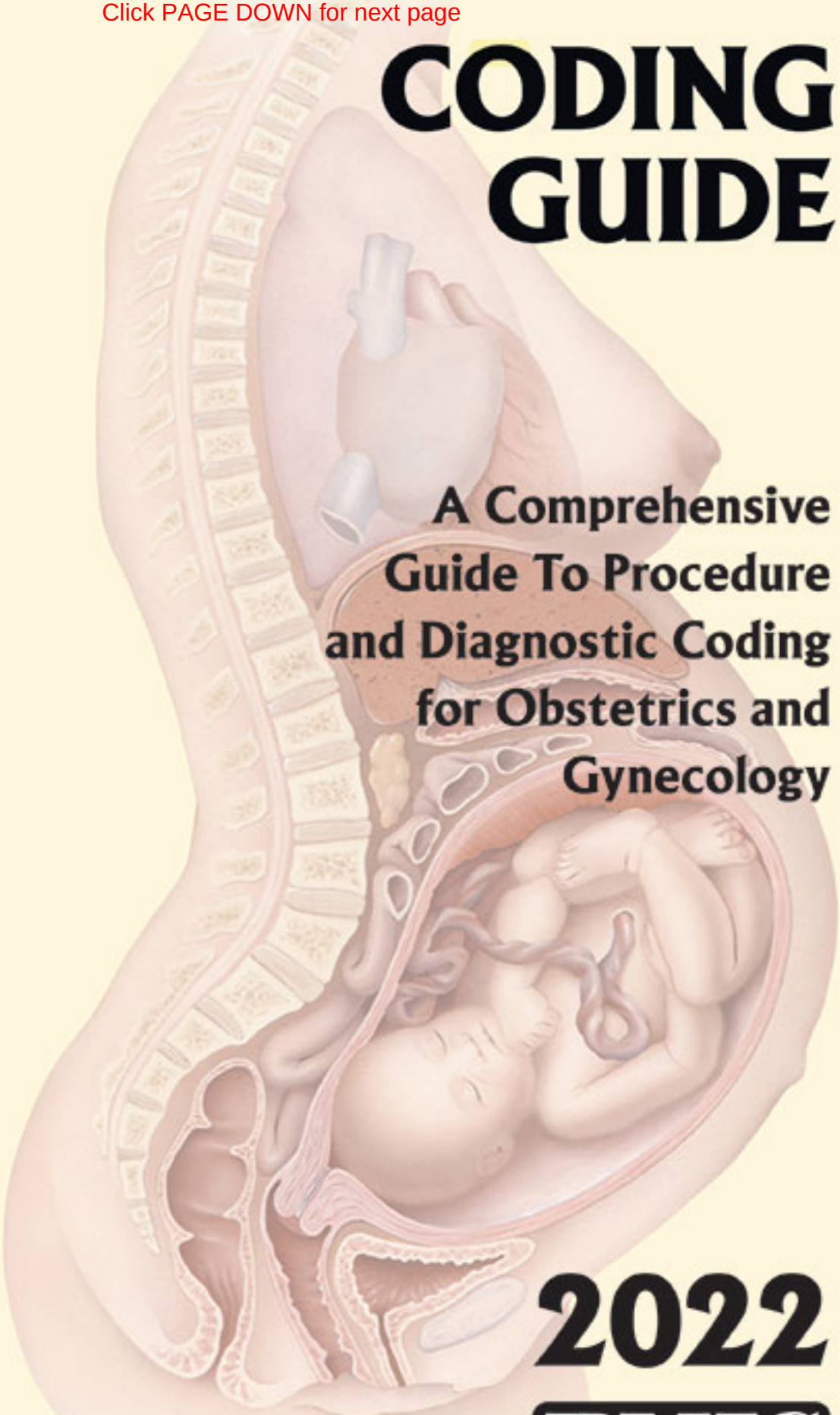
OBSTETRICS & GYNECOLOGY

CODING GUIDE



A Comprehensive Guide To Procedure and Diagnostic Coding for Obstetrics and Gynecology

2022

PMIC
CODING & COMPLIANCE

CONTENTS

INTRODUCTION

Coding and medical terminology is the *language* of medical billing and reimbursement. Fluency in this language is required for all medical personnel involved in the processes of billing for medical services, chart abstracting, coding, medical transcription, and reimbursement management.

Experienced coders know that the process of selecting the correct CPT, HCPCS and ICD-10-CM codes to report medical services and procedures is actually very complicated and complex. Not only do you have to select the correct CPT and ICD-10-CM codes, you have to know: 1) how to interpret, decipher, and transfer medical acronyms, eponyms and abbreviations, 2) when to use HCPCS procedure codes instead of CPT procedure codes, 3) how to sequence multiple procedure codes properly, 4) when to use CPT or HCPCS modifiers, 5) how to sequence multiple ICD-10-CM diagnosis codes, 5) when a medical report is required to support your procedures, 6) if a procedure is covered by Medicare, 7) if there are special billing rules or payment policies for Medicare, and a variety of other rules, regulations, policies and procedures.

This text is designed to provide assistance with coding, compliance, coverage, reimbursement and terminology questions related to the linking of procedure codes and diagnosis codes.

LINKING DIAGNOSIS CODES TO PROCEDURE CODES

While it would appear that "linking" a CPT code to the corresponding ICD-10-CM is a simple process, those with experience in medical coding know that this is not necessarily the case. There are very few procedures which have a single matching diagnosis code.

The correct linking of the ICD-10-CM code to the CPT procedure code is a critical step in both the documentation process and the reimbursement process. Mistakes in the linking process can result in documentation audits for medical necessity in the first instance, and reimbursement audits in the second instance.

In addition to selecting ICD-10-CM codes of the highest specificity, the type of ICD-10-CM chosen, and the order that ICD-10-CM codes are listed on the health insurance claim form can mean the difference between a claim that is delayed or denied versus a claim that is paid.

SOURCES OF THE DATA AND DATA ANALYSIS

The CPT code to ICD-10-CM linkages listed in this book are the result of a computer analysis of over 600 million health insurance claim transactions. To create the source data file, we extracted the specialty code, CPT code, and ICD-10-CM code from each of the input records. From this master data file we extracted a secondary master file for each of the medical specialties.

To maximize the statistical validity of our master data files, we established minimum frequencies for both CPT reporting and CPT/ICD-10-CM link reporting. We excluded all diagnostic linkages which did not meet the minimum frequencies. You will also find some CPT codes that do not include diagnostic data. These CPT codes include those that are within the specialty code ranges but did not pass the minimum frequency for links, and CPT codes that are new and therefore do not have established diagnostic linkages.

Following output, the data files were further scrubbed to omit obviously incorrect CPT codes, i.e. ophthalmology CPT codes included in the orthopaedic specialty file, etc. Diagnosis codes were also scrubbed to exclude obviously incorrect ICD-10-CM codes. Medicare policy data was extracted from the Medicare Physician Fee Schedule. The entire process of data file selection, extraction, and scrubbing was designed, created and implemented by our physician staff working in coordination with our data processing and professional coding staff.

FORMAT OF THE LISTINGS

The coding guide is organized in a simple and familiar format. Each entry includes the CPT code with full description, followed by relevant CPT coding notes, a section on Medicare policies which apply to the procedure, a listing of diagnosis codes that are linked to the procedure code, and the National Correct Coding Initiative (NCCI) Column 2 codes. The format of the book follows the general format of most CPT coding books. The Evaluation and Management codes are listed first,

following by the relevant codes from the Surgery section, then Radiology codes, followed by Laboratory codes and Medicine codes. Each listing includes:

① CPT/HCPCS code with full description
② Coding notes
③ Relative Value Units (RVUs)
④ Medicare policies for follow-up period, multiple procedures, bilateral procedures and payment for assistant surgeon
⑤ Linked ICD-10-CM diagnosis Codes with full descriptions
⑥ Backward mapping to ICD-9-CM codes [in brackets]
⑦ NCCI Column 2 Codes with modifier indicators

Following is an example of a typical listing:

①**58940** Oophorectomy, partial or total, unilateral or bilateral;

②For oophorectomy with concomitant debulking for ovarian malignancy, use 58952.

③**RVUs:** NonFacility Total 15.04 Facility Total 15.04

④**Medicare Policies:** major surgical procedure; follow-up period is 90 days, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment does not apply, assistant surgeon may be paid

⑤**Linked ICD-10-CM Diagnosis Codes:**

C56.1	Malignant neoplasm of right ovary **[183.0]** ⑥
C56.2	Malignant neoplasm of left ovary **[183.0]**
C56.9	Malignant neoplasm of unspecified ovary **[183.0]**
C79.60	Secondary malignant neoplasm of unspecified ovary **[198.6]**
C79.61	Secondary malignant neoplasm of right ovary **[198.6]**
C79.62	Secondary malignant neoplasm of left ovary **[198.6]**
D27.0	Benign neoplasm of right ovary **[220]**
D27.1	Benign neoplasm of left ovary **[220]**
D27.9	Benign neoplasm of unspecified ovary **[220]**
D39.10	Neoplasm of uncertain behavior of unspecified ovary **[236.2]**
D39.11	Neoplasm of uncertain behavior of right ovary **[236.2]**
D39.12	Neoplasm of uncertain behavior of left ovary **[236.2]**
N73.6	Female pelvic peritoneal adhesions (postinfective) **[614.6]**
N83.20	Unspecified ovarian cysts **[620.2]**
N83.29	Other ovarian cysts **[620.2]**
N94.89	Other specified conditions associated with female genital organs and menstrual cycle **[625.9]**
R10.2	Pelvic and perineal pain **[625.9]**
R19.00	Intra-abdominal and pelvic swelling, mass and lump, unspecified site **[789.30]**

⑦**NCCI Column 2 Codes with Modifier Indicators:** 0213T^{N}, 0216T^{N}, 0228T^{N}, 0230T^{N}, 11000^{A}, 11001^{A}, 11004^{A}, 11005^{A}, 11006^{A}, 11042^{A}, 11043^{A}, 11044^{A}, 11045^{A}, 11046^{A}, 11047^{A}, 12001^{A}, 12002^{A}, 12004^{A}, 12005^{A}, 12006^{A}, 12007^{A}, 12011^{A}, 12013^{A}, 12014^{A}, 12015^{A}, 12016^{A}, 12017^{A}, 12018^{A}, 12020^{A}, 12021^{A}, 12031^{A}, 12032^{A}, 12034^{A}, 12035^{A}, 12036^{A}, 12037^{A}, 12041^{A}, 12042^{A}, 12044^{A}, 12045^{A}, 12046^{A}, 12047^{A}, 12051^{A}, 12052^{A}, 12053^{A}, 12054^{A}, 12055^{A}, 12056^{A}, 12057^{A}, 13100^{A}, 13101^{A}, 13102^{A}, 13120^{A}, 13121^{A}, 13122^{A}, 13131^{A}, 13132^{A}, 13133^{A}, 13151^{A}, 13152^{A}, 13153^{A}, 36000^{A}, 36400^{A}, 36405^{A}, 36406^{A}, 36410^{A}, 36420^{A}, 36425^{A}, 36430^{A}, 36440^{A}, 36591^{N}, 36592^{N}, 36600^{A}, 36640^{A}, 43752^{A}, 44005^{N}, 44180^{N}, 44602^{A}, 44603^{A}, 44604^{A}, 44605^{A}, 44820^{N}, 44850^{N}, 44950^{N}, 44970^{N}, 49000^{N}, 49002^{A}, 49010^{N}, 49255^{N}, 49320^{A}, 49321^{A}, 49322^{A}, 49406^{N}, 49570^{N}, 50715^{A}, 51701^{A}, 51702^{A}, 51703^{A}, 52000^{A}, 57410^{N}, 58660^{N}, 58661^{A}, 58662^{A}, 58740^{N}, 58805^{N}, 62320^{N}, 62321^{N}, 62322^{N}, 62323^{N}, 62324^{N}, 62325^{N}, 62326^{N}, 62327^{N}, 64400^{N}, 64402^{N}, 64405^{N}, 64408^{N}, 64410^{N}, 64413^{N}, 64415^{N}, 64416^{N}, 64417^{N}, 64418^{N}, 64420^{N}, 64421^{N}, 64425^{N}, 64430^{N}, 64435^{N}, 64445^{N}, 64446^{N}, 64447^{N}, 64448^{N}, 64449^{N}, 64450^{N}, 64461^{N}, 64463^{N}, 64479^{N}, 64483^{N}, 64486^{N}, 64487^{N}, 64488^{N}, 64489^{N}, 64490^{N}, 64493^{N}, 64505^{N}, 64508^{N}, 64510^{N}, 64517^{N}, 64520^{N}, 64530^{N}, 69990^{N}, 92012^{A}, 92014^{A}, 93000^{A}, 93005^{A}, 93010^{A}, 93040^{A}, 93041^{A}, 93042^{A}, 93318^{A}, 93355^{A}, 94002^{A}, 94200^{A}, 94250^{A}, 94680^{A}, 94681^{A}, 94690^{A}, 94770^{A}, 95812^{A}, 95813^{A}, 95816^{A}, 95819^{A}, 95822^{A}, 95829^{A}, 95955^{A}, 96360^{A}, 96361^{A}, 96365^{A}, 96366^{A}, 96367^{A}, 96368^{A}, 96372^{A}, 96374^{A}, 96375^{A}, 96376^{A}, 96377^{A}, 97597^{A}, 97598^{A}, 97602^{A}, 99155^{N}, 99156^{N}, 99157^{N}, 99211^{A}, 99212^{A}, 99213^{A}, 99214^{A}, 99215^{A}, 99217^{A}, 99218^{A}, 99219^{A}, 99220^{A}, 99221^{A}, 99222^{A}, 99223^{A}, 99231^{A}, 99232^{A}, 99233^{A}, 99234^{A}, 99235^{A}, 99236^{A}, 99238^{A}, 99239^{A}, 99241^{A}, 99242^{A}, 99243^{A}, 99244^{A}, 99245^{A}, 99251^{A}, 99252^{A}, 99253^{A}, 99254^{A}, 99255^{A}, 99291^{A}, 99292^{A}, 99304^{A}, 99305^{A}, 99306^{A}, 99307^{A}, 99308^{A}, 99309^{A}, 99310^{A}, 99315^{A}, 99316^{A}, 99334^{A}, 99335^{A}, 99336^{A}, 99337^{A}, 99347^{A}, 99348^{A}, 99349^{A}, 99350^{A}, 99374^{A}, 99375^{A}, 99377^{A}, 99378^{A}, 99446^{N}, 99447^{N}, 99448^{N}, 99449^{N}, 99495^{N}, 99496^{N}, G0463^{A}, G0471^{A}

GENITOURINARY EXAMINATION

SYSTEM/BODY AREA	ELEMENTS OF EXAMINATION
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth, Throat	
Neck	• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary (female)]
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood test when indicated
Genitourinary (female)	Includes **at least seven of the following eleven** elements identified by bullets: • Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses • Pelvic examination (with or without specimen collection for smears and cultures) including: • External genitalia (e.g., general appearance, hair distribution, lesions) • Urethral meatus (e.g., size, location, lesions, prolapse) • Urethra (e.g., masses, tenderness, scarring) • Bladder (e.g., fullness, masses, tenderness) • Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin ↓	• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)

SYSTEM/BODY AREA	ELEMENTS OF EXAMINATION
Neurologic/Psychiatric	Brief assessment of mental status including: • Orientation to time, place and person • Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS	
LEVEL OF EXAM	**PERFORM AND DOCUMENT:**
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

NATIONAL CORRECT CODING POLICY

INTRODUCTION

Healthcare providers utilize HCPCS/CPT codes to report medical services performed on patients to Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries (FIs). HCPCS (Healthcare Common Procedure Coding System) 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 coding system 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 three times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific 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 by 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 NCCI to prevent inappropriate payment of services that should not be reported together. Prior to April 1, 2012, NCCI 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 the NCCI PTP edits are currently contained in this single table.

Combining the two 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 two 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 utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment. (NCCI-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 two 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 an 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) under most circumstances reportable 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. More information concerning MUEs is discussed in Section V of this chapter.

In this publication many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this publication, 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.

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.

Physicians must report services correctly. This publication 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 utilized with an endoscopic procedure code.

- A physician shall not unbundle a bilateral procedure code into two 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 two units of service 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 down coding. 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 up coding. 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 units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician shall not report units of service 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. MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service.

Physicians 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 coding system modified the numbering of codes so that the sequence of codes as they appear in the CPT coding system does not necessarily correspond to a sequential numbering of

EVALUATION & MANAGEMENT SERVICES

The evaluation and management codes, commonly referred to as E/M service codes, were developed by a special CPT editorial panel working in conjunction with the Physician Payment Review Committee (PPRC). The use of these codes was mandated by law for all Medicare claims for services rendered on or after January 1, 1992. Private carriers were not required to adopt or use these new codes; however, the historical trend is that new policies and procedures mandated by Medicare are followed shortly by Medicaid and private health insurance.

CLASSIFICATION OF EVALUATION AND MANAGEMENT SERVICES

The Evaluation and Management section of the CPT code book includes codes for reporting visits, consultations, prolonged service, case management services, preventive medicine services, newborn care, and special services. The section is divided into categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories.

The subcategories for E/M services are further classified into levels of service that are identified by specific codes. The level of service classification is important, because the physician work required to provide the service varies by the type of service, the place of service, and the patient's clinical status.

The basic format of the E/M service codes and definitions is the same for most categories.

- A unique five-digit CPT code number is listed.
- The *place* and/or *type* of service is specified, for example, "office consultation."
- The *content* of the service is defined, for example, "comprehensive history and comprehensive examination."
- The *nature* of the presenting problem(s) usually associated with a given level is described.
- The *time* typically required to provide the service is specified.

SUBSECTION INFORMATION

The Evaluation and Management section of the CPT code book is divided into 19 subsections, namely:

Office or Other Outpatient Services	99201-99215
Hospital Observation Discharge Services	99217
Hospital Observation Services	99217-99220
Hospital Inpatient Services	99221-99239
Consultations	99241-99255
Emergency Department Services	99281-99288
Critical Care Services	99291-99292
Nursing Facility Services	99304-99318
Domiciliary, Rest Home, or Custodial Care Services	99324-99328
Domiciliary, Rest Home, or Home Care Plan Oversight	99339-99340
Home Services	99341-99350
Prolonged Services	99354-99360
Case Management Services	99361-99373
Care Plan Oversight Services	99374-99380
Preventive Medicine Services	99381-99429
Non-Face-to-Face Physician Services	99441-99444
Special Evaluation and Management Services	99450-99456
Newborn Care	99460-99465
Neonatal and Pediatric Critical Care Services	99466-99480
Other Evaluation and Management Services	99499

All subsections within the Evaluation and Management section have extensive notes that should be reviewed carefully prior to selecting codes for services located within the section.

MATERIALS SUPPLIED BY THE PHYSICIAN

Supplies and materials provided by the physician over and above those usually included with the E/M or other services rendered may be listed separately. List all drugs, trays, supplies, and materials provided.

DEFINITIONS OF COMMONLY USED TERMS

Certain key words and phrases are used throughout the Evaluation and Management section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

NEW AND ESTABLISHED PATIENTS

E/M services are further classified depending upon the relationship of the patient to the physician. *New* patients typically require more physician work and more time than *established* patients, a fact that is acknowledged by the relative values of the E/M service codes.

In the CPT code book, a *new patient* is defined as "one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years."

An *established patient* is defined as "one who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years."

If the physician is on call or providing coverage for another physician, the patient's encounter is classified as "new" or "established" exactly as it would have been by the original physician.

There is no distinction made between new and established patients in the emergency department. E/M services in the emergency category may be reported for any new or established patient who presents for treatment in the emergency department. See the Decision Tree on the next page.

CHIEF COMPLAINT

Provide a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter with the patient. This is usually stated in the patient's own words.

CONCURRENT CARE

Concurrent care is the provision of similar services, for example hospital visits, to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. However, in order to distinguish your services from those of another physician on the same date, it is important that you carefully record the diagnostic codes that made the visit necessary.

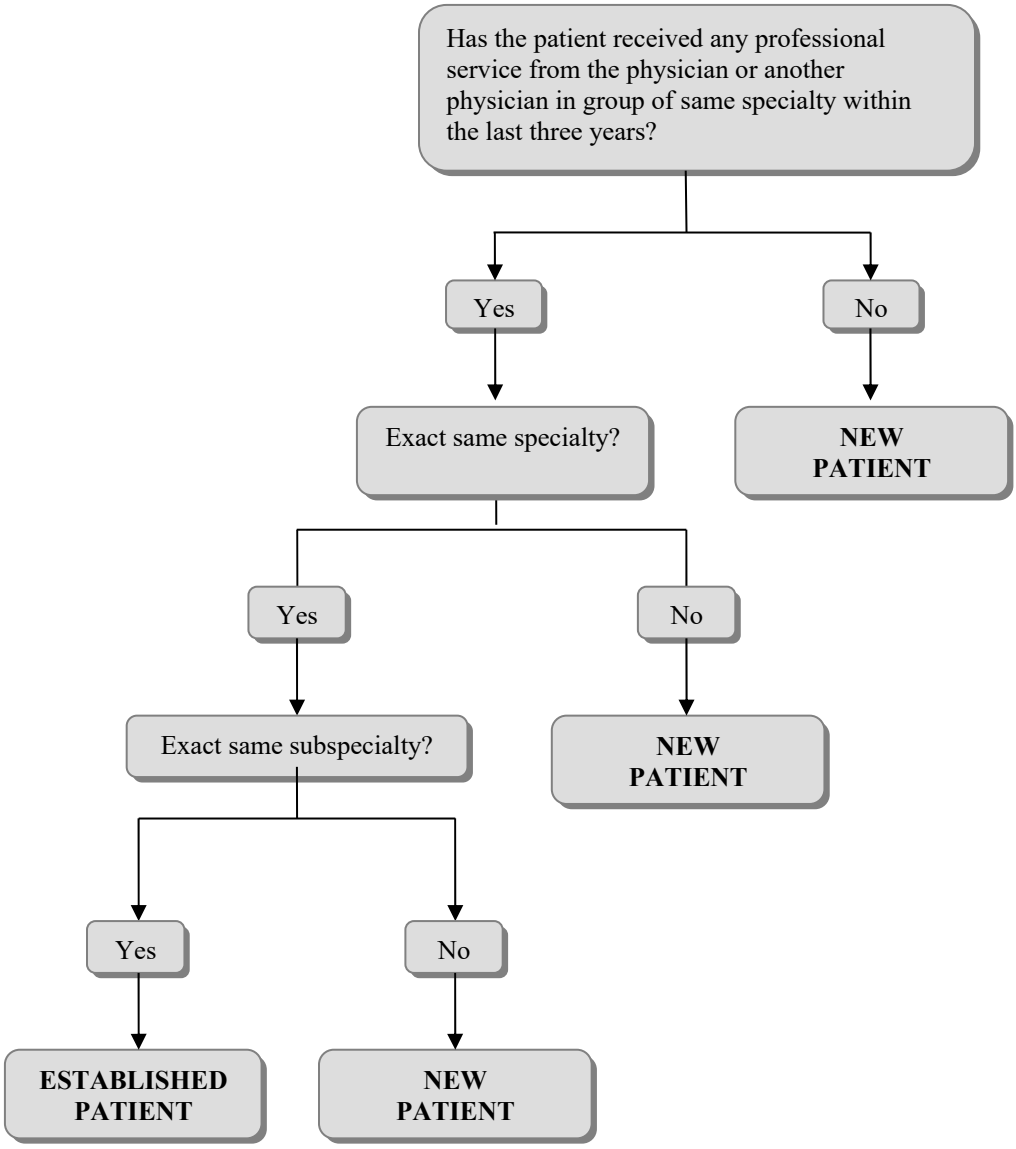
COUNSELING

Counseling is defined in the CPT code book as "a discussion with a patient and/or family" concerning one or more of the following:

- diagnostic results, impressions, and/or recommended diagnostic studies
- the prognosis
- the risks and benefits of treatment options
- instructions for treatment and/or follow-up
- the importance of compliance with treatment options
- risk factor reduction
- patient and family education

Counseling is listed as one of the seven components of E/M services; however, there are no specified measurements included in the definition of the services.

Decision Tree for New vs Established Patients



HISTORY

FAMILY HISTORY

The family history includes a review of medical events in the patient's family that includes: 1) significant information about the health status or cause of death of parents, siblings, and children, 2) specific diseases related to problems identified in the chief complaint or history of the present illness or system review, and 3) diseases of family members that may be hereditary or place the patient at risk.

HISTORY OF THE PRESENT ILLNESS

Provide a chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem.

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.

EVALUATION & MANAGEMENT SERVICES CODES

OFFICE OR OTHER OUTPATIENT VISITS

The following codes are used to report E./M services provided to new and established patients in the office or other outpatient facility, including the emergency department when the physician is not assigned to the emergency department. The key coding issues are the extent of history obtained, the extent of examination performed, and the complexity of medical decision making. Additional reporting issues include counseling and/or coordination of care, the nature of presenting problem(s), and the duration of face-to-face time spent with the patient and/or family.

CODING RULES

1. A patient is considered an outpatient until admitted as an inpatient to a health care facility.

2. If outpatient evaluation and management services are provided in conjunction with, or result in, an inpatient admission, the service is reported using CPT codes for initial hospital care.

3. CPT codes in this section may also be used to report the services provided by a physician to a patient in an observation area of a hospital.

4. Laboratory tests, radiology services, and diagnostic or therapeutic procedures performed in conjunction with evaluation and management services are reported in addition to the basic evaluation and management service.
5. Supplies and materials provided by the physician over and above those usually included with the evaluation and management or other services rendered may be listed separately. List all drugs, trays, supplies and materials provided.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or initial nursing facility care.

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history;
- a detailed examination;
- and medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination;
- and medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination;
- and medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a problem focused history;
- a problem focused examination;
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- an expanded problem focused history;
- an expanded problem focused examination;
- medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed history;
- a detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

SURGERY SERVICES

SURGERY SECTION OVERVIEW

The third section of the CPT coding system is the surgery section, and it includes surgical procedure codes for all body areas. Within each subsection, the CPT codes are arranged by anatomical site. It is essential to understand the organization of the CPT surgery section in order to locate the correct procedure code. Understanding other or alternative terms which may apply to a procedure, injury, illness or condition may also make the location of the appropriate procedure easier and faster.

All procedures listed in the surgery section of the CPT coding system include local, metacarpal/digital block or topical anesthesia if used, the surgical procedure, and normal uncomplicated follow-up care. For diagnostic surgical procedures, follow-up care includes only the care related to recovery from the diagnostic procedure. For therapeutic surgical procedures, follow-up care includes only the care which would usually be included in the surgical service. Any complications resulting in additional services are not considered to be included and should be coded separately.

KEY POINTS ABOUT SURGERY SERVICES

- Evaluation and management services provided by surgeons in the office, home or hospital, plus consultations and other medical services are coded using evaluation and management service codes.
- Any supplies and/or materials provided by the surgeon which are not considered to be included in the standard service may be coded separately.

GLOBAL SURGICAL PACKAGE

Third-party payers differ in their definition of a surgical or global surgical package concept. Medicare defines the global surgical package as follows:

- The surgeon's initial evaluation or consultation will be paid separately.
- There is a one day preoperative period covered under the global surgical package.
- Included in the package are all intraoperative services that are considered to be usual and necessary. Separate billing of these services would be considered unbundling.
- Any treatment of complications by the surgeon not requiring a return to the operating room is included in the package.
- The surgical package contains a standard 90-day postoperative period which includes all visits to the physician during that time unless the visit is for a totally different reason than that for the surgery.
- In cases of organ transplant, immunosuppressive therapy is not included in the global package.
- Minor surgical procedures are those with a 0 or 10-day postoperative period, and are excluded from the surgical package definition.

SPECIAL REPORT

Surgical procedures which are new, unusual or vary significantly from the standard definition may require a special report. When preparing reports to accompany health insurance claim forms the provider should include a description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provides the service. Try to keep these reports as brief and simple as possible. Additional items which may be needed are:

- complexity of symptoms
- final diagnosis
- pertinent physical findings
- diagnostic and therapeutic procedures
- concurrent problems
- follow-up care

MULTIPLE SURGICAL PROCEDURES

It is common for several surgical procedures to be performed at the same operative session. When multiple procedures are performed on the same day or at the same session, the "major" procedure or service is listed first followed by secondary, additional, or "lesser" procedures or services. CPT modifier -51 is added to all procedures following the first one.

Reporting multiple procedures incorrectly may have a serious impact on reimbursement from health insurance payers. An inexperienced health insurance biller may simply list the procedures on the health insurance claim form in the order dictated or described in the operative report.

There are two critical decisions related to reporting multiple surgical procedures correctly; namely: 1) The order in which the procedures are listed on the health insurance claim form, and 2) whether or not to list the additional procedures with full or reduced fees.

ORDER OF LISTING MULTIPLE PROCEDURES

The first procedure to be listed when reporting services under the multiple procedure rule is the procedure with the highest fee. Additional procedures should be listed in descending order by fee. Modifier -51 should be added to each additional procedure.

All third party payers will reduce the allowance for the additional procedures, typically by 50 percent for the second procedure, and 50 to 75 percent for the third and subsequent procedures. Listing the procedures in descending order by fee minimizes the possibility of an incorrect reduction.

SEPARATE PROCEDURE

Some surgical procedures are considered to be an integral part of a more extensive surgical procedure. In this circumstance, the integral procedure is not coded. When the integral procedure is performed independently and is unrelated to other services, it should be listed as a "separate procedure."

SURGERY SUBSECTIONS

The SURGERY section of the CPT coding system is divided into subsections:

Integumentary System	10040-19499
Musculoskeletal System	20000-29999
Respiratory System	30000-32999
Cardiovascular System	33010-37799
Hemic and Lymphatic Systems	38100-38999
Mediastinum and Diaphragm	39000-39599
Digestive System	40490-49999
Urinary System	50010-53899
Male Genital System	54000-55899
Intersex Surgery	55970-55980
Female Genital Surgery	56405-58999
Maternity Care and Delivery	59000-59899
Endocrine System	60000-60699
Nervous System	61000-64999
Eye and Ocular Adnexa	65091-68899
Auditory System	69000-69979
Operating Microscope	69990

Each sub-section of the SURGERY section of the CPT coding system is divided into organs then into procedures involving anatomic sites. Each anatomic site is further separated into surgical processes such as incision, excision, repair, removal, amputation, etc.

SURGERY SECTION MODIFIERS

Due to various circumstances, surgical procedures may be considered to be modified in comparison to the full or complete procedure. Modified procedures are identified by reporting a two-digit modifier to the CPT procedure code(s). The following CPT modifiers may be coded with surgical procedures:

-22 Unusual Procedural Services
-26 Professional Component
-32 Mandated Services
-47 Anesthesia by Surgeon
-50 Bilateral Procedure
-51 Multiple Procedures
-52 Reduced Services
-54 Surgical Care Only
-55 Postoperative Management Only
-56 Preoperative Management Only
-57 Decision for Surgery
-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
-62 Two Surgeons
-66 Surgical Team
-76 Repeat Procedure by Same Physician
-77 Repeat Procedure by Another Physician
-78 Return to the Operating Room for a Related Procedure During the Postoperative Period
-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period
-80 Assistant Surgeon
-81 Minimum Assistant Surgeon
-82 Assistant Surgeon (when qualified resident surgeon not available)
-90 Reference (Outside) Laboratory
-99 Multiple modifiers

ADD-ON CODES

Many surgical procedures are performed secondary to primary surgical procedures. These procedures are classified as "additional" or "supplemental" procedures and are designated as "add-on" codes in the CPT coding system.

"Add-on" CPT codes are identified in the CPT code book by a black plus sign "+" placed to the left of the code number. Many of the CPT "Add-on" codes are further identified by phrases included within the descriptions of the definition of the CPT code or include the phrase "(List separately in addition to primary procedure)" following the definition.

STARRED PROCEDURES

CPT used to define minor surgical procedures by placing a star (*) after the procedure code number. This designation was removed in CPT 2004.

MEDICAL AND SURGICAL SUPPLIES

HCPCS Level II codes for medical and surgical supplies, A4000-A4999, may be used to report supplies and materials provided to Medicare patients if the supplies and materials are not considered to be included with or part of the basic service(s) or procedure(s).

EVALUATION AND MANAGEMENT (E & M) SERVICES

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E & M) services with procedures covered by these rules. This section summarizes some of the rules.

DIGESTIVE SYSTEM

CORRECT CODING GUIDELINES

INTRODUCTION

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 40000-49999. 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 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.

ENDOSCOPIC SERVICES

Endoscopic services may be performed in many places of service (e.g., office, outpatient, ambulatory surgical centers (ASC)). Services that are an integral component of an endoscopic procedure are not separately reportable. These services include, but are not limited to, venous access (e.g., CPT code 36000), infusion/injection (e.g., CPT codes 96360-96377), non-invasive oximetry (e.g., CPT codes 94760 and 94761), and anesthesia provided by the surgeon.

1. Per CPT coding system instructions, surgical endoscopy includes diagnostic endoscopy. A diagnostic endoscopy HCPCS/CPT code shall not be reported with a surgical endoscopy code.

2. If multiple endoscopic services are performed, the most comprehensive code describing the service(s) rendered shall be reported. If multiple services are performed and not adequately described by a single HCPCS/CPT code, more than one code may be reported. The multiple procedure modifier 51 should be appended to the secondary HCPCS/CPT code. Only medically necessary services may be reported. Incidental examination of other areas shall not be reported separately.

3. If the same endoscopic procedure (e.g., polypectomy) is performed multiple times at a single patient encounter in the same region as defined by the CPT coding system narrative, only one CPT code may be reported with one unit of service.

4. 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.

5. If an endoscopy or enteroscopy is performed as a common standard of practice when performing another service, the endoscopy or enteroscopy is not separately reportable. For example, if a small intestinal endoscopy or enteroscopy is performed during the creation or revision of an enterostomy, the small intestinal endoscopy or enteroscopy is not separately reportable.

6. A “scout” endoscopy to assess anatomic landmarks or assess extent of disease preceding another surgical procedure at the same patient encounter is not separately reportable. However, an endoscopic procedure for diagnostic purposes to decide whether a more extensive open procedure needs to be performed is separately reportable. In the latter situation,

modifier 58 may be utilized to indicate that the diagnostic endoscopy and more extensive open procedure were staged procedures.

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.

7. If a non-endoscopic esophageal dilation (e.g., CPT codes 43450, 43453) fails and is followed by an endoscopic esophageal dilation procedure (e.g., CPT codes 43213, 43214, 43233), only the endoscopic esophageal dilation procedure may be reported. The physician shall not report the failed procedure.

8. If it is necessary to perform diagnostic or surgical endoscopy of the hepatic/biliary/pancreatic system utilizing different methodologies (e.g., biliary T-tube endoscopy, ERCP) multiple CPT codes may be reported. Modifier 51 indicating multiple procedures were performed at the same patient encounter should be appended.

9. Intubation of the gastrointestinal tract (e.g., percutaneous placement of G-tube) includes subsequent non-endoscopic removal of the tube. CPT codes such as 43247 (upper gastrointestinal endoscopic removal of foreign body(s)) shall not be reported for non-endoscopic removal of previously placed therapeutic devices. However, if a previously placed therapeutic device must be removed endoscopically because it cannot be removed by a non-endoscopic procedure, a CPT code such as 43247 may be reported for the endoscopic removal.

10. Rules for reporting biopsies performed at the same patient encounter as an excision, destruction, or other type of removal are discussed in Section H (General Policy Statements) (paragraph 21).

11. Control of bleeding is an integral component of endoscopic procedures and is not separately reportable. For example, if a provider performs endoscopic band ligation(s) by flexible sigmoidoscopy (CPT code 45350) or colonoscopy (CPT code 45398), control of bleeding is not separately reportable with CPT codes 45334 (flexible sigmoidoscopic control of bleeding) or 45382 (colonoscopic control of bleeding) respectively.

    If it is necessary to repeat an endoscopy to control bleeding at a separate patient encounter on the same date of service, the HCPCS/CPT code for endoscopy for control of bleeding is separately reportable with modifier 78 indicating that the procedure required return to the operating room (or endoscopy suite) for a related procedure during the postoperative period.

12. Only the more extensive endoscopic procedure may be reported for a patient encounter. For example if a sigmoidoscopy is completed and the physician also performs a colonoscopy during the same patient encounter, only the colonoscopy may be reported.

13. If an endoscopic procedure fails and is converted into an open procedure at the same patient encounter, only the open procedure is reportable. Neither a surgical endoscopy nor diagnostic endoscopy procedure code shall be reported with the open procedure code when an endoscopic procedure is converted to an open procedure.

14. If a transabdominal colonoscopy via colostomy and/or standard sigmoidoscopy or colonoscopy is performed as a necessary part of an open procedure (e.g., colectomy), the endoscopic procedure(s) is (are)not separately reportable. However, if either endoscopic procedure is performed as a diagnostic procedure upon which the decision to perform the open procedure is made, the endoscopic procedure may be reported separately. Modifier 58 may be utilized to indicate that the diagnostic endoscopy and the open procedure were staged or planned services. (CPT code 45355 was deleted January 1, 2015.)

15. If the larynx is viewed through an esophagoscope or upper gastrointestinal endoscope during endoscopy, a laryngoscopy CPT code cannot be reported separately. However, if a medically necessary laryngoscopy is performed with a separate laryngoscope, both the laryngoscopy and esophagoscopy (or upper gastro-intestinal endoscopy) CPT codes may be reported with NCCI-associated modifiers.

16. Fluoroscopy (CPT code 76000) is an integral component of all endoscopic procedures when performed. CPT code 76000 shall not be reported separately with an endoscopic procedure. For example, fluoroscopy (e.g., CPT code 76000) is not separately reportable with CPT codes describing gastrointestinal endoscopy for foreign body removal (e.g., 43194, 43215, 43247, 44390, 45332, 45379). (CPT code 76001 was deleted January 1, 2019.)

ESOPHAGEAL PROCEDURES

CPT codes 39000 and 39010 describe mediastinotomy by cervical or thoracic approach respectively with "exploration, drainage, removal of foreign body, or biopsy". Exploration of the surgical field is not separately reportable with another procedure performed in the surgical field. CPT codes 39000 and 39010 shall not be reported separately for exploration of the mediastinum when performed with an esophageal procedure. These codes may be reported separately if mediastinal drainage, removal of foreign body, or biopsy is performed. However, these codes shall not be reported separately for removal of foreign body with CPT code 43020 (esophagotomy, cervical approach, with removal of foreign body) or CPT code 43045 (esophagotomy, thoracic approach, with removal of foreign body).

ABDOMINAL PROCEDURES

1. During an open abdominal procedure exploration of the surgical field is routinely performed to identify anatomic structures and disease. An exploratory laparotomy (CPT code 49000) is not separately reportable with an open abdominal procedure.

2. Hepatectomy procedures (e.g., CPT codes 47120-47130, 47133-47142) include removal of the gallbladder based on anatomic considerations and standards of practice. A cholecystectomy CPT code is not separately reportable with a hepatectomy CPT code.

3. A medically necessary appendectomy may be reported separately. However, an incidental appendectomy of a normal appendix during another abdominal procedure is not separately reportable.

4. If a hernia repair is performed at the site of an incision for an open or laparoscopic abdominal procedure, the hernia repair (e.g., CPT codes 49560-49566, 49652-49657) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and shall not be reported separately.

5. If a recurrent hernia requires repair, a recurrent hernia repair code may be reported. A code for incisional hernia repair shall not be reported in addition to the recurrent hernia repair code unless a medically necessary incisional hernia repair is performed at a different site. In the latter case, modifier 59 should be appended to the incisional hernia repair code.

6. CPT code 49568 is an add-on code describing implantation of mesh or other prosthesis for incisional or ventral hernia repair. This code may be reported with incisional or ventral hernia repair CPT codes 49560-49566. Although mesh or other prosthesis may be implanted with other types of hernia repairs, CPT code 49568 shall not be reported with these other hernia repair codes. If a provider performs an incisional or ventral hernia repair with mesh/prosthesis implantation as well as another type of hernia repair at the same patient encounter, CPT code 49568 may be reported with modifier 59 to bypass edits bundling CPT code 49568 into all hernia repair codes other than the incisional or ventral hernia repair codes.

7. Most CPT codes that describe a procedure that includes a hernia repair include insertion of mesh or other prosthesis. CPT codes describing implantation of mesh or other prosthesis (e.g., 15777, 49568, 57267, 0437T) shall not be reported with a procedure including a hernia repair unless there is a CPT coding system instruction specifically stating that the implantation of mesh or other prosthesis CPT code may be reported with that procedure.

8. Removal of excessive skin and subcutaneous tissue (panniculectomy) at the site of an abdominal incision for an open procedure including hernia repair is not separately reportable. CPT code 15830 shall not be reported for this type of panniculectomy. However, an abdominoplasty which requires significantly more work than a panniculectomy is separately reportable.

9. Open enterolysis (CPT code 44005) and laparoscopic enterolysis (CPT code 44180) are defined by the CPT coding system as "separate procedures". They are not separately reportable with other intra-abdominal or pelvic procedures. However, if a provider performs an extensive and time-consuming enterolysis in conjunction with another intra-abdominal or pelvic procedure, the provider may append modifier 22 to the CPT code describing the latter procedure. The local carrier (A/B MAC processing practitioner service claims) will determine whether additional payment is appropriate.

corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

28. 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.

29. If the code descriptor for a HCPCS/CPT code, CPT coding system 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-associated modifier if appropriate.

30. A cystourethroscopy (CPT code 52000) performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.

31. 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.

32. 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.

APPENDIX

44950 Appendectomy;

Incidental appendectomy during intra-abdominal surgery does not usually warrant a separate identification. If necessary to report, add modifier 52.

RVUs: Non-Facility Total 18.62 Facility Total 18.62

Medicare Policies: major surgical procedure; follow-up period is 90 days, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon may be paid,

Linked ICD-10-CM Diagnosis Codes:

C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
D27.0	Benign neoplasm of right ovary
D27.1	Benign neoplasm of left ovary
D27.9	Benign neoplasm of unspecified ovary

NCCI Column 2 Codes with Modifier Indicators: 0213T^{N}, 0216T^{N}, 0228T^{N}, 0230T^{N}, 11000^{A}, 11001^{A}, 11004^{A}, 11005^{A}, 11006^{A}, 11042^{A}, 11043^{A}, 11044^{A}, 11045^{A}, 11046^{A}, 11047^{A}, 12001^{A}, 12002^{A}, 12004^{A}, 12005^{A}, 12006^{A}, 12007^{A}, 12011^{A}, 12013^{A}, 12014^{A}, 12015^{A}, 12016^{A}, 12017^{A}, 12018^{A}, 12020^{A}, 12021^{A}, 12031^{A}, 12032^{A}, 12034^{A}, 12035^{A}, 12036^{A}, 12037^{A}, 12041^{A}, 12042^{A}, 12044^{A}, 12045^{A}, 12046^{A}, 12047^{A}, 12051^{A}, 12052^{A}, 12053^{A}, 12054^{A}, 12055^{A}, 12056^{A}, 12057^{A}, 13100^{A}, 13101^{A}, 13102^{A}, 13120^{A}, 13121^{A}, 13122^{A}, 13131^{A}, 13132^{A}, 13133^{A}, 13151^{A}, 13152^{A}, 13153^{A}, 36000^{A}, 36400^{A}, 36405^{A}, 36406^{A}, 36410^{A}, 36420^{A}, 36425^{A}, 36430^{A}, 36440^{A}, 36591^{N}, 36592^{N}, 36600^{A}, 36640^{A}, 43284^{A}, 43752^{A}, 44701^{A}, 44955^{N}, 44970^{N}, 49585^{A}, 51701^{A}, 51702^{A}, 51703^{A}, 62320^{N}, 62321^{N}, 62322^{N}, 62323^{N}, 62324^{N}, 62325^{N}, 62326^{N}, 62327^{N}, 64400^{N}, 64402^{N}, 64405^{N}, 64408^{N}, 64410^{N}, 64413^{N}, 64415^{N}, 64416^{N}, 64417^{N}, 64418^{N}, 64420^{N}, 64421^{N}, 64425^{N}, 64430^{N}, 64435^{N}, 64445^{N}, 64446^{N}, 64447^{N}, 64448^{N}, 64449^{N}, 64450^{N}, 64461^{N}, 64462^{N},

64463[N], 64479[N], 64480[N], 64483[N], 64484[N], 64486[N], 64487[N], 64488[N], 64489[N], 64490[N], 64491[N], 64492[N], 64493[N], 64494[N], 64495[N], 64505[N], 64510[N], 64517[N], 64520[N], 64530[N], 69990[N], 92012[A], 92014[A], 93000[A], 93005[A], 93010[A], 93040[A], 93041[A], 93042[A], 93318[A], 93355[A], 94002[A], 94200[A], 94250[A], 94680[A], 94681[A], 94690[A], 94770[A], 95812[A], 95813[A], 95816[A], 95819[A], 95822[A], 95829[A], 95955[A], 96360[A], 96361[A], 96365[A], 96366[A], 96367[A], 96368[A], 96372[A], 96374[A], 96375[A], 96376[A], 96377[A], 97597[A], 97598[A], 97602[A], 99155[N], 99156[N], 99157[N], 99211[A], 99212[A], 99213[A], 99214[A], 99215[A], 99217[A], 99218[A], 99219[A], 99220[A], 99221[A], 99222[A], 99223[A], 99231[A], 99232[A], 99233[A], 99234[A], 99235[A], 99236[A], 99238[A], 99239[A], 99241[A], 99242[A], 99243[A], 99244[A], 99245[A], 99251[A], 99252[A], 99253[A], 99254[A], 99255[A], 99291[A], 99292[A], 99304[A], 99305[A], 99306[A], 99307[A], 99308[A], 99309[A], 99310[A], 99315[A], 99316[A], 99334[A], 99335[A], 99336[A], 99337[A], 99347[A], 99348[A], 99349[A], 99350[A], 99374[A], 99375[A], 99377[A], 99378[A], 99446[N], 99447[N], 99448[N], 99449[N], 99451[N], 99452[N], 99495[N], 99496[N], G0463[A], G0471[A]

ABDOMEN, PERITONEUM, AND OMENTUM

49000 Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)

To report wound exploration due to penetrating trauma without laparotomy, use 20102.

RVUs: Non-Facility Total 22.32 Facility Total 22.32

Medicare Policies: major surgical procedure; follow-up period is 90 days, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon may be paid,

Linked ICD-10-CM Diagnosis Codes:

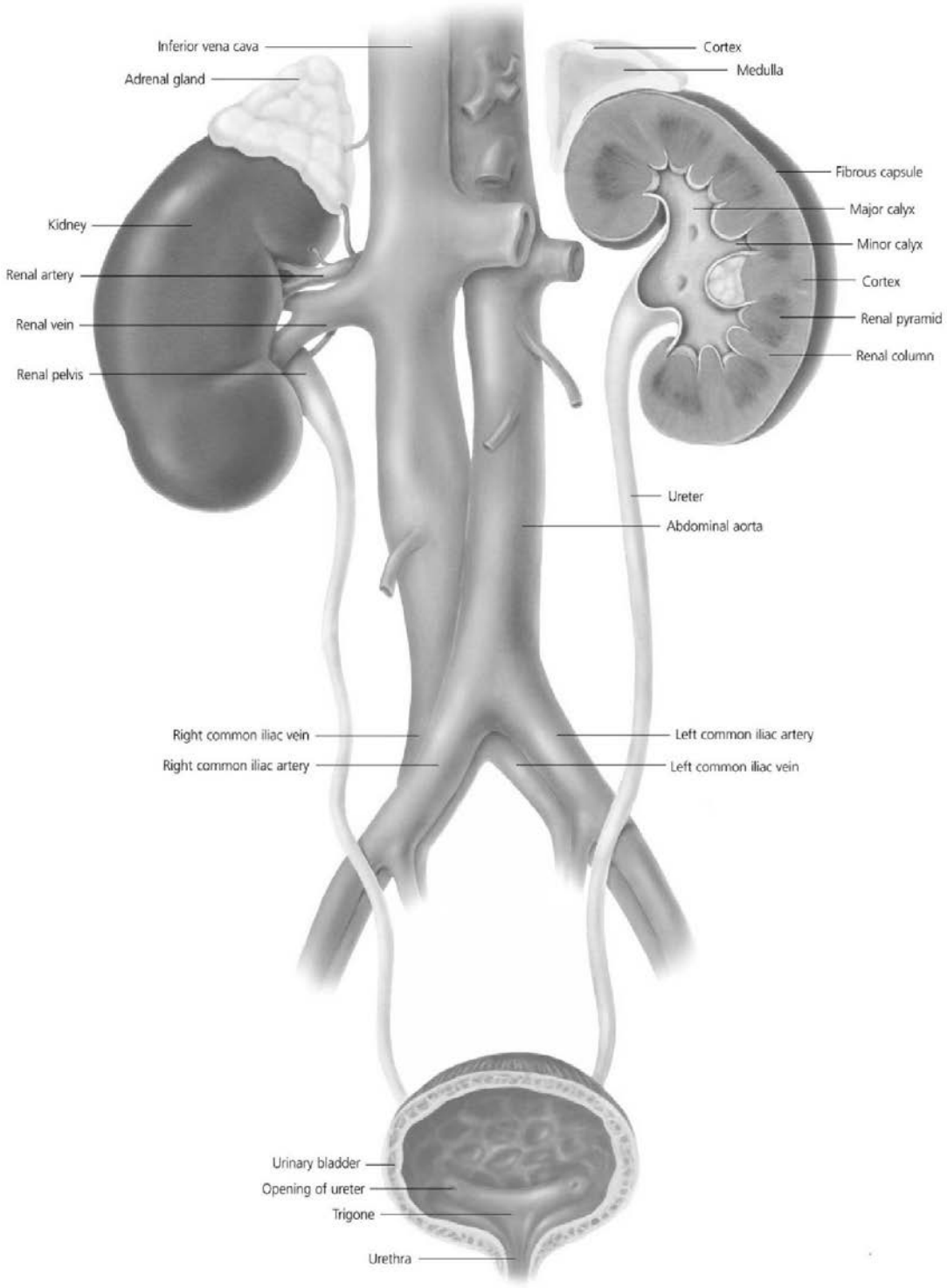
C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
D25.9	Leiomyoma of uterus, unspecified
D27.0	Benign neoplasm of right ovary
D27.1	Benign neoplasm of left ovary
D27.9	Benign neoplasm of unspecified ovary
N73.6	Female pelvic peritoneal adhesions (postinfective)
N83.20	Unspecified ovarian cysts
N83.29	Other ovarian cysts
N94.89	Other specified conditions associated with female genital organs and menstrual cycle
R10.2	Pelvic and perineal pain
R19.00	Intra-abdominal and pelvic swelling, mass and lump, unspecified site
R19.03	Right lower quadrant abdominal swelling, mass and lump
R19.09	Other intra-abdominal and pelvic swelling, mass and lump

NCCI Column 2 Codes with Modifier Indicators: 0213T[N], 0216T[N], 0228T[N], 0230T[N], 10005[A], 10007[A], 10009[A], 10011[A], 10021[A], 11000[A], 11001[A], 11004[A], 11005[A], 11006[A], 11042[A], 11043[A], 11044[A], 11045[A], 11046[A], 11047[A], 12001[A], 12002[A], 12004[A], 12005[A], 12006[A], 12007[A], 12011[A], 12013[A], 12014[A], 12015[A], 12016[A], 12017[A], 12018[A], 12020[A], 12021[A], 12031[A], 12032[A], 12034[A], 12035[A], 12036[A], 12037[A], 12041[A], 12042[A], 12044[A], 12045[A], 12046[A], 12047[A], 12051[A], 12052[A], 12053[A], 12054[A], 12055[A], 12056[A], 12057[A], 13100[A], 13101[A], 13102[A], 13120[A], 13121[A], 13122[A], 13131[A], 13132[A], 13133[A], 13151[A], 13152[A], 13153[A], 20102[A], 36000[A], 36400[A], 36405[A], 36406[A], 36410[A], 36420[A], 36425[A], 36430[A], 36440[A], 36591[N], 36592[N], 36600[A], 36640[A], 43752[A], 44015[N], 44180[N], 44950[N], 44970[N], 49255[N], 51701[A], 51702[A], 51703[A], 57410[N], 62320[N], 62321[N], 62322[N], 62323[N], 62324[N], 62325[N], 62326[N], 62327[N], 64400[N], 64402[N], 64405[N], 64408[N], 64410[N], 64413[N], 64415[N], 64416[N], 64417[N], 64418[N], 64420[N], 64421[N], 64425[N], 64430[N], 64435[N], 64445[N], 64446[N], 64447[N], 64448[N], 64449[N], 64450[N], 64461[N], 64462[N], 64463[N], 64479[N], 64480[N], 64483[N], 64484[N], 64486[N], 64487[N], 64488[N], 64489[N], 64490[N], 64491[N], 64492[N], 64493[N], 64494[N], 64495[N], 64505[N], 64510[N], 64517[N], 64520[N], 64530[N], 69990[N], 92012[A], 92014[A], 93000[A], 93005[A], 93010[A], 93040[A], 93041[A], 93042[A], 93318[A], 93355[A], 94002[A], 94200[A], 94250[A], 94680[A], 94681[A], 94690[A], 94770[A], 95812[A], 95813[A], 95816[A], 95819[A], 95822[A], 95829[A], 95955[A], 96360[A], 96361[A], 96365[A], 96366[A], 96367[A], 96368[A], 96372[A], 96374[A], 96375[A], 96376[A], 96377[A], 97597[A], 97598[A], 97602[A], 99155[N], 99156[N], 99157[N], 99211[A], 99212[A], 99213[A], 99214[A], 99215[A], 99217[A], 99218[A], 99219[A], 99220[A], 99221[A], 99222[A], 99223[A], 99231[A], 99232[A], 99233[A], 99234[A], 99235[A], 99236[A], 99238[A], 99239[A], 99241[A], 99242[A], 99243[A], 99244[A], 99245[A], 99251[A], 99252[A], 99253[A], 99254[A], 99255[A], 99291[A], 99292[A], 99304[A], 99305[A], 99306[A], 99307[A], 99308[A], 99309[A], 99310[A], 99315[A], 99316[A], 99334[A], 99335[A], 99336[A], 99337[A], 99347[A], 99348[A], 99349[A], 99350[A], 99374[A], 99375[A], 99377[A], 99378[A], 99446[N], 99447[N], 99448[N], 99449[N], 99451[N], 99452[N], 99495[N], 99496[N], G0463[A], G0471[A]

49002 Reopening of recent laparotomy

To report re-exploration of hepatic wound for removal of packing, use 47362.

URINARY SYSTEM



CORRECT CODING GUIDELINES

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

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

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

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

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

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

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

7. If a diagnostic endoscopy leads to the performance of a laparoscopic or open procedure, the diagnostic endoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic endoscopy and non-endoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic endoscopy. However, if an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reportable. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a separate diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and shall not be reported separately with a diagnostic or surgical endoscopy code.

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

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

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

10. When multiple endoscopic procedures are performed at the same patient encounter, the most comprehensive code accurately describing the service(s) performed shall be reported. If several procedures not included in a more comprehensive code are performed at the same endoscopic session, multiple HCPCS/CPT codes may be reported with

CYSTOSCOPY, URETHROSCOPY, AND CYSTOURETHROSCOPY

The descriptions of codes in this section are listed so that the main procedure can be identified without having to list all of the minor related procedures performed at the same time. For example:

52601 Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

All of the secondary procedures are included in the single code 52601. If any of the secondary procedures requires significant additional time and effort to the point of making the procedure "unusual," modifier -22 should be added with an appropriate increase in fee and a report explaining what made the procedure unusual.

BLADDER

51040 Cystostomy, cystotomy with drainage

RVUs: Non-Facility Total 8.36 Facility Total 8.36

Medicare Policies: major surgical procedure; follow-up period is 90 days, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon may be paid,

Linked ICD-10-CM Diagnosis Codes:

N36.41	Hypermobility of urethra
N36.43	Combined hypermobility of urethra and intrinsic sphincter deficiency
N39.3	Stress incontinence (female) (male)
N81.10	Cystocele, unspecified
N81.11	Cystocele, midline
N81.2	Incomplete uterovaginal prolapse
N81.2	Incomplete uterovaginal prolapse
N81.3	Complete uterovaginal prolapse
N81.4	Uterovaginal prolapse, unspecified
N94.89	Other specified conditions associated with female genital organs and menstrual cycle
N99.3	Prolapse of vaginal vault after hysterectomy
R39.14	Feeling of incomplete bladder emptying

NCCI Column 2 Codes with Modifier Indicators: 00910^{N}, 0213T^{N}, 0216T^{N}, 0228T^{N}, 0230T^{N}, 11000^{A}, 11001^{A}, 11004^{A}, 11005^{A}, 11006^{A}, 11042^{A}, 11043^{A}, 11044^{A}, 11045^{A}, 11046^{A}, 11047^{A}, 12001^{A}, 12002^{A}, 12004^{A}, 12005^{A}, 12006^{A}, 12007^{A}, 12011^{A}, 12013^{A}, 12014^{A}, 12015^{A}, 12016^{A}, 12017^{A}, 12018^{A}, 12020^{A}, 12021^{A}, 12031^{A}, 12032^{A}, 12034^{A}, 12035^{A}, 12036^{A}, 12037^{A}, 12041^{A}, 12042^{A}, 12044^{A}, 12045^{A}, 12046^{A}, 12047^{A}, 12051^{A}, 12052^{A}, 12053^{A}, 12054^{A}, 12055^{A}, 12056^{A}, 12057^{A}, 13100^{A}, 13101^{A}, 13102^{A}, 13120^{A}, 13121^{A}, 13122^{A}, 13131^{A}, 13132^{A}, 13133^{A}, 13151^{A}, 13152^{A}, 13153^{A}, 36000^{A}, 36400^{A}, 36405^{A}, 36406^{A}, 36410^{A}, 36420^{A}, 36425^{A}, 36430^{A}, 36440^{A}, 36591^{N}, 36592^{N}, 36600^{A}, 36640^{A}, 43752^{A}, 44602^{A}, 44603^{A}, 44604^{A}, 44605^{A}, 44950^{N}, 44970^{N}, 49000^{N}, 49002^{A}, 49320^{A}, 50715^{A}, 51045^{N}, 51100^{A}, 51101^{A}, 51102^{A}, 51520^{N}, 51525^{N}, 51570^{N}, 51701^{N}, 51702^{N}, 51703^{A}, 52000^{N}, 52005^{A}, 52276^{A}, 52281^{A}, 62320^{N}, 62321^{N}, 62322^{N}, 62323^{N}, 62324^{N}, 62325^{N}, 62326^{N}, 62327^{N}, 64400^{N}, 64402^{N}, 64405^{N}, 64408^{N}, 64410^{N}, 64413^{N}, 64415^{N}, 64416^{N}, 64417^{N}, 64418^{N}, 64420^{N}, 64421^{N}, 64425^{N}, 64430^{N}, 64435^{N}, 64445^{N}, 64446^{N}, 64447^{N}, 64448^{N}, 64449^{N}, 64450^{N}, 64461^{N}, 64462^{N}, 64463^{N}, 64479^{N}, 64480^{N}, 64483^{N}, 64484^{N}, 64486^{N}, 64487^{N}, 64488^{N}, 64489^{N}, 64490^{N}, 64491^{N}, 64492^{N}, 64493^{N}, 64494^{N}, 64495^{N}, 64505^{N}, 64510^{N}, 64517^{N}, 64520^{N}, 64530^{N}, 69990^{N}, 92012^{A}, 92014^{A}, 93000^{A}, 93005^{A}, 93010^{A}, 93040^{A}, 93041^{A}, 93042^{A}, 93318^{A}, 93355^{A}, 94002^{A}, 94200^{A}, 94250^{A}, 94680^{A}, 94681^{A}, 94690^{A}, 94770^{A}, 95812^{A}, 95813^{A}, 95816^{A}, 95819^{A}, 95822^{A}, 95829^{A}, 95955^{A}, 96360^{A}, 96361^{A}, 96365^{A}, 96366^{A}, 96367^{A}, 96368^{A}, 96372^{A}, 96374^{A}, 96375^{A}, 96376^{A}, 96377^{A}, 97597^{A}, 97598^{A}, 97602^{A}, 99155^{N}, 99156^{N}, 99157^{N}, 99211^{A}, 99212^{A}, 99213^{A}, 99214^{A}, 99215^{A}, 99217^{A}, 99218^{A}, 99219^{A}, 99220^{A}, 99221^{A}, 99222^{A}, 99223^{A}, 99231^{A}, 99232^{A}, 99233^{A}, 99234^{A}, 99235^{A}, 99236^{A}, 99238^{A}, 99239^{A}, 99241^{A}, 99242^{A}, 99243^{A}, 99244^{A}, 99245^{A}, 99251^{A}, 99252^{A}, 99253^{A}, 99254^{A}, 99255^{A}, 99291^{A}, 99292^{A}, 99304^{A}, 99305^{A}, 99306^{A}, 99307^{A}, 99308^{A}, 99309^{A}, 99310^{A}, 99315^{A}, 99316^{A}, 99334^{A}, 99335^{A}, 99336^{A}, 99337^{A}, 99347^{A}, 99348^{A}, 99349^{A}, 99350^{A}, 99374^{A}, 99375^{A}, 99377^{A}, 99378^{A}, 99446^{N}, 99447^{N}, 99448^{N}, 99449^{N}, 99451^{N}, 99452^{N}, 99495^{N}, 99496^{N}, G0463^{A}, G0471^{N}

51102 Aspiration of bladder; with insertion of suprapubic catheter

For imaging guidance, see 76942, 77002, 77012.

RVUs: Non-Facility Total 6.60 Facility Total 4.18

Medicare Policies: endoscopic or minor procedure; E/M services on the same day not generally paid, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid,

Linked ICD-10-CM Diagnosis Codes:

N39.3	Stress incontinence (female) (male)
N39.46	Mixed incontinence
N81.10	Cystocele, unspecified
N81.11	Cystocele, midline
N81.2	Incomplete uterovaginal prolapse
N81.3	Complete uterovaginal prolapse
N81.6	Rectocele
N81.9	Female genital prolapse, unspecified
N99.3	Prolapse of vaginal vault after hysterectomy
R33.9	Retention of urine, unspecified
R39.14	Feeling of incomplete bladder emptying

NCCI Column 2 Codes with Modifier Indicators: 00910[N], 0213T[N], 0216T[N], 0228T[N], 0230T[N], 11000[A], 11001[A], 11004[A], 11005[A], 11006[A], 11042[A], 11043[A], 11044[A], 11045[A], 11046[A], 11047[A], 12001[A], 12002[A], 12004[A], 12005[A], 12006[A], 12007[A], 12011[A], 12013[A], 12014[A], 12015[A], 12016[A], 12017[A], 12018[A], 12020[A], 12021[A], 12031[A], 12032[A], 12034[A], 12035[A], 12036[A], 12037[A], 12041[A], 12042[A], 12044[A], 12045[A], 12046[A], 12047[A], 12051[A], 12052[A], 12053[A], 12054[A], 12055[A], 12056[A], 12057[A], 13100[A], 13101[A], 13102[A], 13120[A], 13121[A], 13122[A], 13131[A], 13132[A], 13133[A], 13151[A], 13152[A], 13153[A], 36000[A], 36400[A], 36405[A], 36406[A], 36410[A], 36420[A], 36425[A], 36430[A], 36440[A], 36591[N], 36592[N], 36600[A], 36640[A], 43752[A], 44970[N], 51100[A], 51101[A], 51701[N], 51702[N], 52000[N], 52281[A], 62320[N], 62321[N], 62322[N], 62323[N], 62324[N], 62325[N], 62326[N], 62327[N], 64400[N], 64402[N], 64405[N], 64408[N], 64410[N], 64413[N], 64415[N], 64416[N], 64417[N], 64418[N], 64420[N], 64421[N], 64425[N], 64430[N], 64435[N], 64445[N], 64446[N], 64447[N], 64448[N], 64449[N], 64450[N], 64461[N], 64462[N], 64463[N], 64479[N], 64480[N], 64483[N], 64484[N], 64486[N], 64487[N], 64488[N], 64489[N], 64490[N], 64491[N], 64492[N], 64493[N], 64494[N], 64495[N], 64505[N], 64510[N], 64517[N], 64520[N], 64530[N], 69990[N], 76000[A], 77001[A], 92012[A], 92014[A], 93000[A], 93005[A], 93010[A], 93040[A], 93041[A], 93042[A], 93318[A], 93355[A], 94002[A], 94200[A], 94250[A], 94680[A], 94681[A], 94690[A], 94770[A], 95812[A], 95813[A], 95816[A], 95819[A], 95822[A], 95829[A], 95955[A], 96360[A], 96361[A], 96365[A], 96366[A], 96367[A], 96368[A], 96372[A], 96374[A], 96375[A], 96376[A], 96377[A], 97597[A], 97598[A], 97602[A], 99155[N], 99156[N], 99157[N], 99211[A], 99212[A], 99213[A], 99214[A], 99215[A], 99217[A], 99218[A], 99219[A], 99220[A], 99221[A], 99222[A], 99223[A], 99231[A], 99232[A], 99233[A], 99234[A], 99235[A], 99236[A], 99238[A], 99239[A], 99241[A], 99242[A], 99243[A], 99244[A], 99245[A], 99251[A], 99252[A], 99253[A], 99254[A], 99255[A], 99291[A], 99292[A], 99304[A], 99305[A], 99306[A], 99307[A], 99308[A], 99309[A], 99310[A], 99315[A], 99316[A], 99334[A], 99335[A], 99336[A], 99337[A], 99347[A], 99348[A], 99349[A], 99350[A], 99374[A], 99375[A], 99377[A], 99378[A], 99446[N], 99447[N], 99448[N], 99449[N], 99451[N], 99452[N], 99495[A], 99496[A], G0463[A], G0471[N], J0670[A], J2001[A]

51600 Injection procedure for cystography or voiding urethrocystography

For radiological supervision and interpretation, see 74430, 74455.

RVUs: Non-Facility Total 5.57 Facility Total 1.29

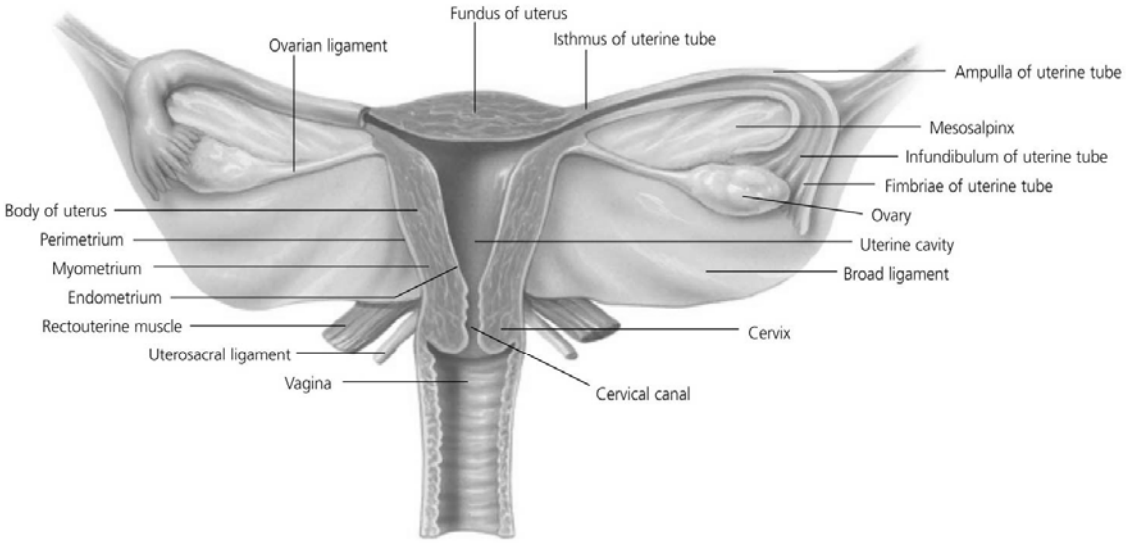
Medicare Policies: endoscopic or minor procedure; E/M services on the same day not generally paid, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid,

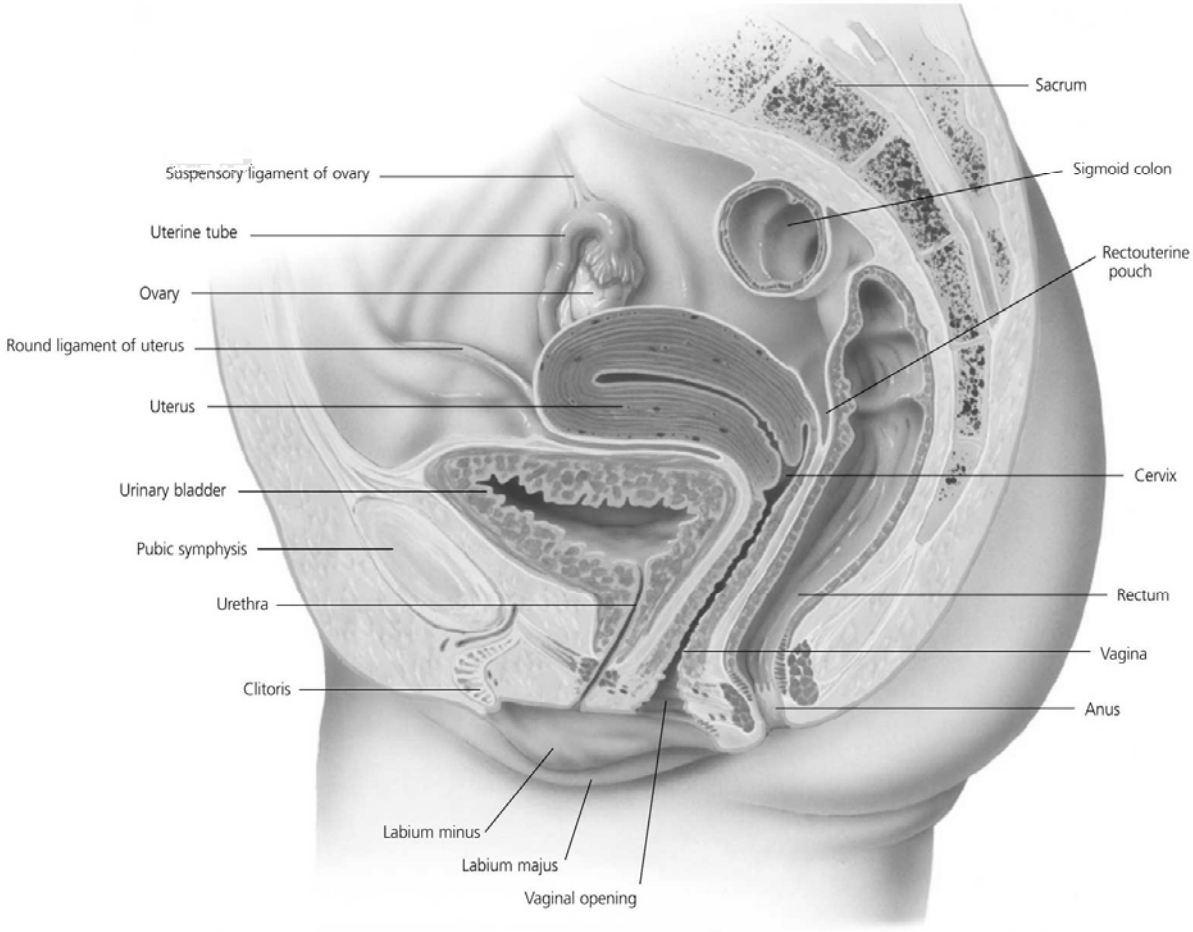
Linked ICD-10-CM Diagnosis Codes:

N31.2	Flaccid neuropathic bladder, not elsewhere classified
N32.81	Overactive bladder
N36.42	Intrinsic sphincter deficiency (ISD)
N36.43	Combined hypermobility of urethra and intrinsic sphincter deficiency
N39.3	Stress incontinence (female) (male)
N39.41	Urge incontinence
N39.46	Mixed incontinence
R32	Unspecified urinary incontinence
R33.9	Retention of urine, unspecified
R35.1	Nocturia
R39.14	Feeling of incomplete bladder emptying

NCCI Column 2 Codes with Modifier Indicators: 00910[N], 0213T[N], 0216T[N], 0228T[N], 0230T[N], 12001[A], 12002[A], 12004[A], 12005[A], 12006[A], 12007[A], 12011[A], 12013[A], 12014[A], 12015[A], 12016[A], 12017[A], 12018[A], 12020[A], 12021[A], 12031[A], 12032[A], 12034[A], 12035[A], 12036[A], 12037[A], 12041[A], 12042[A], 12044[A], 12045[A], 12046[A], 12047[A], 12051[A], 12052[A], 12053[A], 12054[A], 12055[A], 12056[A], 12057[A], 13100[A], 13101[A], 13102[A], 13120[A], 13121[A], 13122[A], 13131[A], 13132[A], 13133[A], 13151[A], 13152[A], 13153[A], 36000[A], 36400[A], 36405[A], 36406[A], 36410[A], 36420[A], 36425[A], 36430[A], 36440[A], 36591[N], 36592[N], 36600[A], 36640[A], 43752[A], 50715[A], 51700[N], 51701[N], 51702[N], 51703[N], 62320[N], 62321[N], 62322[N], 62323[N], 62324[N], 62325[N], 62326[N], 62327[N], 64400[N], 64402[N], 64405[N], 64408[N], 64410[N], 64413[N], 64415[N], 64416[N], 64417[N], 64418[N], 64420[N], 64421[N], 64425[N], 64430[N], 64435[N], 64445[N], 64446[N], 64447[N], 64448[N], 64449[N], 64450[N], 64461[N], 64462[N], 64463[N], 64479[N], 64480[N], 64483[N], 64484[N], 64486[N], 64487[N], 64488[N], 64489[N], 64490[N], 64491[N], 64492[N], 64493[N],

FEMALE GENITAL SYSTEM





CORRECT CODING GUIDELINES

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

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

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

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

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

6. Pelvic exenteration procedures (CPT codes 45126, 51597, 58240) include extensive removal of structures from the pelvis. Physicians shall not separately report codes for the removal of pelvic structures (e.g., colon, rectum, urinary bladder, uterine body and/or cervix, fallopian tubes, ovaries, lymph nodes, prostate gland).

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

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

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

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

11. Radiofrequency ablation of uterine fibroid(s) (e.g., CPT codes 58674, 0404T) and myomectomy of leiomyoma(ta) (e.g., CPT codes 58140-58146, 58545, 58546, 58561) shall not be reported for a procedure on the same leiomyoma. For example if a physician initiates a laparoscopic radiofrequency ablation of a uterine fibroid but must complete the procedure by laparoscopic myomectomy, only the completed procedure, laparoscopic myomectomy, may be reported. In the unusual circumstance where a physician performs radiofrequency ablation on one or more leiomyoma(ta) and it is medically reasonable and necessary to perform a myomectomy on a different leiomyoma, the physician may report both procedures.

LAPAROSCOPY

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

2. If a laparoscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic laparoscopy lead to the decision to perform an open procedure, the diagnostic laparoscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic laparoscopy and non-laparoscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic laparoscopy.

3. CPT code 49321 describes a laparoscopic biopsy. If this procedure is performed for diagnostic purposes and the decision to proceed with an open or laparoscopic –ectomy procedure is based on this biopsy, CPT code 49321 may be reported in addition to the CPT code for the –ectomy procedure. However, if the laparoscopic biopsy is performed for a different purpose such as assessing the margins of resection, CPT code 49321 is not separately reportable.

4. If a laparoscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical laparoscopy nor a diagnostic laparoscopy code shall be reported with the open procedure code when a laparoscopic procedure is converted to an open procedure.

5. Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures.

6. CPT code 44970 describes a laparoscopic appendectomy and may be reported separately with another laparoscopic procedure code when a diseased appendix is removed. Since removal of a normal appendix with another laparoscopic procedure is not separately reportable, this code shall not be reported for an incidental laparoscopic appendectomy.

7. Fluoroscopy (CPT code 76000) is an integral component of all laparoscopic procedures when performed. CPT code 76000 shall not be reported separately with a laparoscopic procedure. (CPT code 76001 was deleted January 1, 2019.)

8. A diagnostic laparoscopy includes "washing", infusion and/or removal of fluid from the body cavity. A physician shall not report CPT codes 49082-49083 (abdominal paracentesis) or 49084 (peritoneal lavage) for infusion and/or removal of fluid from the body cavity performed during a diagnostic or surgical laparoscopic procedure.

9. Injection of air into the abdominal or pelvic cavity is integral to many laparoscopic procedures. Physicians shall not separately report CPT code 49400 (injection of air or contrast into peritoneal cavity (separate procedure)) for this service.

MEDICALLY UNLIKELY EDITS (MUES)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the NCCI/MUE contractor. Written requests for reconsideration of an MUE may be sent to the entity and address identified on the CMS NCCI website (https://www.cms.gov/Medicare/Coding/ NationalCorrectCodInitEd/index.html).

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

   For example, CPT code 52353 (cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)) shall be reported with only one unit of service (UOS) per ureter regardless of the number of

procedure" when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

13. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of "1") because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

14. If fluoroscopy is performed during an endoscopic procedure, it is integral to the procedure. This principle applies to all endoscopic procedures including, but not limited to, laparoscopy, hysteroscopy, thoracoscopy, arthroscopy, esophagoscopy, colonoscopy, other GI endoscopy, laryngoscopy, bronchoscopy, and cystourethroscopy.

15. If the code descriptor for a HCPCS/CPT code, CPT coding system 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-associated modifier if appropriate.

16. A cystourethroscopy (e.g., CPT code 52000) or cystourethroscopy with ureteroscopy (e.g., CPT code 52351) performed near the termination of an intra-abdominal, intra-pelvic, or retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.

17. 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.

18. 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.

LAPAROSCOPY—HYSTEROSCOPY

The descriptions of codes in this section are listed so that the main procedure can be identified without having to list all of the minor related procedures performed at the same time. For example:

58558 Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C

The secondary procedure(s) is (are) included in the single code 58558. If any of the secondary procedures requires significant additional time and effort to the point of making the procedure "unusual," modifier -22 should be added with an appropriate increase in fee and a report explaining why the procedure was unusual.

VULVA, PERINEUM, AND INTROITUS

56405 Incision and drainage of vulva or perineal abscess

RVUs: Non-Facility Total 3.25 Facility Total 3.22

Medicare Policies: minor surgical procedure; follow-up period is 10 days, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid,

Linked ICD-10-CM Diagnosis Codes:

D28.0	Benign neoplasm of vulva
L03.314	Cellulitis of groin
L03.315	Cellulitis of perineum
L03.316	Cellulitis of umbilicus
L03.324	Acute lymphangitis of groin
L03.325	Acute lymphangitis of perineum
L03.326	Acute lymphangitis of umbilicus
N75.1	Abscess of Bartholin's gland
N76.0	Acute vaginitis
N76.1	Subacute and chronic vaginitis
N76.2	Acute vulvitis
N76.3	Subacute and chronic vulvitis
N76.4	Abscess of vulva
N90.3	Dysplasia of vulva, unspecified
N90.7	Vulvar cyst
N90.89	Other specified noninflammatory disorders of vulva and perineum
N90.9	Noninflammatory disorder of vulva and perineum, unspecified

NCCI Column 2 Codes with Modifier Indicators: 00940^{N}, 0213T^{N}, 0216T^{N}, 0228T^{N}, 0230T^{N}, 12001^{A}, 12002^{A}, 12004^{A}, 12005^{A}, 12006^{A}, 12007^{A}, 12011^{A}, 12013^{A}, 12014^{A}, 12015^{A}, 12016^{A}, 12017^{A}, 12018^{A}, 12020^{A}, 12021^{A}, 12031^{A}, 12032^{A}, 12034^{A}, 12035^{A}, 12036^{A}, 12037^{A}, 12041^{A}, 12042^{A}, 12044^{A}, 12045^{A}, 12046^{A}, 12047^{A}, 12051^{A}, 12052^{A}, 12053^{A}, 12054^{A}, 12055^{A}, 12056^{A}, 12057^{A}, 13100^{A}, 13101^{A}, 13102^{A}, 13120^{A}, 13121^{A}, 13122^{A}, 13131^{A}, 13132^{A}, 13133^{A}, 13151^{A}, 13152^{A}, 13153^{A}, 36000^{A}, 36400^{A}, 36405^{A}, 36406^{A}, 36410^{A}, 36420^{A}, 36425^{A}, 36430^{A}, 36440^{A}, 36591^{N}, 36592^{N}, 36600^{A}, 36640^{A}, 43752^{A}, 51701^{A}, 51702^{A}, 51703^{A}, 56440^{A}, 56605^{N}, 56810^{N}, 56820^{N}, 57100^{A}, 57180^{A}, 57500^{A}, 62320^{N}, 62321^{N}, 62322^{N}, 62323^{N}, 62324^{N}, 62325^{N}, 62326^{N}, 62327^{N}, 64400^{N}, 64402^{N}, 64405^{N}, 64408^{N}, 64410^{N}, 64413^{N}, 64415^{N}, 64416^{N}, 64417^{N}, 64418^{N}, 64420^{N}, 64421^{N}, 64425^{N}, 64430^{N}, 64435^{N}, 64445^{N}, 64446^{N}, 64447^{N}, 64448^{N}, 64449^{N}, 64450^{N}, 64461^{N}, 64462^{N}, 64463^{N}, 64479^{N}, 64480^{N}, 64483^{N}, 64484^{N}, 64486^{N}, 64487^{N}, 64488^{N}, 64489^{N}, 64490^{N}, 64491^{N}, 64492^{N}, 64493^{N}, 64494^{N}, 64495^{N}, 64505^{N}, 64510^{N}, 64517^{N}, 64520^{N}, 64530^{N}, 69990^{N}, 92012^{A}, 92014^{A}, 93000^{A}, 93005^{A}, 93010^{A}, 93040^{A}, 93041^{A}, 93042^{A}, 93318^{A}, 93355^{A}, 94002^{A}, 94200^{A}, 94250^{A}, 94680^{A}, 94681^{A}, 94690^{A}, 94770^{A}, 95812^{A}, 95813^{A}, 95816^{A}, 95819^{A}, 95822^{A}, 95829^{A}, 95955^{A}, 96360^{A}, 96361^{A}, 96365^{A}, 96366^{A}, 96367^{A}, 96368^{A}, 96372^{A}, 96374^{A}, 96375^{A}, 96376^{A}, 96377^{A}, 99155^{N}, 99156^{N}, 99157^{N}, 99211^{A}, 99212^{A}, 99213^{A}, 99214^{A}, 99215^{A}, 99217^{A}, 99218^{A}, 99219^{A}, 99220^{A}, 99221^{A}, 99222^{A}, 99223^{A}, 99231^{A}, 99232^{A}, 99233^{A}, 99234^{A}, 99235^{A}, 99236^{A}, 99238^{A}, 99239^{A}, 99241^{A}, 99242^{A}, 99243^{A}, 99244^{A}, 99245^{A}, 99251^{A}, 99252^{A}, 99253^{A}, 99254^{A}, 99255^{A}, 99291^{A}, 99292^{A}, 99304^{A}, 99305^{A}, 99306^{A}, 99307^{A}, 99308^{A}, 99309^{A}, 99310^{A}, 99315^{A}, 99316^{A}, 99334^{A}, 99335^{A}, 99336^{A}, 99337^{A}, 99347^{A}, 99348^{A}, 99349^{A}, 99350^{A}, 99374^{A}, 99375^{A}, 99377^{A}, 99378^{A}, 99446^{N}, 99447^{N}, 99448^{N}, 99449^{N}, 99451^{N}, 99452^{N}, 99495^{N}, 99496^{N}, G0463^{A}, G0471^{A}, J0670^{A}, J2001^{A}

56420 Incision and drainage of Bartholin's gland abscess

For incision and drainage of Skene's gland abscess or cyst, see 53060.

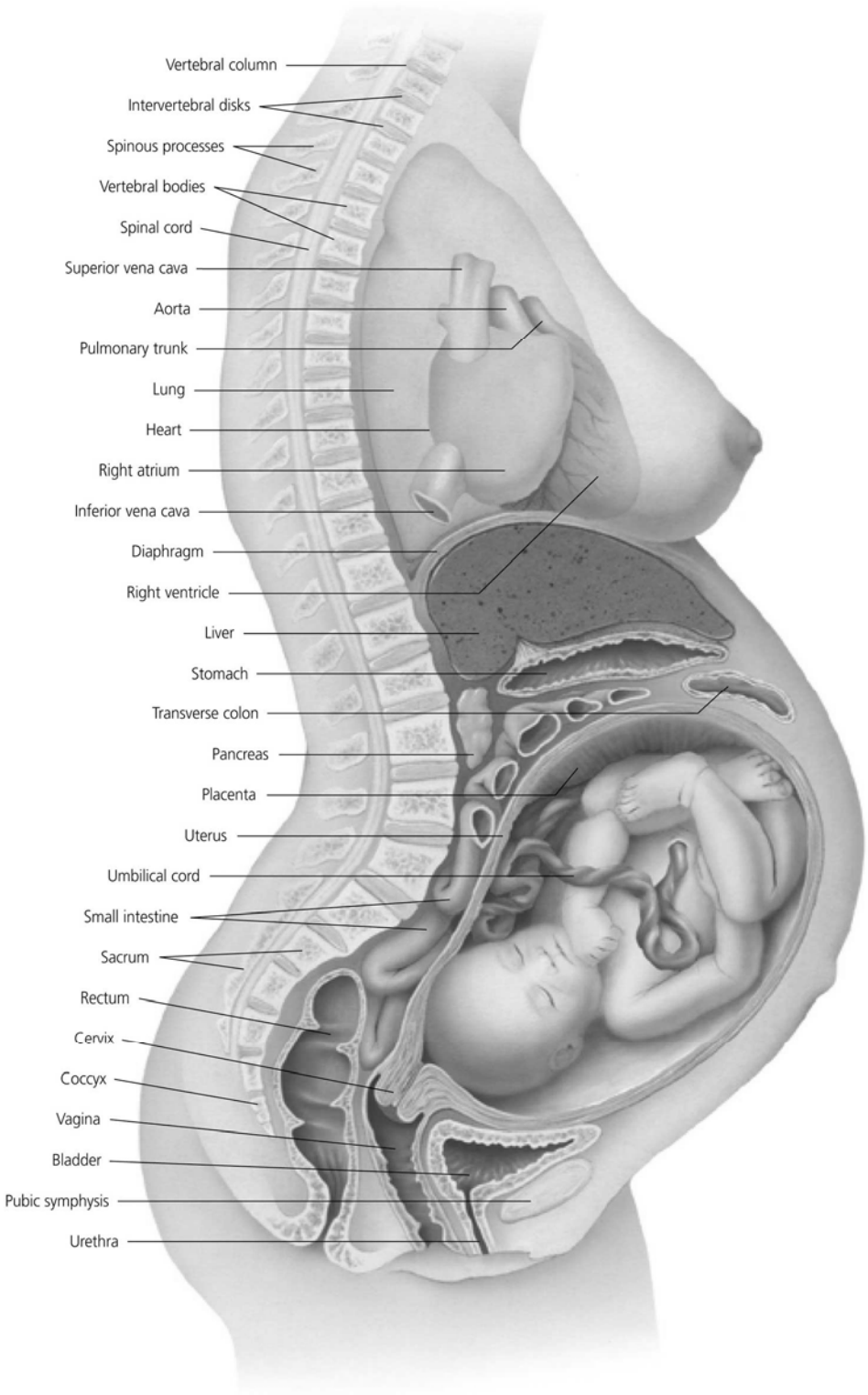
RVUs: Non-Facility Total 3.86 Facility Total 2.75

Medicare Policies: minor surgical procedure; follow-up period is 10 days, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid,

Linked ICD-10-CM Diagnosis Codes:

L03.314	Cellulitis of groin
L03.315	Cellulitis of perineum
L03.316	Cellulitis of umbilicus
L03.324	Acute lymphangitis of groin
L03.325	Acute lymphangitis of perineum
L03.326	Acute lymphangitis of umbilicus
N34.0	Urethral abscess
N75.0	Cyst of Bartholin's gland
N75.8	Other diseases of Bartholin's gland
N75.1	Abscess of Bartholin's gland
N76.0	Acute vaginitis
N76.1	Subacute and chronic vaginitis
N76.2	Acute vulvitis
N76.3	Subacute and chronic vulvitis
N76.4	Abscess of vulva
N90.3	Dysplasia of vulva, unspecified
N90.7	Vulvar cyst
N90.89	Other specified noninflammatory disorders of vulva and perineum

MATERNITY CARE AND DELIVERY



ANTEPARTUM CARE

The definition of antepartum care for coding purposes includes the initial and subsequent history; physical examinations; recording of weight, blood pressures, and fetal heart tones; routine chemical urinalysis; and routine visits. Routine antepartum visits are defined as:

- Monthly visits up to 28 weeks' gestation,
- Biweekly visits up to 36 weeks' gestation, and
- Weekly visits until delivery.

Any other visits or services provided within this time period should be coded separately. Using six to eight weeks' gestation as the typical starting point, the above definition translates into between nine and 11 routine visits per patient.

DELIVERY

Delivery services are defined as including hospital admission, the admission history and physical examination, management of uncomplicated labor, and vaginal or cesarean delivery.

- The definition of delivery services *includes* the hospital admission, admission history, and physical.
- Resuscitation of newborn infants when necessary, defined in previous editions, is not included in the delivery services. If the delivering physician has to resuscitate the newborn infant, the physician may code this service as a separate procedure.
- Medical problems "complicating labor and delivery management" may require additional resources and should be reported using E/M service codes.

POSTPARTUM CARE

Postpartum care is defined as hospital and office visits following vaginal or cesarean delivery. No number of visits is defined by CPT; however, the typical fee for total obstetrical care includes a single office follow-up visit six weeks postpartum.

COMPLICATIONS OF PREGNANCY

The services defined previously are for normal, uncomplicated maternity care. For medical complications of pregnancy, for example, cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, and premature rupture of membranes, use E/M service codes.

For surgical complications of pregnancy, such as appendectomy, hernia, ovarian cyst, Bartholin cysts, etc., use codes from the Surgery section of the CPT code book. Note that in either case, complications are not considered to be part of routine maternity care and should be coded and billed in addition to maternity codes.

PARTIAL MATERNITY SERVICES

Occasionally, a physician may provide all or part of the antepartum and/or postpartum care but does not perform the actual delivery due to termination of the pregnancy by abortion or referral to another physician for delivery. In this circumstance, the physician has the option of using the inclusive codes 59420 or 59430 from the Maternity Care and Delivery section or to code and bill for each visit using E/M service codes 99201-99215.

CORRECT CODING GUIDELINES

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

2. CPT codes 59050 and 59051(fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT codes 59400 (routine obstetric care, vaginal delivery), 59409 (vaginal delivery only), 59410 (vaginal

delivery and postpartum care), 59510 (routine obstetric care, cesarean delivery), 59514 (cesarean delivery only), 59515 (cesarean delivery and postpartum care), 59610 (routine obstetric care, vaginal delivery, after previous cesarean delivery), 59612 (vaginal delivery only after previous cesarean delivery), 59614 (vaginal delivery and postpartum care after previous cesarean delivery), 59618 (routine obstetric care, cesarean delivery, after previous cesarean delivery), 59620 (cesarean delivery only after previous cesarean delivery), and 59622 (cesarean delivery and postpartum care after previous cesarean delivery). They are not separately reportable.

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

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

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

ANTEPARTUM AND FETAL INVASIVE SERVICES

59000 Amniocentesis; diagnostic

For radiological supervision and interpretation, see 76946.

RVUs: Non-Facility Total 3.53 Facility Total 2.33

Medicare Policies: endoscopic or minor procedure; E/M services on the same day not generally paid, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid,

Linked ICD-10-CM Diagnosis Codes:

O09.511	Supervision of elderly primigravida, first trimester
O09.512	Supervision of elderly primigravida, second trimester
O09.513	Supervision of elderly primigravida, third trimester
O09.521	Supervision of elderly multigravida, first trimester
O09.522	Supervision of elderly multigravida, second trimester
O09.523	Supervision of elderly multigravida, third trimester
O35.1XX0	Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified
O35.1XX1	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1
O35.1XX2	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2
O35.1XX3	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 3
O35.1XX4	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 4
O35.1XX5	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 5
O35.1XX9	Maternal care for (suspected) chromosomal abnormality in fetus, other fetus
O35.8XX0	Maternal care for other (suspected) fetal abnormality and damage, not applicable or unspecified
O35.8XX1	Maternal care for other (suspected) fetal abnormality and damage, fetus 1
O35.8XX2	Maternal care for other (suspected) fetal abnormality and damage, fetus 2
O35.8XX3	Maternal care for other (suspected) fetal abnormality and damage, fetus 3
O35.8XX4	Maternal care for other (suspected) fetal abnormality and damage, fetus 4
O35.8XX5	Maternal care for other (suspected) fetal abnormality and damage, fetus 5
O35.8XX9	Maternal care for other (suspected) fetal abnormality and damage, other fetus
O35.9XX0	Maternal care for (suspected) fetal abnormality and damage, unspecified, not applicable or unspecified
O35.9XX1	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 1
O35.9XX2	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 2
O35.9XX3	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 3
O35.9XX4	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 4
O35.9XX5	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 5
O35.9XX9	Maternal care for (suspected) fetal abnormality and damage, unspecified, other fetus
O75.89	Other specified complications of labor and delivery
Z36	Encounter for antenatal screening of mother

NCCI Column 2 Codes with Modifier Indicators: 0213T[N], 0216T[N], 0228T[N], 0230T[N], 12001[A], 12002[A], 12004[A], 12005[A], 12006[A], 12007[A], 12011[A], 12013[A], 12014[A], 12015[A], 12016[A], 12017[A], 12018[A], 12020[A], 12021[A], 12031[A], 12032[A], 12034[A], 12035[A], 12036[A], 12037[A], 12041[A], 12042[A], 12044[A], 12045[A], 12046[A], 12047[A], 12051[A], 12052[A], 12053[A], 12054[A], 12055[A], 12056[A], 12057[A], 13100[A], 13101[A], 13102[A], 13120[A], 13121[A], 13122[A], 13131[A], 13132[A], 13133[A], 13151[A], 13152[A], 13153[A], 36000[A], 36400[A], 36405[A], 36406[A], 36410[A], 36420[A], 36425[A], 36430[A], 36440[A], 36591[N], 36592[N], 36600[A], 36640[A], 43752[A], 51701[N], 51702[N], 51703[A], 57410[N], 62320[N], 62321[N], 62322[N], 62323[N], 62324[N], 62325[N], 62326[N], 62327[N], 64400[N], 64402[N], 64405[N], 64408[N], 64410[N], 64413[N], 64415[N], 64416[N], 64417[N], 64418[N], 64420[N], 64421[N], 64425[N], 64430[N], 64435[N], 64445[N], 64446[N], 64447[N], 64448[N], 64449[N], 64450[N], 64461[N], 64462[N], 64463[N], 64479[N], 64480[N], 64483[N], 64484[N], 64486[N], 64487[N], 64488[N], 64489[N], 64490[N], 64491[N], 64492[N], 64493[N], 64494[N], 64495[N], 64505[N], 64510[N], 64517[N], 64520[N], 64530[N], 69990[N], 76000[A], 76942[A], 76970[A], 76998[A], 77001[A], 77002[A], 92012[A], 92014[A], 93000[A], 93005[A], 93010[A], 93040[A], 93041[A], 93042[A], 93318[A], 93355[A], 94002[A], 94200[A], 94250[A], 94680[A], 94681[A], 94690[A], 94770[A], 95812[A], 95813[A], 95816[A], 95819[A], 95822[A], 95829[A], 95955[A], 96360[A], 96361[A], 96365[A], 96366[A], 96367[A], 96368[A], 96372[A], 96374[A], 96375[A], 96376[A], 96377[A], 99155[N], 99156[N], 99157[N], 99211[A], 99212[A], 99213[A], 99214[A], 99215[A], 99217[A], 99218[A], 99219[A], 99220[A], 99221[A], 99222[A], 99223[A], 99231[A], 99232[A], 99233[A], 99234[A], 99235[A], 99236[A], 99238[A], 99239[A], 99241[A], 99242[A], 99243[A], 99244[A], 99245[A], 99251[A], 99252[A], 99253[A], 99254[A], 99255[A], 99291[A], 99292[A], 99304[A], 99305[A], 99306[A], 99307[A], 99308[A], 99309[A], 99310[A], 99315[A], 99316[A], 99334[A], 99335[A], 99336[A], 99337[A], 99347[A], 99348[A], 99349[A], 99350[A], 99374[A], 99375[A], 99377[A], 99378[A], 99446[N], 99447[N], 99448[N], 99449[N], 99451[N], 99452[N], 99495[A], 99496[A], G0463[A], G0471[N]

59001 Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)

RVUs: Non-Facility Total 5.15 Facility Total 5.15

Medicare Policies: endoscopic or minor procedure; E/M services on the same day not generally paid, standard payment adjustment rules for multiple procedures apply, 150% payment adjustment for bilateral procedures does not apply, assistant surgeon is not paid,

Linked ICD-10-CM Diagnosis Codes:

O09.511	Supervision of elderly primigravida, first trimester
O09.512	Supervision of elderly primigravida, second trimester
O09.513	Supervision of elderly primigravida, third trimester
O09.521	Supervision of elderly multigravida, first trimester
O09.522	Supervision of elderly multigravida, second trimester
O09.523	Supervision of elderly multigravida, third trimester
O35.1XX0	Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified
O35.1XX1	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1
O35.1XX2	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2
O35.1XX3	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 3
O35.1XX4	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 4
O35.1XX5	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 5
O35.1XX9	Maternal care for (suspected) chromosomal abnormality in fetus, other fetus
O35.8XX0	Maternal care for other (suspected) fetal abnormality and damage, not applicable or unspecified
O35.8XX1	Maternal care for other (suspected) fetal abnormality and damage, fetus 1
O35.8XX2	Maternal care for other (suspected) fetal abnormality and damage, fetus 2
O35.8XX3	Maternal care for other (suspected) fetal abnormality and damage, fetus 3
O35.8XX4	Maternal care for other (suspected) fetal abnormality and damage, fetus 4
O35.8XX5	Maternal care for other (suspected) fetal abnormality and damage, fetus 5
O35.8XX9	Maternal care for other (suspected) fetal abnormality and damage, other fetus
O35.9XX0	Maternal care for (suspected) fetal abnormality and damage, unspecified, not applicable or unspecified
O35.9XX1	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 1
O35.9XX2	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 2
O35.9XX3	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 3
O35.9XX4	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 4
O35.9XX5	Maternal care for (suspected) fetal abnormality and damage, unspecified, fetus 5
O35.9XX9	Maternal care for (suspected) fetal abnormality and damage, unspecified, other fetus
O75.89	Other specified complications of labor and delivery
Z36	Encounter for antenatal screening of mother

NCCI Column 2 Codes with Modifier Indicators: 0213T[N], 0216T[N], 0228T[N], 0230T[N], 12001[A], 12002[A], 12004[A], 12005[A], 12006[A], 12007[A], 12011[A], 12013[A], 12014[A], 12015[A], 12016[A], 12017[A], 12018[A], 12020[A], 12021[A], 12031[A], 12032[A], 12034[A], 12035[A], 12036[A], 12037[A], 12041[A], 12042[A], 12044[A], 12045[A], 12046[A], 12047[A], 12051[A], 12052[A], 12053[A], 12054[A], 12055[A], 12056[A], 12057[A], 13100[A], 13101[A], 13102[A], 13120[A], 13121[A], 13122[A], 13131[A], 13132[A], 13133[A], 13151[A], 13152[A], 13153[A], 36000[A], 36400[A], 36405[A], 36406[A], 36410[A], 36420[A], 36425[A], 36430[A], 36440[A], 36591[N], 36592[N], 36600[A], 36640[A], 43752[A], 51701[N], 51702[N], 51703[A], 57410[N], 59000[A], 62320[N], 62321[N], 62322[N], 62323[N], 62324[N], 62325[N], 62326[N], 62327[N], 64400[N], 64402[N], 64405[N], 64408[N], 64410[N], 64413[N], 64415[N], 64416[N], 64417[N], 64418[N], 64420[N], 64421[N], 64425[N], 64430[N], 64435[N], 64445[N], 64446[N], 64447[N], 64448[N], 64449[N], 64450[N], 64461[N], 64462[N], 64463[N], 64479[N], 64480[N], 64483[N], 64484[N], 64486[N], 64487[N], 64488[N], 64489[N], 64490[N], 64491[N], 64492[N], 64493[N], 64494[N], 64495[N], 64505[N], 64510[N], 64517[N], 64520[N], 64530[N], 69990[N], 76941[A], 76942[A], 76945[A], 76946[A], 76970[A], 76998[A], 92012[A], 92014[A],

RADIOLOGY SERVICES

RADIOLOGY SECTION OVERVIEW

The fourth section of the CPT coding system is the radiology section, which includes diagnostic and therapeutic radiology, nuclear medicine and diagnostic ultrasound services. Within each subsection, the CPT codes are arranged by anatomical site.

Diagnostic radiology uses all modalities of radiant energy in medical diagnosis and therapeutic procedures requiring radiologic guidance. This includes imaging techniques and methodologies using radiation emitted by x-ray tubes, radionuclides, ultrasonographic devices, and radiofrequency electromagnetic radiation.

RADIOLOGY SUBSECTIONS

The RADIOLOGY section of the CPT coding system is divided into 4 subsections; namely:

Diagnostic Radiology (Diagnostic Imaging)	70010-76499
Diagnostic Ultrasound	76506-76999
Radiation Oncology	77261-77799
Nuclear Medicine	78000-79999

COMPLETE PROCEDURES

Interventional radiologic procedures or diagnostic studies involving injection of contrast media include all usual preinjection and postinjection services, for example, necessary local anesthesia, placement of needle or catheter, injection of contrast media, supervision of the study, and interpretation of results. When one of these procedures is performed in full by a single physician, it is designated as a "complete procedure."

SUPERVISION AND INTERPRETATION ONLY

When a procedure is performed by a radiologist-clinician team, it is designated as "supervision and interpretation only" and the separate injection procedure is listed in the appropriate section of the SURGERY section of the CPT coding system. These CPT codes are used only when a procedure is performed by more than one physician, for example, a radiologist-clinician team.

RADIOLOGY SERVICE MODIFIERS

Listed surgical services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by adding the appropriate two digit modifier to the base procedure code(s). Modifiers commonly used to report RADIOLOGY services include:

-22 Unusual services
-26 Professional component
-32 Mandated services
-51 Multiple procedures
-52 Reduced services
-62 Two surgeons
-66 Surgical team
-76 Repeat procedure by same physician
-77 Repeat procedure by another physician
-78 Return to the operating room for a related procedure during the postoperative period
-79 Unrelated procedure or service by the same physician during the postoperative period
-80 Assistant surgeon
-90 Reference (outside) laboratory
-99 Multiple modifiers
-LT Left side of body
-RT Right side of body

BILATERAL PROCEDURE CODES

The RADIOLOGY section includes some CPT codes which include the term “bilateral” in the definition. When reporting these services, do not add the modifier -50, because the procedure is already defined as “bilateral.”

RADIOLOGY SERVICES MEDICARE CONSIDERATIONS

Most of the CPT codes in this section are subject to Medicare Purchased Diagnostic Services guidelines. Coding and reporting should be as instructed by your local Medicare carrier.

CORRECT CODING GUIDELINES

EVALUATION AND MANAGEMENT (E & M) SERVICES

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate evaluation and management service is not reported. As a rule, if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate evaluation and management service may be reported.

In radiation oncology, evaluation and management CPT codes are separately reportable for an initial visit at which time a decision is made whether to proceed with the treatment.

NON-INTERVENTIONAL DIAGNOSTIC IMAGING

Non-invasive/interventional diagnostic imaging includes but is not limited to standard radiographs, single or multiple views, contrast studies, computerized tomography and magnetic resonance imaging. The CPT coding system allows for various combinations of codes to address the number and type of radiographic views. for a given radiographic series, the procedure code that most accurately describes what was performed shall be reported. Because the number of views necessary to obtain medically useful information may vary, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code describing the services performed rather than billing multiple codes to describe the service.

1. If imaging studies (e.g., radiographs, computerized tomography, magnetic resonance imaging) are repeated during the course of a radiological encounter due to substandard quality or need for additional views, only one unit of service for the appropriate code may be reported. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service shall be reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptors for many of these services refer to a “minimum” number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service shall be reported. However, if additional films are necessary due to a change in the patient’s condition, separate reporting may be appropriate.

2. CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specifically including the additional views. for example, if three views of the shoulder are obtained, CPT code 73030 (Radiologic examination, shoulder; complete, minimum of two views) with one unit of service shall be reported rather than CPT code 73020 (Radiologic examination, shoulder; one view) plus CPT code 73030.

3. When a comparative imaging study is performed to assess potential complications or completeness of a procedure (e.g., post-reduction, post-intubation, post-catheter placement, etc.), the professional component of the CPT code for the post-procedure imaging study is not separately payable and shall not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported.

date of service the physician performs another procedure in addition to the cardiac catheterization, the additional procedure requires fluoroscopy, and fluoroscopy is not integral to the additional procedure, the fluoroscopy procedure may be reported separately with an NCCI-associated modifier.

23. 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.

24. 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.

DIAGNOSTIC RADIOLOGY

72192 Computed tomography, pelvis; without contrast material

For a combined CT abdomen and pelvis study, see 74176...74178. To report 3D rendering, see 76376, 76377. For computed tomographic colonography, diagnostic, see 74261...74262. For computed tomographic colonography, screening, use 74263. Do not report 72192...72194 in conjunction with 74261...74263.

RVUs: Non-Facility Total 4.10 Facility Total 4.10

Medicare Policies: 150% payment adjustment for bilateral procedures does not apply, payment for assistant surgeon subject to documentation of medical necessity,

Linked ICD-10-CM Diagnosis Codes:

C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
N20.0	Calculus of kidney
N20.2	Calculus of kidney with calculus of ureter
R10.0	Acute abdomen
R10.9	Unspecified abdominal pain
R10.32	Left lower quadrant pain
R19.00	Intra-abdominal and pelvic swelling, mass and lump, unspecified site
R19.09	Other intra-abdominal and pelvic swelling, mass and lump

NCCI Column 2 Codes with Modifier Indicators: 01922^{N}, 36591^{N}, 36592^{N}, 76380^{A}

72193 Computed tomography, pelvis; with contrast material(s)

For a combined CT abdomen and pelvis study, see 74176...74178. To report 3D rendering, see 76376, 76377. For computed tomographic colonography, diagnostic, see 74261...74262. For computed tomographic colonography, screening, use 74263. Do not report 72192...72194 in conjunction with 74261...74263.

RVUs: Non-Facility Total 6.59 Facility Total 6.59

Medicare Policies: 150% payment adjustment for bilateral procedures does not apply, payment for assistant surgeon subject to documentation of medical necessity,

Linked ICD-10-CM Diagnosis Codes:

C53.9	Malignant neoplasm of cervix uteri, unspecified
C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified

C56.1 Malignant neoplasm of right ovary
C56.2 Malignant neoplasm of left ovary
C56.9 Malignant neoplasm of unspecified ovary
C57.00 Malignant neoplasm of unspecified fallopian tube
C57.01 Malignant neoplasm of right fallopian tube
C57.02 Malignant neoplasm of left fallopian tube
N94.89 Other specified conditions associated with female genital organs and menstrual cycle
R10.2 Pelvic and perineal pain
N95.0 Postmenopausal bleeding
R10.0 Acute abdomen
R10.9 Unspecified abdominal pain
R10.10 Upper abdominal pain, unspecified
R10.2 Pelvic and perineal pain
R10.30 Lower abdominal pain, unspecified
R10.84 Generalized abdominal pain
R19.00 Intra-abdominal and pelvic swelling, mass and lump, unspecified

NCCI Column 2 Codes with Modifier Indicators: 01922[N], 36000[A], 36005[A], 36011[A], 36406[A], 36410[A], 36591[N], 36592[N], 72192[N], 76000[A], 76380[A], 76942[A], 76970[A], 76998[A], 77001[A], 77002[A], 96360[A], 96365[A], 96372[A], 96374[A], 96375[A], 96376[A], 96377[A], J1642[A], J1644[A]

72194 Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections

For a combined CT abdomen and pelvis study, see 74176...74178. To report 3D rendering, see 76376, 76377. For computed tomographic colonography, diagnostic, see 74261...74262. For computed tomographic colonography, screening, use 74263. Do not report 72192...72194 in conjunction with 74261...74263.

RVUs: Non-Facility Total 7.48 Facility Total 7.48

Medicare Policies: 150% payment adjustment for bilateral procedures does not apply, payment for assistant surgeon subject to documentation of medical necessity,

Linked ICD-10-CM Diagnosis Codes:
C54.1 Malignant neoplasm of endometrium
C54.2 Malignant neoplasm of myometrium
C54.3 Malignant neoplasm of fundus uteri
C54.9 Malignant neoplasm of corpus uteri, unspecified
C56.1 Malignant neoplasm of right ovary
C56.2 Malignant neoplasm of left ovary
C56.9 Malignant neoplasm of unspecified ovary
N94.89 Other specified conditions associated with female genital organs and menstrual cycle
R10.2 Pelvic and perineal pain
R10.0 Acute abdomen
R10.9 Unspecified abdominal pain
R10.31 Right lower quadrant pain
R31.0 Gross hematuria
R31.1 Benign essential microscopic hematuria
R31.2 Other microscopic hematuria
R39.15 Urgency of urination

NCCI Column 2 Codes with Modifier Indicators: 01922[N], 36000[A], 36005[A], 36011[A], 36406[A], 36410[A], 36591[N], 36592[N], 72192[N], 72193[N], 76000[A], 76380[A], 76942[A], 76970[A], 76998[A], 77001[A], 77002[A], 96360[A], 96365[A], 96372[A], 96374[A], 96375[A], 96376[A], 96377[A], J1642[A], J1644[A]

72197 Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences

Do not report 72195, 72196, 72197 in conjunction with 74712, 74713. For magnetic resonance imaging of a fetus(es), see 74712, 74713.

RVUs: Non-Facility Total 11.24 Facility Total 11.24

Medicare Policies: 150% payment adjustment for bilateral procedures does not apply, payment for assistant surgeon subject to documentation of medical necessity,

PATHOLOGY & LABORATORY SERVICES

LABORATORY SECTION OVERVIEW

The fifth section of the CPT coding system is the laboratory section, which includes codes for pathology and laboratory services. Within each subsection, the CPT codes are arranged by the type of testing or service.

LABORATORY SUBSECTIONS

The PATHOLOGY AND LABORATORY section of CPT is divided into the following subsections:

Organ or Disease Oriented Panels	80048-80076
Drug Testing	80100-80103
Therapeutic Drug Assays	80150-80299
Evocative/Suppression Testing	80400-80440
Consultations (Clinical Pathology)	80500-80502
Urinalysis	81000-81099
Chemistry	82000-84999
Hematology and Coagulation	85002-85999
Immunology	86000-86849
Transfusion Medicine	86850-86999
Microbiology	87001-87999
Anatomic Pathology	88000-88099
Cytopathology	88104-88199
Cytogenetic Studies	88230-88299
Surgical Pathology	88300-88399
Transcutaneous Procedures	88400
Other Procedures	89049-89240
Reproductive Medicine Procedures	89250-89356

LABORATORY SERVICE MODIFIERS

Pathology and laboratory services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by adding the appropriate modifier to the basic service code. The addition of modifier -22 requires a special report. Modifiers commonly used to report PATHOLOGY and LABORATORY procedures include:

-22 Unusual services
-26 Professional component
-32 Mandated services
-52 Reduced services
-90 Reference (outside) laboratory

ORGAN OR DISEASE PANELS

Codes for organ-or disease-oriented panels were included in CPT due to the increased use of general screening programs by physicians, clinics, hospitals, and other health care facilities. Other codes in this section define profiles that combine laboratory tests under a problem-oriented classification.

There is a list of specific laboratory tests under each of the panel codes that defines the components of each panel. However, each laboratory typically establishes its own profile and provides a listing of the components of that panel performed by the laboratory with test results.

PATHOLOGY CONSULTATIONS

To be considered a clinical pathology consultation, the following components must be present:

- The consultation must be requested from an attending physician.
- The service must require additional medical interpretive judgment by the pathologist.
- The pathologist must render a written report.

Reporting of a test result(s) without medical interpretive judgment *is not* considered a clinical pathology consultation.

SURGICAL PATHOLOGY

Surgical pathology procedure codes include accession, handling, and reporting. The unit of service for codes 88300 through 88309 is the specimen. A specimen is defined as "tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."

CORRECT CODING GUIDELINES

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 80000-89999. 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 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.

Pathology and laboratory CPT codes describe services to evaluate specimens (e.g., blood, body fluid, tissue) obtained from patients in order to provide information to the treating physician.

Generally, pathology and laboratory specimens are prepared, screened, and/or tested by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed or interpreted personally by the pathologist. CPT coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist. If a pathologist provides significant, separately identifiable face-to-face patient care services that satisfy the criteria set forth in the E & M guidelines developed by CMS and the AMA, a pathologist may report the appropriate code from the evaluation and management section of the CPT coding system.

CMS policy prohibits separate payment for duplicate testing or testing for the same analyte by more than one methodology. (See definition of analyte in Section M (General Policy Statements), subsection ^{N}2.) If, after a test is ordered and performed, additional related procedures are necessary to provide or verify the result, these would be considered part of the ordered test. for example, if a patient with leukemia has a thrombocytopenia, and a manual platelet count (CPT code 85032) is performed in addition to the performance of an automated hemogram with automated platelet count (CPT code 85027), it would be inappropriate to report CPT codes 85032 and 85027 because the former provides verification for the automated hemogram and platelet count (CPT code 85027). As another example, if a patient has an abnormal test result and repeat performance of the test is done to verify the result, the test is reported as one (1) unit of service rather than two (2).

By contrast some laboratory tests if positive require additional separate follow-up testing which is implicit in the physician's order. for example, if an RBC antibody screen (CPT code 86850) is positive, the laboratory routinely proceeds to identify the RBC antibody. The latter testing is separately reportable. Similarly, if a urine culture is positive, the laboratory proceeds to organism identification testing which is separately reportable. In these cases, the initial positive results have limited clinical value without the additional testing. The additional testing is separately reportable because it is not performed to complete the

Linked ICD-10-CM Diagnosis Codes:
C54.1 Malignant neoplasm of endometrium
C54.2 Malignant neoplasm of myometrium
C54.3 Malignant neoplasm of fundus uteri
C54.9 Malignant neoplasm of corpus uteri, unspecified
C56.1 Malignant neoplasm of right ovary
C56.2 Malignant neoplasm of left ovary
C56.9 Malignant neoplasm of unspecified ovary

NCCI Column 2 Codes with Modifier Indicators: 80051[A], 82310[A], 82374[A], 82435[A], 82565[A], 82947[A], 84132[A], 84295[A], 84520[A]

80050 General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)

RVUs: Non-Facility Total 0.00 Facility Total 0.00

Medicare Policies: not covered by Medicare,

Linked ICD-10-CM Diagnosis Codes:
N95.1 Menopausal and female climacteric states
Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings

No NCCI edits apply to this code

80051 Electrolyte panel This panel must include the following: Carbon dioxide (bicarbonate) (82374) Chloride (82435) Potassium (84132) Sodium (84295)

Linked ICD-10-CM Diagnosis Codes:
N19 Unspecified kidney failure
N84.0 Polyp of corpus uteri
N84.8 Polyp of other parts of female genital tract
N84.9 Polyp of female genital tract, unspecified
N95.0 Postmenopausal bleeding

NCCI Column 2 Codes with Modifier Indicators: 82374[A], 82435[A], 84132[A], 84295[A]

80053 Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)

Linked ICD-10-CM Diagnosis Codes:
C54.1 Malignant neoplasm of endometrium
C54.2 Malignant neoplasm of myometrium
C54.3 Malignant neoplasm of fundus uteri
C54.9 Malignant neoplasm of corpus uteri, unspecified
C56.1 Malignant neoplasm of right ovary
C56.2 Malignant neoplasm of left ovary
C56.9 Malignant neoplasm of unspecified ovary

NCCI Column 2 Codes with Modifier Indicators: 80047[A], 80048[N], 80051[A], 80069[N], 80076[N], 82040[A], 82247[A], 82310[A], 82374[A], 82435[A], 82565[A], 82947[A], 84075[A], 84132[A], 84155[A], 84295[A], 84450[A], 84460[A], 84520[A]

80055 Obstetric panel This panel must include the following: Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)

When syphilis screening is performed using a treponemal antibody approach (86780), do not use 80055. Use the individual codes for the tests performed in the obstetric panel.

Linked ICD-10-CM Diagnosis Codes:
N91.0 Primary amenorrhea
N91.1 Secondary amenorrhea
N91.2 Amenorrhea, unspecified
Z33.1 Pregnant state, incidental
Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester

No NCCI edits apply to this code

80061 Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)

Linked ICD-10-CM Diagnosis Codes:
N95.1 Menopausal and female climacteric states
Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings

NCCI Column 2 Codes with Modifier Indicators: 80500[A], 80502[A], 82465[N], 83718[N], 83721[A], 84478[N]

80076 Hepatic function panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Bilirubin, direct (82248) Phosphatase, alkaline (84075) Protein, total (84155) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450)

Linked ICD-10-CM Diagnosis Codes:
C54.1 Malignant neoplasm of endometrium
C54.2 Malignant neoplasm of myometrium
C54.3 Malignant neoplasm of fundus uteri
C54.9 Malignant neoplasm of corpus uteri, unspecified
C56.1 Malignant neoplasm of right ovary
C56.2 Malignant neoplasm of left ovary
C56.9 Malignant neoplasm of unspecified ovary

NCCI Column 2 Codes with Modifier Indicators: 82040[A], 82247[A], 82248[A], 84075[A], 84155[A], 84450[A], 84460[A]

80305 Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay

Linked ICD-10-CM Diagnosis Codes:
Z12.4 Encounter for screening for malignant neoplasm of cervix
Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z36 Encounter for antenatal screening of mother

NCCI Column 2 Codes with Modifier Indicators: 80500[A], 80502[A], 81000[A], 81001[A], 81002[A], 81003[A], 81005[A], 82542[A], 82570[A], 83516[A], 83518[A], 83519[A], 83520[A], 83789[A], 83986[A], 84156[A], 84311[A], 96523[N]

80306 Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay

Linked ICD-10-CM Diagnosis Codes:
Z12.4 Encounter for screening for malignant neoplasm of cervix
Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z36 Encounter for antenatal screening of mother

NCCI Column 2 Codes with Modifier Indicators: 80305[N], 80500[A], 80502[A], 81000[A], 81001[A], 81002[A], 81003[A], 81005[A], 82542[A], 82570[A], 83516[A], 83518[A], 83519[A], 83520[A], 83789[A], 83986[A], 84156[A], 84311[A], 96523[N]

80307 Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay

Linked ICD-10-CM Diagnosis Codes:
Z12.4 Encounter for screening for malignant neoplasm of cervix

MEDICINE SERVICES

GUIDELINES

Medicine services include immunizations, therapeutic or diagnostic injections, psychiatric services, dialysis, ophthalmology services, specialty-specific diagnostic services, chemotherapy administration, physical medicine and rehabilitation services, and osteopathic and chiropractic services. In addition to the standard definitions and general instructions found in the Introduction to the CPT coding system, the Medicine section of the CPT coding system includes specific items that are unique to that section.

MULTIPLE PROCEDURES

Multiple medical procedures provided on the same date should be reported separately. For example, if a physician provides individual psychotherapy in addition to a hospital visit, the psychotherapy should be reported separately from the hospital visit.

SEPARATE PROCEDURES

Some of the procedures listed in the Medicine section are commonly performed or included as an integral part of a total service and therefore do not require or justify separate reporting. However, when such a procedure is provided without performing the basic service and is not directly related to other services, it may be reported as a "separate procedure."

SUBSECTION INFORMATION

The Medicine section of the CPT coding system is divided into subsections:

Immune Globulins	90281-90399
Immunization Administration for Vaccines or Toxoids	90465-90474
Vaccines, Toxoids	90476-90749
Therapeutic or Diagnostic Infusions (excluding chemotherapy)	90780-90781
Therapeutic, Prophylactic, or Diagnostic Injections	90782-90799
Psychiatry	90801-90899
Biofeedback	90901-90911
Dialysis	90935-90999
Gastroenterology	91000-91299
Ophthalmology	92002-92499
Special Otorhinolaryngologic Services	92502-92700
Cardiovascular	92950-93799
Noninvasive Vascular Diagnostic Studies	93875-93990
Pulmonary	94010-94799
Allergy and Clinical Immunology	95004-95199
Neurology and Neuromuscular Procedures	95805-95999
Central Nervous System Assessments or Tests	96100-96117
Chemotherapy Administration	96400-96549
Photodynamic Therapy	96567-96571
Special Dermatological Procedures	96900-96999
Physical Medicine and Rehabilitation	97001-97799
Osteopathic Manipulative Treatment	98925-98929
Chiropractic Manipulative Treatment	98940-98943
Special Services, Procedures, and Reports	99000-99091
Qualifying Circumstances for Anesthesia	99100-99140
Sedation With or Without Analgesia	99141-99142
Other Services and Procedures	99170-99199

Most of the subsections have special needs or instructions unique to that section that should be reviewed carefully before reporting.

UNLISTED SERVICE OR PROCEDURE

A Medicine service or procedure may be provided that is not listed in the current edition of the CPT coding system. If a specific CPT code cannot be found to report such a service, the appropriate "unlisted procedure" code may be used to report the service. A report that describes the unlisted service or procedure should be filed with the health insurance claim form.

MODIFIERS

Medicine services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of the appropriate modifier code. The following modifiers are frequently used with Medicine services:

-22 Unusual services

-26 Professional component

-51 Multiple procedures

This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures.

-52 Reduced services

-76 Repeat procedure by same physician

-77 Repeat procedure by another physician

-90 Reference (outside) laboratory

-99 Multiple modifiers

SPECIAL REPORT

A Medicine service that is unlisted in the CPT coding system, rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. When providing such services, you may need to provide additional documentation either routinely, for example, when reporting unlisted procedure codes or using modifier -22, or upon request from the health insurance carrier.

MATERIALS SUPPLIED BY PHYSICIAN

Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. List all drugs, trays, supplies, and materials provided. HCPCS Level II codes must be used instead of CPT codes when reporting supplies, materials, and/or injections provided to Medicare patients.

IMMUNE GLOBULINS, SERUM OR RECOMBINANT PRODUCTS

Codes 90281-90399 identify the serum globulins, extracted from human blood; or recombinant immune globulin products created in a laboratory through genetic modification of human and/or animal proteins. Both are reported in addition to the administration codes 96365-96368, 96372, 96374, 96375 as appropriate. Modifier 51 should not be reported with this section of products codes when performed with another procedure. The serum or recombinant globulin products listed here include broad-spectrum anti-infective immune globulins, antitoxins, various isoantibodies, and monoclonal antibodies.

IMMUNIZATION ADMINISTRATION FOR VACCINES/TOXOIDS

Immunization is the administration of a vaccine or toxoid to stimulate the immune system to provide protection against disease. Immunizations are usually given in conjunction with an evaluation and management service. When an immunization

Separate codes are available for combination vaccines (eg., DTP-Hib, DtaP-Hib, HepB-Hib). It is inappropriate to code each component of a combination vaccine separately. If a specific vaccine code is not available, the unlisted procedure code should be reported, until a new code becomes available.

MEDICAL GENETICS

96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family

For genetic counseling and education provided to an individual by a physician or other qualified health care professional who may report evaluation and management services, see the appropriate Evaluation and Management codes. For genetic counseling and education to a group by a physician or other qualified health care professional, use 99078. For education regarding genetic risks by a nonphysician to a group, see 98961, 98962. For genetic counseling and/or risk factor reduction intervention provided to patient(s) without symptoms or established disease, by a physician or other qualified health care professional who may report evaluation and management services, see 99401...99412.

RVUs: Non-Facility Total 1.30 Facility Total 1.30

Medicare Policies: bundled code; no separate payment made,

Linked ICD-10-CM Diagnosis Codes:

O09.511 Supervision of elderly primigravida, first trimester
O09.512 Supervision of elderly primigravida, second trimester
O09.513 Supervision of elderly primigravida, third trimester
O09.521 Supervision of elderly multigravida, first trimester
O09.522 Supervision of elderly multigravida, second trimester
O09.523 Supervision of elderly multigravida, third trimester
O26.11 Low weight gain in pregnancy, first trimester
O26.12 Low weight gain in pregnancy, second trimester
O26.13 Low weight gain in pregnancy, third trimester
O26.31 Retained intrauterine contraceptive device in pregnancy, first trimester
O26.32 Retained intrauterine contraceptive device in pregnancy, second trimester
O26.33 Retained intrauterine contraceptive device in pregnancy, third trimester
O26.41 Herpes gestationis, first trimester
O26.42 Herpes gestationis, second trimester
O26.43 Herpes gestationis, third trimester
O26.711 Subluxation of symphysis (pubis) in pregnancy, first trimester
O26.712 Subluxation of symphysis (pubis) in pregnancy, second trimester
O26.713 Subluxation of symphysis (pubis) in pregnancy, third trimester
O26.811 Pregnancy related exhaustion and fatigue, first trimester
O26.812 Pregnancy related exhaustion and fatigue, second trimester
O26.813 Pregnancy related exhaustion and fatigue, third trimester
O26.86 Pruritic urticarial papules and plaques of pregnancy (PUPPP)
O26.891 Other specified pregnancy related conditions, first trimester
O26.892 Other specified pregnancy related conditions, second trimester
O26.893 Other specified pregnancy related conditions, third trimester
O26.91 Pregnancy related conditions, unspecified, first trimester
O26.92 Pregnancy related conditions, unspecified, second trimester
O26.93 Pregnancy related conditions, unspecified, third trimester
O29.011 Aspiration pneumonitis due to anesthesia during pregnancy, first trimester
O29.012 Aspiration pneumonitis due to anesthesia during pregnancy, second trimester
O29.013 Aspiration pneumonitis due to anesthesia during pregnancy, third trimester
O29.021 Pressure collapse of lung due to anesthesia during pregnancy, first trimester
O29.022 Pressure collapse of lung due to anesthesia during pregnancy, second trimester
O29.023 Pressure collapse of lung due to anesthesia during pregnancy, third trimester
O29.091 Other pulmonary complications of anesthesia during pregnancy, first trimester
O29.092 Other pulmonary complications of anesthesia during pregnancy, second trimester
O29.093 Other pulmonary complications of anesthesia during pregnancy, third trimester
O29.111 Cardiac arrest due to anesthesia during pregnancy, first trimester
O29.112 Cardiac arrest due to anesthesia during pregnancy, second trimester
O29.113 Cardiac arrest due to anesthesia during pregnancy, third trimester
O29.121 Cardiac failure due to anesthesia during pregnancy, first trimester
O29.122 Cardiac failure due to anesthesia during pregnancy, second trimester
O29.123 Cardiac failure due to anesthesia during pregnancy, third trimester

O29.191	Other cardiac complications of anesthesia during pregnancy, first trimester
O29.192	Other cardiac complications of anesthesia during pregnancy, second trimester
O29.193	Other cardiac complications of anesthesia during pregnancy, third trimester
O29.211	Cerebral anoxia due to anesthesia during pregnancy, first trimester
O29.212	Cerebral anoxia due to anesthesia during pregnancy, second trimester
O29.213	Cerebral anoxia due to anesthesia during pregnancy, third trimester
O29.291	Other central nervous system complications of anesthesia during pregnancy, first trimester
O29.292	Other central nervous system complications of anesthesia during pregnancy, second trimester
O29.293	Other central nervous system complications of anesthesia during pregnancy, third trimester
O29.3X1	Toxic reaction to local anesthesia during pregnancy, first trimester
O29.3X2	Toxic reaction to local anesthesia during pregnancy, second trimester
O29.3X3	Toxic reaction to local anesthesia during pregnancy, third trimester
O29.41	Spinal and epidural anesthesia induced headache during pregnancy, first trimester
O29.42	Spinal and epidural anesthesia induced headache during pregnancy, second trimester
O29.43	Spinal and epidural anesthesia induced headache during pregnancy, third trimester
O29.5X1	Other complications of spinal and epidural anesthesia during pregnancy, first trimester
O29.5X2	Other complications of spinal and epidural anesthesia during pregnancy, second trimester
O29.5X3	Other complications of spinal and epidural anesthesia during pregnancy, third trimester
O29.61	Failed or difficult intubation for anesthesia during pregnancy, first trimester
O29.62	Failed or difficult intubation for anesthesia during pregnancy, second trimester
O29.63	Failed or difficult intubation for anesthesia during pregnancy, third trimester
O29.8X1	Other complications of anesthesia during pregnancy, first trimester
O29.8X2	Other complications of anesthesia during pregnancy, second trimester
O29.8X3	Other complications of anesthesia during pregnancy, third trimester
O29.91	Unspecified complication of anesthesia during pregnancy, first trimester
O29.92	Unspecified complication of anesthesia during pregnancy, second trimester
O29.93	Unspecified complication of anesthesia during pregnancy, third trimester
O99.351	Diseases of the nervous system complicating pregnancy, first trimester
O99.352	Diseases of the nervous system complicating pregnancy, second trimester
O99.353	Diseases of the nervous system complicating pregnancy, third trimester
O99.89	Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium
O35.1XX0	Maternal care for (suspected) chromosomal abnormality in fetus, not applicable or unspecified
O35.1XX1	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1
O35.1XX2	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 2
O35.1XX3	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 3
O35.1XX4	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 4
O35.1XX5	Maternal care for (suspected) chromosomal abnormality in fetus, fetus 5
O35.1XX9	Maternal care for (suspected) chromosomal abnormality in fetus, other fetus
O35.8XX0	Maternal care for other (suspected) fetal abnormality and damage, not applicable or unspecified
O35.8XX1	Maternal care for other (suspected) fetal abnormality and damage, fetus 1
O35.8XX2	Maternal care for other (suspected) fetal abnormality and damage, fetus 2
O35.8XX3	Maternal care for other (suspected) fetal abnormality and damage, fetus 3
O35.8XX4	Maternal care for other (suspected) fetal abnormality and damage, fetus 4
O35.8XX5	Maternal care for other (suspected) fetal abnormality and damage, fetus 5
O35.8XX9	Maternal care for other (suspected) fetal abnormality and damage, other fetus
Z31.5	Encounter for genetic counseling

NCCI Column 2 Codes with Modifier Indicators: 36591[N], 36592[N]

HYDRATION, THERAPEUTIC, PROPHYLACTIC, DIAGNOSTIC INJECTIONS AND INFUSIONS

CORRECT CODING GUIDELINES

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

HCPCS CODES

The HCPCS coding system is primarily used to bill Medicare for supplies, materials and injections. It is also used to bill for certain services and procedures which are not defined in CPT. HCPCS codes must be used when billing Medicare carriers, and in some states, Medicaid carriers. Some private insurance carriers also allow or mandate the use of HCPCS codes, mostly those that are processing Medicare claims.

STRUCTURE OF HCPCS

HCPCS is a systematic method for coding supplies, materials, injections and services performed by health care professionals. Each supply, material, injection or service is identified with a five digit alphanumeric code. With the HCPCS coding system, the supplies, materials and injections can be accurately identified and properly reimbursed.

SECTIONS

The main body of HCPCS National Level II codes is divided into sections. The supplies, materials, injections and services are presented in alphanumeric order within each section. The sections of HCPCS National Level II are:

Transportation Services	A0000-A0999
Medical And Surgical Supplies	A4000-A8999
Miscellaneous And Experimental	A9000-A9999
Enteral And Parenteral Therapy	B0000-B9999
Temporary Hospital Outpatient PPS	C0000-C9999
Durable Medical Equipment (DME)	E0000-E9999
Temporary Procedures & Professional Services	G0000-G9999
Rehabilitative Services	H0000-H9999
Drugs Administered Other Than Oral Method	J0000-J8999
Chemotherapy Drugs	J9000-J9999
Temporary Codes For DMERCS	K0000-K9999
Orthotic Procedures	L0000-L4999
Prosthetic Procedures	L5000-L9999
Medical Services	M0000-M9999
Pathology and Laboratory	P0000-P9999
Temporary Codes	Q0000-Q9999
Diagnostic Radiology Services	R0000-R9999
Private Payer Codes	S0000-S9999
State Medicaid Agency Codes	T0000-T9999
Vision Services	V0000-V2999
Hearing Services	V5000-V5999

INSTRUCTIONS FOR USE OF HCPCS NATIONAL LEVEL II CODES

A health care professional using the HCPCS National Level II codes selects the name of the material, supply, injection, service or procedure that most accurately identifies the service performed or supply delivered. Most often, HCPCS National Level II codes will be used instead of, or in addition to, CPT codes for visits, evaluation and management services, or other procedures performed at the same time or during the same visit. All services, procedures, supplies, materials and injections should be properly documented in the medical record.

The listing of a supply, material, injection or service and its code number in a specific section of HCPCS does not usually restrict its use to a specific profession or specialty group. However, there are some HCPCS National Level II codes that are by definition, profession or specialty specific.

GUIDELINES

Specific GUIDELINES are presented at the beginning of most of the sections. These GUIDELINES define items that are necessary to appropriately interpret and report the supplies, materials, injections, services and procedures listed in that section.

HCPCS MODIFIERS

A modifier provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. HCPCS modifiers may be used to indicate the following:

- A service was supervised by an anesthesiologist
- A service was performed by a specific health care professional, for example, a clinical psychologist, clinical social worker, nurse practitioner, or physician assistant.
- A service was provided as part of a specific government program
- A service was provided to a specific side of the body
- Equipment was purchased or rented
- Single or multiple patients were seen during nursing home visits

It is important to note that HCPCS National Level II modifiers can be combined with CPT codes when reporting services to Medicare.

UNLISTED PROCEDURE OR SERVICE

A service or procedure may be provided that is not listed in this edition of HCPCS National Level II. When reporting such a service, the appropriate "unlisted procedure" code may be used to indicate the service, identifying it by "special report" as defined below. HCPCS National Level II terminology is inconsistent in defining unlisted procedures. The procedure definition may include the term(s) "unlisted," "not otherwise classified," "unspecified," "unclassified," "other" and "miscellaneous." Prior to using these codes, try to determine if a Local Level III or CPT code is available. When an unlisted procedure code is used, the supply, material, injection, service or procedure must be described. Each of these unlisted procedure codes relates to a specific section of HCPCS National Level II and is presented in the GUIDELINES of that section.

SPECIAL REPORT

A supply, material, injection, service or procedure that is rarely provided, unusual, variable or new may require a special report for reimbursement purposes. Pertinent information should include an adequate definition or description of the nature, extent, and need for the supply, material, injection, service or procedure.

TRANSPORTATION SERVICES

CPT includes only one code to report transportation services. If the medical professional accompanied the patient on a long hospital transfer by ambulance, air ambulance, or long distance by common carrier, CPT code 99082 is reported in addition to any other services provided.

HCPCS Level II codes A0000-A0999 cover emergency ambulance service using surface, air, or water transport, plus non-emergency transportation services. There are also specific Ambulance Service Modifiers and a waiting-time table to be used with these codes.

corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.

12. 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.

13. If the code descriptor for a HCPCS/CPT code, CPT coding system 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-associated modifier if appropriate.

14. 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.

15. 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.

MEDICAL AND SURGICAL SUPPLIES

A4206 Syringe with needle, sterile, 1 cc or less, each

RVUs: Non-Facility Total 0.00 Facility Total 0.00

Medicare Policies:

Linked ICD-10-CM Diagnosis Codes:

C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
D64.9	Anemia, unspecified
D69.6	Thrombocytopenia, unspecified
E28.39	Other primary ovarian failure
N95.1	Menopausal and female climacteric states
Z30.40	Encounter for surveillance of contraceptives, unspecified

No NCCI edits apply to this code

A4208 Syringe with needle, sterile 3cc, each

RVUs: Non-Facility Total 0.00 Facility Total 0.00

Medicare Policies:

Linked ICD-10-CM Diagnosis Codes:

C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
C57.00	Malignant neoplasm of unspecified fallopian tube
C57.01	Malignant neoplasm of right fallopian tube
C57.02	Malignant neoplasm of left fallopian tube
E28.8	Other ovarian dysfunction
N95.1	Menopausal and female climacteric states
N95.8	Other specified menopausal and perimenopausal disorders
Z30.49	Encounter for surveillance of other contraceptives

No NCCI edits apply to this code

A4209 Syringe with needle, sterile 5cc or greater, each

RVUs: Non-Facility Total 0.00 Facility Total 0.00

Medicare Policies:

Linked ICD-10-CM Diagnosis Codes:

C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
C57.00	Malignant neoplasm of unspecified fallopian tube
C57.01	Malignant neoplasm of right fallopian tube
C57.02	Malignant neoplasm of left fallopian tube
D63.0	Anemia in neoplastic disease
N30.10	Interstitial cystitis (chronic) without hematuria
N30.11	Interstitial cystitis (chronic) with hematuria
N31.9	Neuromuscular dysfunction of bladder, unspecified
N39.3	Stress incontinence (female) (male)
N39.45	Continuous leakage
R11.2	Nausea with vomiting, unspecified

No NCCI edits apply to this code

A4210 Needle-free injection device, each

RVUs: Non-Facility Total 0.00 Facility Total 0.00

Medicare Policies: not covered by Medicare,

Linked ICD-10-CM Diagnosis Codes:

C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
N95.0	Postmenopausal bleeding

No NCCI edits apply to this code

A4212 Non-coring needle or stylet with or without catheter

RVUs: Non-Facility Total 0.00 Facility Total 0.00

Medicare Policies: bundled code; no separate payment made,

Linked ICD-10-CM Diagnosis Codes:

C48.2	Malignant neoplasm of peritoneum, unspecified
C52	Malignant neoplasm of vagina
C53.0	Malignant neoplasm of endocervix
C54.1	Malignant neoplasm of endometrium
C54.2	Malignant neoplasm of myometrium
C54.3	Malignant neoplasm of fundus uteri
C54.9	Malignant neoplasm of corpus uteri, unspecified
C56.1	Malignant neoplasm of right ovary
C56.2	Malignant neoplasm of left ovary
C56.9	Malignant neoplasm of unspecified ovary
C57.00	Malignant neoplasm of unspecified fallopian tube
C57.01	Malignant neoplasm of right fallopian tube
C57.02	Malignant neoplasm of left fallopian tube
D63.0	Anemia in neoplastic disease