that the edit should be deleted from the initial proposal. On the other hand, because of the similarity in the procedures (percutaneous procurement of tissue), it was felt that a potential abuse scenario could occur with a provider reporting both codes (19100 and 88170) when only one procedure was, in fact, performed. This code pair was, therefore, placed in the Priority 3 (fraud/abuse potential) category.

b.   Policy Number 13.DeletePR4 - Priority 4 Example.--In the example of the comprehensive code 93350 and component codes 93015 through 93018, because of changes in instruction under procedure 93350 according to the 1995 CPT Manual, these combinations of correct coding edits were deleted from the recommendations. A parenthetical note under this code now directs the provider of services to report the appropriate stress testing codes in addition to the echocardiogram code 93350.

M.   Correct Coding Edit Files.--The following are the updated record layouts for the Correct Coding Edit Files available to the Standard Systems, Carriers, NTIS, and the Regional Offices via Network Data Mover and HCFA Data Center.

Carrier/Standard Systems Record Format:

Field	Type	Record Position	Length
Comprehensive Column 1 Code or Mutually Exclusive Column 1 Code	Character	1	5
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	6	5
Prior Rebundled Code Indicator "*" rebundled prior to 1996 edits "_" rebundled 1/1/96 or later	Character	11	1
Correspondence Language Reference	Character	12	12
Effective Date (4 position year followed by Julian day)	Numeric	24	7
Deletion Date (4 position year followed by Julian day)	Numeric	31	7
Modifier Indicators "0" No CCE modifier allowed "1" CCE modifier acceptable "9" Use of CCE modifier not specified	Numeric	38	1
Savings Type Indicator Edit "1" CCE "2" Mutually Exclusive	Character	39	1