

CHAPTER I

GENERAL CORRECT CODING POLICIES

MEDICAID NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

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Chapter I General Correct Coding Policies

A. Introduction

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

The 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, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) with 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.

The 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.

CMS established the National Correct Coding Initiative (NCCI) program to ensure the correct coding of services. The NCCI program includes 2 types of edits: National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUEs).

NCCI PTP edits prevent inappropriate payment of services that generally should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the 2 codes of an edit pair for the same beneficiary on the same date of service, the Column Two code is denied and the Column One code is eligible for payment. However, if it is clinically appropriate to use an NCCI PTP-associated modifier, both the Column One and Column Two codes are eligible for payment. (NCCI PTP-associated modifiers and their appropriate use are discussed in Section E of this chapter.)

For some NCCI PTP edits, the Column Two code is a component of a more comprehensive Column One code (e.g., an exploratory laparotomy is not a separately reportable service when an abdominal hysterectomy is performed). However, the comprehensive/component relationship is not true for many edits. For some edits, the code pair simply represents 2 codes that should not be reported together. For example, a provider shall not report a vaginal hysterectomy code and total abdominal hysterectomy code together because those procedures are considered to be mutually exclusive.

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In this chapter, sections B – R address various issues relating to NCCI PTP edits.

Medically Unlikely Edits (MUEs) prevent payment for a potentially inappropriate number/quantity of the same service on a single day. An MUE is the maximum UOS reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. For more information concerning MUEs, see Section V of this chapter.

The presence of a HCPCS/CPT code in an NCCI PTP edit, or of an MUE value for a HCPCS/CPT code does not necessarily indicate that the code is covered by any state Medicaid program or by all state Medicaid programs.

Claim lines that are denied due to an NCCI PTP edit or MUE may be resubmitted pursuant to the instructions established by each state Medicaid agency.

HCPCS/CPT codes that are denied based on NCCI PTP edits or MUEs may not be billed to Medicaid beneficiaries.

For information concerning the process for requesting reconsideration of NCCI PTP edits or MUEs, please refer to the Introduction Chapter of this Manual in the section titled Correspondence with CMS about the Medicaid NCCI program and its Contents.

In this Manual, many policies are described using the term “physician”. Unless indicated differently, the use of this term does not restrict the policies to physicians only but applies to all practitioners (including dentists), hospitals, or providers eligible to bill the relevant HCPCS/CPT codes pursuant to Medicaid program rules in each state. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them.

Physicians must report services correctly. This is true even in the absence of specific edits in the Medicaid NCCI program or their implementation in individual states. 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

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procedure)).

- A physician shall not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician shall report CPT code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code 46600 (Anoscopy; diagnostic...) plus CPT code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be used with an endoscopic procedure code.
- A physician shall not unbundle a bilateral procedure code into 2 unilateral procedure codes. For example, if a physician performs bilateral mammography, the physician shall report CPT code 77066 (Diagnostic mammography... bilateral). The physician shall not report CPT code 77065 (Diagnostic mammography... unilateral) with 2 UOS or 77065LT plus 77065RT.
- A physician shall not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician shall not report CPT code 49000 (Exploratory laparotomy...) when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).
- Providers/suppliers shall only report a biopsy separately when pathologic examination results in a decision to immediately proceed with a more extensive procedure (e.g., excision, destruction, removal) on the same lesion; or when performed on a separate lesion.
- Providers/suppliers shall not report a biopsy separately when it is to assess resection margins or to verify resectability; or when performed and submitted for pathologic evaluation completed after performing the more extensive procedure.

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

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

Physicians must report UOS correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician shall not report UOS for a HCPCS/CPT code using a criterion that differs from the code's defined unit of service. For example, some therapy codes are

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reported in fifteen-minute increments (e.g., CPT codes 97110-97124). Others are reported per session. A physician shall not report a “per session” code using fifteen-minute increments.

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

In 2010 the “CPT Manual” modified the numbering of codes so that the sequence of codes as they appear in the “CPT Manual” does not necessarily correspond to a sequential numbering of codes. In the “National Correct Coding Initiative Policy Manual for Medicaid Services,” use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the “CPT Manual”.

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

B. Coding Based on Standards of Medical/Surgical Practice

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

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

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

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

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

1. The component service is an accepted standard of care when performing the comprehensive service.
2. The component service is usually necessary to complete the comprehensive service.
3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

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

Medical Examples

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1. Since interpretation of cardiac rhythm is an integral component of the interpretation of an electrocardiogram, a rhythm strip is not separately reportable.
2. Since determination of ankle/brachial indices requires both upper and lower extremity Doppler studies, an upper extremity Doppler study is not separately reportable.
3. Since a cardiac stress test includes multiple electrocardiograms, an electrocardiogram is not separately reportable.

Surgical Examples

1. Since a myringotomy requires access to the tympanic membrane through the external auditory canal, removal of impacted cerumen from the external auditory canal is not separately reportable.
2. A bronchoscopy to assess the surgical field, anatomic landmarks, extent of disease, etc., is not separately reportable with an open pulmonary procedure such as a pulmonary lobectomy. By contrast, an initial diagnostic bronchoscopy is separately reportable. If the diagnostic bronchoscopy is performed at the same patient encounter as the open pulmonary procedure and does not duplicate an earlier diagnostic bronchoscopy by the same or another physician, the diagnostic bronchoscopy may be reported with modifier 58 appended to the open pulmonary procedure code to indicate a staged procedure. A cursory examination of the upper airway during a bronchoscopy with the bronchoscope shall not be reported separately as a laryngoscopy. However, separate endoscopies of anatomically distinct areas with different endoscopes may be reported separately (e.g., thoracoscopy and mediastinoscopy).
3. If an endoscopic procedure is performed at the same patient encounter as a non-endoscopic procedure to ensure no intraoperative injury occurred or verify the procedure was performed correctly, the endoscopic procedure is not separately reportable with the non-endoscopic procedure.
4. Since a colectomy requires exposure of the colon, the laparotomy and adhesiolysis to expose the colon are not separately reportable.

C. Medical/Surgical Package

Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work. Many NCCI PTP edits address coding issues related to the medical/surgical package.

The component elements of the pre-procedure and post-procedure work for each procedure are

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included component services of that procedure as a standard of medical/surgical practice. Some general guidelines follow:

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

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

Intravenous access (e.g., CPT codes 36000, 36400, 36410) is not separately reportable when performed with many types of procedures (e.g., surgical procedures, anesthesia procedures, radiological procedures requiring intravenous contrast, nuclear medicine procedures requiring intravenous radiopharmaceutical).

After vascular access is achieved, the access must be maintained by a slow infusion (e.g., saline) or injection of heparin or saline into a “lock.” Since these services are necessary for maintenance of the vascular access, they are not separately reportable with the vascular access CPT codes or procedures requiring vascular access as a standard of medical/surgical practice CPT codes 37211-37214 (Transcatheter therapy with infusion for thrombolysis) shall not be reported for use of an anticoagulant to maintain vascular access.

The global surgical package includes the administration of fluids and drugs during the operative procedure. The CPT codes 96360-96379 shall not be reported separately for that operative procedure. In an outpatient hospital facility, the administration of fluids and drugs during, or for, an operative procedure are included services and are not separately reportable (e.g., CPT codes 96360-96379).

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

Insertion of a central venous access device (e.g., central venous catheter, pulmonary artery catheter) requires passage of a catheter through central venous vessels and, in the case of a pulmonary artery catheter, through the right atrium and ventricle. These services often require the use of fluoroscopic guidance. Separate reporting of CPT codes for right heart catheterization, selective venous catheterization, or pulmonary artery catheterization is not appropriate when

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reporting a CPT code for insertion of a central venous access device. Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 77002) shall not be reported separately. (CPT code 76001 was deleted January 1, 2019.)

2. Under the NCCI program, separate reporting is not allowed for most anesthesia services by the same physician performing a surgical or medical procedure. (Refer to Section G for additional information.)

If it is medically reasonable and necessary that a separate provider (anesthesia practitioner) perform anesthesia services (e.g., monitored anesthesia care) for a surgical or medical procedure, a separate anesthesia service may be reported by the second provider.

In an outpatient hospital facility, the facility component of anesthesia services for a surgical or medical procedure is included in the code for the procedure itself and is therefore not separately reportable.

When anesthesia services are not separately reportable, physicians and facilities shall not unbundle components of anesthesia and report them in lieu of an anesthesia code. For example, the physician performing a surgical or medical procedure shall not report CPT codes 96360-96379 for the administration of anesthetic agents during the procedure.

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

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

5. **For more information regarding biopsies**, see Section A, Introduction.

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

7. If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement,

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incision, and drainage) is not separately reportable. Types of procedures to which this principle applies include, but are not limited to, -ectomy, -otomy, excision, resection, -plasty, insertion, revision, replacement, relocation, removal, or closure. For example, debridement of skin and subcutaneous tissue at the site of an abdominal incision made to perform an intra-abdominal procedure is not separately reportable. (See Chapter IV, Section I (General Policy Statements), paragraph 10 for guidance on reporting debridement with open fractures and dislocations.)

8. If removal, destruction, or other form of elimination of a lesion requires coincidental elimination of other pathology, only the primary procedure may be reported. For example, if an area of pilonidal disease contains an abscess, incision, and drainage of the abscess during the procedure to excise the area of pilonidal disease is not separately reportable.

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

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

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

12. If a laparoscopic procedure fails and is converted to an open procedure, the physician shall not report a diagnostic laparoscopy in lieu of the failed laparoscopic procedure. For example, if a laparoscopic cholecystectomy is converted to an open cholecystectomy, the physician shall not report the failed laparoscopic cholecystectomy or a diagnostic laparoscopy.

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

14. Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intra-operative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable:

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

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

D. Evaluation & Management (E&M) Services

Physician services can be categorized as either major surgical procedures, minor surgical procedures, non-surgical procedures, or Evaluation & Management (E&M) services. This section summarizes some of the rules for reporting E&M services in relation to major, minor, and non-surgical procedures. Even in the absence of NCCI PTP edits, providers shall bill for their services following these rules.

The Medicaid NCCI program uses the same definition of major and minor surgery procedures as the Medicare program.

- Major surgery – those codes with 090 Global Days in the “Medicare Physician Fee Schedule Database/Relative Value File”
- Minor surgery – those codes with 000 or 010 Global Days

The Medicare designation of global days can be found on the Medicare / National Physician Fee Schedule / PFS Relative Value Files page of the CMS Medicare webpage.

Select the calendar year and the file name with highest alphabetical suffix – e.g., RVUxxD – for the most recent version of the fee schedule. In the zip file, select document “PPRRVU...xlsx” and refer to “Column O, Global Days.”

An E&M service is separately reportable on the same date of service as a major or minor surgical procedure under limited circumstances.

If an E&M service is performed on the same date of service as a major surgical procedure **to decide** whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other E&M preoperative services on the same date of service as a major surgical procedure are included in the global surgical package for the procedure and are not separately reportable.

In general, E&M services performed on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the global surgical package for the minor surgical procedure and shall

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not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed, unless related to a complication of surgery, may be reported separately on the same day as a surgical procedure with modifier 24 (Unrelated E&M Service by the same Physician or Other Qualified Health Care Professional During a Postoperative Period).

Many non-surgical procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code. Other non-surgical procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most non-surgical procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the non-surgical procedure but cannot include any work inherent in the non-surgical procedure, supervision of others performing the non-surgical procedure, or time for interpreting the result of the non-surgical procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as a non-surgical procedure is correct coding.

E. Modifiers and Modifier Indicators

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

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

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Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

Anatomic modifiers : E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI

Global surgery modifiers: 24, 25, 57, 58, 78, 79

Other modifiers: 27, 59, 91, XE, XP, XS, XU

These modifiers are referred to as NCCI PTP-associated modifiers.

Modifiers 22 (increased procedural services), 76 (repeat procedure or service by same physician), and 77 (repeat procedure by another physician) are not NCCI PTP-associated modifiers. Use of any of these modifiers does not bypass an NCCI PTP edit.

Each NCCI PTP edit has an assigned modifier indicator. A modifier indicator of “0” indicates that an NCCI PTP edit will not be bypassed even if an NCCI PTP-associated modifier is appended to 1 of the codes. A modifier indicator of “1” indicates that an NCCI PTP-associated modifier may be used to bypass an edit under appropriate circumstances. However, if both codes in the edit pair have the same anatomic modifier and neither code has modifier 58, 59, 78, 79, XE, XP, XS, or XU, the PTP edit is not bypassed. A modifier indicator of “9” indicates that the edit has been deleted, and the modifier indicator is not relevant. The Correct Coding Modifier Indicator can be found in the files containing MCD NCCI PTP edits on the CMS webpage.

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

A separate and distinct E&M service is billed with modifier 24, 25, or 57. Modifiers 24, 25, and 57 should only be appended to an E&M code (99202–99499, 92002–92014), regardless of whether the E&M code is the Column One or Column Two code. They should never be appended to other types of codes, such as surgery codes. Modifiers 24 and 57 are used with E&M codes only when the related code is a surgery service.

States may implement edits that deny or reject claim lines in which a modifier is inappropriately

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appended to a HCPCS/CPT code (e.g., use of modifier 24, 25, or 57 with a non-E&M code). However, if they do, those edits must be applied to claims **before** the application of NCCI edits and any resulting denials or rejections must be characterized as being due to state-specific edits, not NCCI edits, and they should not be reported as NCCI savings.

The appropriate use of most of the NCCI PTP-associated modifiers is straightforward. However, further explanation is provided regarding modifiers 25, 58, 59, XE, XP, XS, and XU.

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

b. **Modifier 58:** Modifier 58 is defined by the “CPT Manual” as a “Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period.” It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI PTP-associated modifiers.

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

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

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

c. **Modifier 59:** Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. With regard to NCCI PTP edits, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters. It shall

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only be used if no other modifier more appropriately describes the relationships of the 2 or more procedure codes (See Section E for modifiers -X{EPSU}). The “CPT Manual” defines modifier 59 as follows:

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

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used. Modifier “-59” shall not be used with code 77427 (Radiation treatment management, 5 treatments).

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

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe “different procedure or surgery.” The code descriptors of the 2 codes of a code pair edit consisting of 2 surgical procedures, 2 non-surgical therapeutic procedures, and/or 2 diagnostic procedures usually represent different procedures or surgeries. The edit indicates that the 2 procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the 2 codes being different procedures/surgeries. However, if the 2 procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifiers 59 or -X{EPSU} may be appended to indicate that they are different procedures/surgeries on that date of service.

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

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

1. If a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, the 2 procedures may be reported with modifier 59. However, if the diagnostic procedure is an inherent component of the surgical procedure, it cannot be reported separately. If the diagnostic procedure follows the surgical or non-surgical therapeutic procedure at the same patient encounter, modifier 59 may be used if appropriate.

2. If a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure at the same patient encounter and the post-procedure diagnostic procedure is not an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, the 2 procedures may be reported with modifier 59 if appropriate.

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

4. There is an appropriate use for modifiers 59 or -X{ES} that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If 2 separate and distinct timed services are provided in separate and distinct time blocks, modifier 59 may be used to identify the services. The separate and distinct time blocks for the 2 services may be sequential to 1 another or split. When the 2 services are split, the time block for 1 service may be followed by a time block for the second service followed by another time block for the first service. All Medicaid NCCI rules for reporting timed services are applicable. For example, the total time is calculated for all related timed services performed. The number of reportable UOS is based on the total time, and these UOS are allocated between the HCPCS/CPT codes for the individual services performed. The practitioner is not permitted to perform multiple services, each for the minimal reportable time, and report each of these as separate UOS (e.g., A physician or therapist performs 8 minutes of neuromuscular reeducation (CPT code 97112) and 8 minutes of therapeutic exercises (CPT code 97110). Since the physician or therapist performed 16 minutes of related timed services, only 1 unit of service may be reported for 1, not each, of these codes).

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous

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structures in the same organ or anatomic region. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site.

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

Example 1

The NCCI PTP edit with Column One CPT code 38221 (Diagnostic bone marrow biopsies) and Column Two CPT code 38220 (Diagnostic bone marrow, aspiration(s)) includes 2 distinct procedures when performed at separate anatomic sites (e.g., contralateral iliac bones) or separate patient encounters. In these circumstances, it would be acceptable to use modifier 59. However, if both 38221 and 38220 are performed on the same iliac bone at the same patient encounter which is the usual practice, modifier 59 shall NOT be used. Although the NCCI program does not allow separate reporting of CPT code 38220 with CPT code 38221 when bone marrow aspiration and biopsy are performed on the same iliac bone at a single patient encounter, a physician may report CPT code 38222 (Diagnostic bone marrow; biopsy(ies) and aspiration(s)).

Example 2

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

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

XE – “Separate encounter, A service that is distinct because it occurred during a separate encounter.” This modifier shall only be used to describe separate encounters on the same date of service.

XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”

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XS – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”

XU – “Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service”

F. Standard Preparation/Monitoring Services for Anesthesia

With few exceptions, anesthesia HCPCS/CPT codes do not specify the mode of anesthesia (e.g., regional nerve block, monitored anesthesia care, general) for a particular procedure. Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service HCPCS/CPT codes when performed in association with the anesthesia service. However, if the provider/supplier of the anesthesia service performs one or more of these services before and unrelated to the anticipated anesthesia service or after the patient is released from the anesthesia practitioner’s postoperative care, the service may be separately reportable with modifiers 59 or -X{EU}. Refer to Chapter 2 for additional information concerning anesthesia coding.

G. Anesthesia Service Included in the Surgical Procedure

With the exception of moderate conscious sedation, the NCCI program does not allow separate reporting of anesthesia for a medical or surgical procedure when it is provided by the physician performing the procedure. Anesthesia services are included in the HCPCS/CPT code for the medical or surgical procedure itself. Likewise, under OPPS, payment for the anesthesia service is generally included in the payment for the medical or surgical procedure. For example, separate reporting is not allowed for the physician’s performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. However, the NCCI program generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

The CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia shall not be reported in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician. Examples of improperly reported services that are bundled into the anesthesia service when anesthesia is provided by the physician performing the medical or surgical procedure include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), intravenous infusion/injection (CPT codes 96360-96368, 96374-96379) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042). However, if these services are not related to the delivery of an anesthetic agent or are not an inherent component of the procedure or global service, they may be reported separately.

The physician performing a surgical or medical procedure shall not report an

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epidural/subarachnoid injection (CPT codes 62320-62327) or nerve block (CPT codes 64400-64530) for anesthesia for that procedure.

H. HCPCS/CPT Procedure Code Definition

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

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

CPT code 70120	Radiologic examination, mastoids; less than 3 views per side
CPT code 70130	Radiologic examination, mastoids ; complete, minimum of 3 views per side

The portion of the descriptor preceding the semicolon (Radiologic examination, mastoids) is common to both CPT codes 70120 and 70130. The difference between the 2 codes is the portion of the descriptors following the semicolon. Often as in this case, 2 codes from a family may not be reported separately. A physician cannot report CPT codes 70120 and 70130 for a procedure performed on ipsilateral mastoids at the same patient encounter. It is important to recognize, however, that there are numerous circumstances when it may be appropriate to report more than one code from a family of codes. For example, CPT codes 70120 and 70130 may be reported separately if the 2 procedures are performed on contralateral mastoids or at 2 separate patient encounters on the same date of service.

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

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

- a. A “partial” procedure is not separately reportable with a “complete” procedure.
- b. A “partial” procedure is not separately reportable with a “total” procedure.
- c. A “unilateral” procedure is not separately reportable with a “bilateral” procedure.
- d. A “single” procedure is not separately reportable with a “multiple” procedure.

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- e. A “with” procedure is not separately reportable with a “without” procedure.
- f. An “initial” procedure is not separately reportable with a “subsequent” procedure.

I. CPT Manual and NCCI Program Instructions

The “CPT Manual” includes coding instructions which may be found in the “Introduction,” individual chapters, and appendices. In individual chapters, the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter, or after specific CPT codes. Physicians should follow “CPT Manual” instructions unless the state has provided different coding or reporting instructions.

The AMA publishes “CPT Assistant” which contains coding guidelines. The NCCI program does not review nor approve the information in this publication. In the development of NCCI PTP edits, the NCCI program occasionally disagrees with the information in this publication. If a physician uses information from CPT Assistant to report services rendered to Medicaid patients, it is possible that state Medicaid agencies or fiscal agent may use different criteria to process claims.

J. “Separate Procedure” Definition

If a CPT code descriptor includes the term “separate procedure,” the CPT code may not be reported separately with a related procedure.

The NCCI program interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region, often through the same skin incision, orifice, or surgical approach.

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

K. Family of Codes

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

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

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

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

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

L. More Extensive Procedure

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

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

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

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

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

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

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

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

M. Sequential Procedure

Some surgical procedures may be performed by different surgical approaches. If an initial surgical approach to a procedure fails and a second surgical approach is used at the same patient encounter, only the HCPCS/CPT code corresponding to the second surgical approach may be reported. If there are different HCPCS/CPT codes for the 2 different surgical approaches, the 2 procedures are considered “sequential,” and only the HCPCS/CPT code corresponding to the second surgical approach may be reported. For example, a physician may begin a cholecystectomy procedure using a laparoscopic approach and have to convert the procedure to an open abdominal approach. Only the CPT code for the open cholecystectomy may be reported. The CPT code for the failed laparoscopic cholecystectomy is not separately reportable.

N. Laboratory Panel

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

O. Misuse of Column Two Code with Column One Code

The NCCI program defines certain groups of HCPCS/CPT codes that should not be reported together. Edits based on these instructions are often included as misuse of a Column Two code with a Column One code.

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

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1. Three or more HCPCS/CPT codes may be reported on the same date of service. Although the Column Two code is misused if reported as a service associated with the Column One code, the Column Two code may be appropriately reported with a third HCPCS/CPT code reported on the same date of service. For example, the NCCI program limits separate payment for use of the operating microscope for microsurgical techniques (CPT code 69990) to a group of procedures listed in the National Correct Coding Initiative Policy Manual for Medicaid Services, Chapter 8, Section F. There are NCCI PTP edits with Column One codes of surgical procedures not listed in this section of the Manual and Column Two CPT code of 69990. Some of these edits allow use of NCCI PTP-associated modifiers because the 2 services listed in the edit may be performed at the same patient encounter as a third procedure for which CPT code 69990 is separately reportable.

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

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

P. Mutually Exclusive Procedures

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

Pairs of HCPCS/CPT codes that are mutually exclusive of 1 another based either on the HCPCS/CPT code descriptors or the medical impossibility/improbability that the 2 procedures could be performed at the same patient encounter are included in the NCCI PTP edit tables.

Many of these edits allow the use of NCCI PTP-associated modifiers. For example, the 2 procedures of a code pair edit may be performed at different anatomic sites (e.g., contralateral eyes) or separate patient encounters on the same date of service.

Q. Gender-Specific Procedures

The descriptor of some HCPCS/CPT codes includes a gender-specific restriction on the use of the code. HCPCS/CPT codes specific for one gender should not be reported with HCPCS/CPT codes for the opposite gender. For example, CPT code 53210 describes a total urethrectomy including cystostomy in a female, and CPT code 53215 describes the same procedure in a male. Since the patient cannot have both the male and female procedures performed, the 2 CPT codes cannot be reported together.

R. Add-On Codes

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

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

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

The HCPCS/CPT codes that are not designated as AOCs shall not be misused as an AOC to report a supplemental service. A HCPCS/CPT code may be reported if and only if all services described by the CPT code are performed. A HCPCS/CPT code shall not be reported with another service because a portion of the service described by the HCPCS/CPT code was performed with the other procedure. For example, if an ejection fraction is estimated from an echocardiogram study, it would be inappropriate to additionally report CPT code 78472 (Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing) with the echocardiography (CPT code 93307). Although the procedure described by CPT code 78472 includes an ejection fraction, it is measured by gated equilibrium with a radionuclide which is not used in echocardiography.

S. Reserved for Future Use

T. Unlisted Procedure Codes

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

U. Reserved for Future Use

V. Medically Unlikely Edits (MUEs)

MUEs are unit of service edits that were established by CMS to prevent payment for an inappropriate number/quantity of the same service. **An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. is the maximum number of UOS under most circumstances allowable by the same provider for the same beneficiary on the same date of service.**

All practitioner, ambulatory surgical center (ASC), outpatient hospital facility, and provider claims submitted to state Medicaid agencies or fiscal agents are tested against MUEs. Each line of a claim is adjudicated separately against the MUE value for the HCPCS/CPT code reported on that line.

If the unit of service on that line exceeds the MUE value, the entire line is denied.

If appropriate use of CPT modifiers (i.e., 59 or -X{EPSU}, 76, 77, 91, anatomic) causes the same HCPCS/CPT code to appear on separate lines of a claim, each line is separately adjudicated against the MUE value for that HCPCS/CPT code. State Medicaid agencies or fiscal agents may have rules limiting use of these modifiers with some HCPCS/CPT codes.

The MUE value for each HCPCS/CPT code is based on one or more of the following criteria: (Note: For situations in which Medicare policy or data was used to establish a Medicaid MUE value, CMS has determined that it is equally appropriate as NCCI policy for Medicaid.)

1. Anatomic considerations may limit UOS based on anatomic structures. For example:
 - a. The MUE value for an appendectomy is “1” since there is only 1 appendix.

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- b. The MUE for a knee brace is “2” because there are 2 knees and Medicare policy does not cover back-up equipment.
- c. The MUE value for a lumbar spine procedure reported per lumbar vertebra or per lumbar interspace cannot exceed “5” since there are only 5 lumbar vertebrae or interspaces.
- d. The MUE value for a procedure reported per lung lobe cannot exceed “5” since there are only 5 lung lobes (3 in right lung and 2 in left lung).

2. The CPT code descriptors/CPT coding instructions in the “CPT Manual” may limit UOS. For example:

- a. A procedure described as the “initial 30 minutes” would have an MUE value of “1” because of the use of the term “initial.” A different code may be reported for additional time.
- b. If a code descriptor uses the plural form of the procedure, it must not be reported with multiple UOS. For example, if the code descriptor states “biopsies,” the code is reported with “1” unit of service regardless of the number of biopsies performed.
- c. The MUE value for a procedure with “per day,” “per week,” or “per month” in its code descriptor is “1” because MUEs are based on number of services per day of service.
- d. The MUE value of a code for a procedure described as “unilateral” is “1” if there is a different code for the procedure described as “bilateral.”
- e. The code descriptors of a family of codes may define different levels of service, each having an MUE of “1.” For example, CPT codes 78102-78104 describe bone marrow imaging. CPT code 78102 is reported for imaging a “limited area.” CPT code 78103 is reported for imaging “multiple areas.” CPT code 78104 is reported for imaging the “whole body.”
- f. The MUE value for CPT code 86021(Antibody identification; leukocyte antibodies) is “1” because the code descriptor is plural including testing for any and all leukocyte antibodies. On a single date of service only one specimen from a patient would be tested for leukocyte antibodies.
- g. When reporting codes, it is important to assure the accuracy of coding and the correct UOS by selecting a code that accurately identifies the service performed based on factors including but not limited to, the route of administration. For example, for intravitreal injection of bevacizumab, select an intravitreal code (e.g., C9257) rather than an intravenous code (e.g., J9035).

- 3. Edits based on the NCCI program policies may limit UOS. For example:
 - a. The MUE value for a surgical or diagnostic procedure may be based on the bilateral surgery indicator on the Medicare Physician Fee Schedule Database (MPFSDB).
 - i. If the bilateral surgery indicator is “0,” a bilateral procedure must be reported with “1” unit of service. There is no additional payment for the code if reported as a unilateral or bilateral procedure because of

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anatomy or physiology. Alternatively, the code descriptor may specifically state that the procedure is a unilateral procedure, and there is a separate code for a bilateral procedure.

- ii. If the bilateral surgery indicator is “1,” a bilateral surgical procedure must be reported with “1” unit of service and modifier 50 (bilateral modifier). A bilateral diagnostic procedure may be reported with “1” unit of service and modifier 50 on 1 claim line, or “1” unit of service and modifier RT on 1 claim line plus “1” unit of service and modifier LT on a second claim line.
- iii. If the bilateral surgery indicator is “2,” a bilateral procedure must be reported with “1” unit of service. The procedure is priced as a bilateral procedure because (1) the code descriptor defines the procedure as bilateral; (2) the code descriptor states that the procedure is performed unilaterally or bilaterally; or (3) the procedure is usually performed as a bilateral procedure.
- iv. If the bilateral surgery indicator is “3,” a bilateral surgical procedure must be reported with “1” unit of service and modifier 50 (bilateral modifier). A bilateral diagnostic procedure may be reported with “2” UOS on 1 claim line, “1” unit of service and modifier 50 on 1 claim line, or “1” unit of service and modifier RT on 1 claim line plus “1” unit of service and modifier LT on a second claim line.
- b. The MUE value for a code may be “1” because the code descriptor does not specify a unit of service, and NCCI policy considers the default UOS to be “per day.”
- c. The MUE value for a code may be “0” for reasons including but not limited to the following:
 - i. The outpatient hospital (OPH) MUE may be “0” for a surgical or non-surgical therapeutic procedure code(s) that Medicare has determined would not be performed in an outpatient setting. The corresponding practitioner (PRA) MUE will not be “0.”
 - ii. The OPH MUE may be “0” for an Evaluation & Management code that specifies an inpatient hospital service. The corresponding PRA MUE will not be “0.”
 - iii. The MUE for a drug may be “0” if it is no longer being manufactured.
 - iv. The MUEs are “0” for compounded nebulizer drugs based on Medicare policy.
 - v. The DME MUE for an injectable drug may be “0” if Medicare has determined that it should not be administered in the home setting.
- 4. The nature of an analyte may limit UOS and is in general determined by:
 - a. The nature of the specimen may limit the UOS. For example, CPT code 82575 describes a creatinine clearance test and has an MUE of “1” because the test requires a twenty-four-hour urine collection; or
 - b. The physiology, pathophysiology, or clinical application of the analyte is such that a maximum unit of service for a single date of service can be determined. For example, the MUE for CPT code 82747 (RBC folic acid) is “1” because

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the test result would not be expected to change during a single day, and thus it is not necessary to perform the test more than once on a single date of service.

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

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

6. The nature of equipment may limit UOS and is in general determined by the number of items of equipment that would be used. For example, the MUE value for a wheelchair code is “1” because only 1 wheelchair is used at 1 time and Medicare policy does not cover back-up equipment.

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

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

9. The NCCI program uses Medicare claims data to establish some Medicaid MUE values and to evaluate reconsideration requests. Submitted and paid claims data (100%) from a 6-month period is used to ascertain the distribution pattern of UOS typically reported for a given HCPCS/CPT code.

HCPCS J code and drug related C and Q code MUEs are based on prescribing information and 100% Medicare claims data for a 6-month period of time. Using the prescribing information, the highest total daily dose for each drug was determined. This dose and its corresponding UOS were evaluated against paid and submitted claims data. Some of the guiding principles used in developing these edits are as follows:

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

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

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surface area (BSA), a dose based on a BSA range of 2.4-3.0 square meters was evaluated against claims data.

(3) For drugs where the maximum daily dose is based on patient response or need, prescribing information and claims data were used to establish MUE values.

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

(5) The MUE values for some drug codes are set to “0.” The rationale for such value includes but is not limited to discontinued manufacture of drug and non-FDA approved compounded drug.

Non-drug-related HCPCS/CPT codes may be assigned an MUE of “0” for a variety of reasons including, but not limited to, outpatient hospital MUE value for a surgical procedure only performed as an inpatient procedure.

The MUE files on the Medicaid.gov NCCI website display an “Edit Rationale” for each HCPCS/CPT code. Although an MUE may be based on several rationales, only one is displayed on the website. One of the listed rationales is Medicare “Data.” This rationale indicates that 100% claims data from a 6-month period of time was the major factor in determining the MUE value. If a physician appeals an MUE denial for a HCPCS/CPT code where the MUE is based on Medicare “Data,” the reviewer will usually confirm that (1) the correct code is reported; (2) the correct UOS are used; (3) the number of reported UOS were performed; and (4) all UOS were medically reasonable and necessary.

Many surgical procedures may be performed bilaterally. The NCCI program requires that bilateral surgical procedures may be reported using modifier 50 with one unit of service unless the code descriptor defines the procedure as “bilateral.” If the code descriptor defines the procedure as a “bilateral” procedure, it shall be reported with one unit of service without modifier 50. If a bilateral surgical procedure is performed at different sites bilaterally, one unit of service may be reported for each site. That is, the HCPCS/CPT code may be reported with modifier 50 and one unit of service for each site at which it was performed bilaterally.

Some state Medicaid agencies or fiscal agents allow providers to report repetitive services performed over a range of dates on a single line of a claim with multiple UOS. If a provider reports services in this fashion, the provider should report the “from date” and “to date” on the claim line. Contractors are instructed to divide the UOS reported on the claim line by the number of days in the date span and round to the nearest whole number. This number is compared to the MUE value for the code on the claim line. A denial of services due to an MUE is a coding denial, not a medical necessity denial. HCPCS/CPT codes that are denied based on MUEs may not be billed to Medicaid beneficiaries.

Most MUE values are set so that a provider/supplier would only very occasionally have a claim line denied. If a provider encounters a code with frequent denials due to the MUE or frequent use

of a CPT modifier to bypass the MUE, the provider should consider the following: (1) Is the HCPCS/CPT code being used correctly? (2) Is the unit of service being counted correctly? (3) Are all reported services medically reasonable and necessary? and (4) Why does the provider's practice differ from national patterns? A provider may choose to discuss these questions with the local Medicaid contractor or a national health care organization whose members frequently perform the procedure.

Medicaid MUE values are published on the CMS Medicaid NCCI webpage.

Although there are currently no confidential Medicaid MUEs, CMS reserves the right to develop confidential Medicaid MUEs in the future. If that occurs, the confidential MUE values shall not be published in oral or written form by any party that acquires one or more of them.

The MUEs do not define the UOS that are allowable for individual patients. Although the MUE value for some codes may represent the commonly reported UOS service (e.g., MUE of "1" for appendectomy), the usual UOS for many HCPCS/CPT codes is less than the MUE value. Claims reporting UOS less than or equal to the MUE value may be subject to review by state Medicaid agencies or fiscal agents, Unified Program Integrity Contractor (UPICS), Recovery Audit Contractors (RACs), Medicaid Fraud Control Units, and the Department of Justice (DOJ).

Since MUEs are coding edits rather than medical necessity edits, state Medicaid agencies or fiscal agents may have UOS edits that are more restrictive than MUEs. In such cases, these more restrictive edits would be applied to the claim.

W. Medicaid Add-On Code (AOC) edits

Medicaid Add-On Code (AOC) edits are optional for use by the state Medicaid agencies at this time rather than mandatory.

For more information about Medicaid AOCs, please see the Technical Guidance Manual Section 7.8.